

Chapter 4

Queensland children and young people, 2005–06

Key issues

- In the 12-month period between July 2005 and June 2006, 426 children and young people died. Almost 22% of these deaths were due to external causes.
- The Commission has identified 4 cases of deaths of young children where there appeared to be ongoing child protection concerns in the family, that have not been subject to a statutory review. The very young age of these children may offer a partial explanation of why these cases had not yet come to the attention of the Department of Child Safety (DChS).⁸⁰ The Commission has developed recommendations in relation to this issue for the consideration of the DChS.
- Indigenous children die from external causes at a higher rate than non-Indigenous children. In 2005–06, Indigenous children died from external causes at a rate of 21.6 per 100,000 Indigenous children aged 0–17 years, compared with 9.0 deaths per 100,000 children in the non-Indigenous population.

Leading cause of death by age:

- Infants under 1 year accounted for 263 deaths; 73% of these deaths occurred within the first 28 days of life.
- Children aged 1–4 years accounted for 55 deaths; drowning was the leading cause of death, accounting for 15 deaths.
- Children aged 5–9 years accounted for 34 deaths; natural deaths accounted for 13 deaths (neoplasms and diseases of the nervous system). Transport incidents then accounted for 5 deaths in this age group.
- Children aged 10–14 years accounted for 30 deaths; suicide (5 deaths) and transport incidents (5 deaths) were the leading causes of death for children in this age group.
- Adolescents aged 15–17 years accounted for 44 deaths; 21 of those deaths were the result of transport incidents, while 10 were the result of suicide.

Profile of Queensland children and young people

The Commission for Children and Young People and Child Guardian's annual publication *Snapshot: Children and young people in Queensland*⁸¹ compiles data on a variety of issues including child protection, families, health, education and social issues. Snapshot helps to present a comprehensive picture of the characteristics of Queensland's children and young people.

The following is a summary of some of the data presented in the most recent *Snapshot* about Queensland's population of children and young people.⁸²

Population

Of the total Queensland population in 2005, children and young people aged from birth to 17 years made up 24.6%.

Over 520,000 of these were aged 0–9 years (522,655 individuals or 13.2% of the population),

⁸⁰ In the 4 cases identified in the 2005–06 reporting period, the deceased child was aged 1 year or less, and in 3 of the 4 cases the deceased was a very young infant.

⁸¹ *Snapshot* is compiled by the Commission's Research Unit, which is separate from the Child Death Review Team.

⁸² Commission for Children and Young People and Child Guardian, *Snapshot 2006: Children and young people in Queensland* (Brisbane: Commission for Children and Young People and Child Guardian, 2006). A copy of Snapshot is accessible through the Commission's website, www.ccyipc.qld.gov.au

while young people aged 10–17 years comprised 11.4% of the population (450,820 individuals aged 10–17 years).

Indigenous children

In 2005, Indigenous children and young people comprised 6.3% of all young people under the age of 18 in Queensland.

Of the total Indigenous population in Queensland, 45.2% were under the age of 18. In contrast, 23.8% of the non-Indigenous population were under the age of 18. Young people made up a much higher proportion of the Indigenous population than of the non-Indigenous population.

Children born overseas

Of children aged 0–14 years in Queensland, only 6% were born in a country other than Australia, with New Zealand being the most common overseas place of birth.

Family

The majority (69%) of Queensland children aged 0–17 years lived in intact-couple families. A further 10% lived in step or blended families. In Queensland, 19% of children under the age of 18 lived with single mothers and almost 2% with single fathers.

The proportion of children living in single-parent families throughout Australia is increasing. In 1987, 12.7% of Australian children under the age of 15 lived in single-parent families. This had increased to 18.9% by 2005.

Births and family size

Birth numbers have increased slightly, with 25,586 males and 24,354 females born in Queensland in 2004. This is up from 24,847 male births and 23,495 female births in 2003.

The number of children per family varied by type of family, with an average of 1.9 children in intact-couple families, 2.3 in step or blended families and 1.6 in single-parent families.

Age of parents⁸³

The majority of babies born in 2003 were born to mothers aged 25–34 years (61%). This was also the most common age group for fathers of new babies (54%).

Parents of Indigenous babies tended to be younger, with 55% of babies born to mothers aged 20–29 years and 43% born with fathers aged 20–29.

Eighteen percent of Indigenous babies were born to a teenage mother, compared with 6% in the general Queensland population.⁸⁴

Family income

Single-parent families tended to have much lower incomes than other families. Whereas only 14% of couple families had a weekly income less than \$600 (gross), 63% of single-parent families earned less than \$600 per week.

Indigenous families also had lower incomes than other families, with 45% of Indigenous families earning less than \$600 per week, compared with 31% of non-Indigenous families. Further, as Indigenous families were larger, with on average 3.6 people per Indigenous family compared with 2.9 per non-Indigenous family, the disparity in lower incomes would be more marked on a per-person basis.

Remote births⁸⁵

In Queensland 20% of Indigenous babies are born in remote or very remote areas, compared with only 4% of non-Indigenous babies.

Premature births

In 2004, 7.1% of babies had a low birth weight and 8.6% were born before 37 weeks gestation. The proportion of babies born with low birth weight has increased slightly in the last decade.

Indigenous babies were more likely to have a low birth weight and/or shorter gestation than non-Indigenous babies.

83 Updated data were not available at publication. Data given here are the same as those presented in *Children and Young People in Queensland: A snapshot 2005*.

84 These percentages have been updated to 2004 data.

85 Updated data were not available at publication. Data given here are the same as those presented in *Children and Young People in Queensland: A snapshot 2005*.

Breastfeeding

At 5 months of age, 60% of Queensland babies are still being breastfed. However, only 3% are exclusively breastfed at that age. World Health Organisation guidelines recommend exclusive breastfeeding for the first 6 months.

Long-term health conditions

The most common long-term health conditions experienced by children and young people in Queensland were:

- asthma (12% of 0–14 year olds and 10% of 15–17 year olds)
- mental health and behavioural problems (10% of 0–14 year olds and 11% of 15–17 year olds), and
- hay fever and allergic rhinitis (6% of 0–14 year olds and 12% of 15–17 year olds).

Disability

Disabilities restricting communication, mobility, self-care or schooling affected 12% of males and 8% of females aged 5–14 years in 2003. Approximately 1 in 10 children over the age of 4 years had a disability.

Injury

Injuries requiring hospitalisation varied by age group.

In 2004–05, hospitalisation of children aged 1–4 years was most associated with injuries caused by falls, poisoning and burns and scalds.

Falls and transport incidents were the most common causes of injuries requiring hospitalisation in children aged 5–9 years and 10–14 years.

Adolescents aged 15–19 were mainly admitted to hospital for injuries caused by transport incidents, falls, intentional self-harm and assault.

Abuse and neglect

The rates of Queensland children with child abuse and neglect notifications have increased substantially in recent years.

In 2004–05, 13.4 per 1000 children and young people aged 0–17 years were the subject of a substantiated notification of harm or risk of harm. This was similar to the rate noted in 2003–04 (13.3 per 100,000 children).

In 2004–05, 27% of all children who suffered substantiated child abuse were also the subject of a second substantiation within 12 months, compared with 28% in 2003–04.

Single-parent and step or blended families had higher rates of all types of child abuse and neglect. Younger parents were also associated with an increased risk of child abuse and neglect.

Children on protective orders

As at 30 June 2005, 5857 children were on protective orders (up from 4950 in 2004). Of these, 5657 were in out-of-home care (up from 4413 in 2004).

The number of children in out-of-home care has steadily increased since 2002. Six percent of children on protective orders continued to live with one or both parents, while 26% were living with other relatives. Sixty-two percent were living in foster care.

A further 4% were in residential facilities (including residential care with paid carers) and on protective orders in other facilities such as detention, hospitals or disability services, while 2% were living independently.

Indigenous children and young people were over-represented in the child protection system, with rates of out-of-home care more than 3 times higher than the state average (the Indigenous out-of-home care rate was 20.8 per 1000 children, compared with the state average of 5.8 per 1000).

Participation in education

In 2005, 91.5% of 15 year olds and 80.4% of 16 year olds were attending school, compared with only 48.9% of 17 year olds. Fifteen to 17 year old males were slightly less likely to be participating in education than females.

Retention to Year 12

The rate of students continuing their education through to Year 12 has declined slightly over the past few years. Retention rates in Queensland were 81.2% in 2004 and 79.9% in 2005.

Like participation rates, the retention rate was lower for males (75.3% compared with 84.7% for females).

Employment

In 2004–05, 41.7% of secondary students aged 15–19 years were engaged in part-time employment and 7.2% were looking for work.

Use of tobacco, alcohol and illicit drugs⁸⁶

The proportion of Australians aged 14–19 years who smoked daily decreased between 2001 and 2004 from 14.1% to 9.5% for males and from 16.2% to 11.9% for females.

In the same age group, the proportion of young people drinking alcohol weekly decreased from 31.2% to 26.6% for males and from 25.4% to 22.2% for females.

Overall, 3.3% of 12–15 year olds and 21.6% of 16–17 year olds were drinking weekly in 2004.

Between 1998 and 2004 the proportion of Australian 14–19 year olds who had used illicit drugs in the previous 12 months decreased from 38.3% to 20.9% for males and 37.1% to 21.8% for females.

Homelessness⁸⁷

In 2001, the rate of homelessness in Queensland was estimated to be 7 per 1000 people.

Indigenous people were over-represented in the homeless population in Australia.

In 2004–05, 14% of all clients using Supported Accommodation Assistance Program (SAAP) accommodation were unaccompanied children and young people aged under 18 years.

Kids Help Line

In 2005, Kids Help Line responded to 47,957 calls from Queensland. Of these, 41% were about relationships, 9% related to difficulties with emotional responses (such as anger) and 6% were about child abuse and neglect.

Child deaths in Queensland, 1 July 2005 – 30 June 2006

Overview

Between 1 July 2005 and 30 June 2006, the deaths of 426 children and young people were registered in Queensland. Of these, 266 were male and 160 were female (62.4% and 37.6% respectively). Table 4.1 illustrates the gender and age breakdowns for all deaths during the reporting period.

Table 4.1: Child deaths by gender and age group (2005–06)

Age category	Female	Male	Total		
	<i>n</i>	<i>n</i>	<i>n</i>	%	Per 100,000
Under 28 days	72	120	192	45.1	3.7
Between 28 and 364 days	30	41	71	16.7	1.4
Total deaths under 1 year	102	161	263	61.7	509.1
1–4 years	21	34	55	12.9	27.2
5–9 years	13	21	34	8.0	12.7
10–14 years	9	21	30	7.0	10.5
15–17 years	15	29	44	10.3	26.4
Total deaths 1–17 years	58	105	163	38.3	17.7
Total	160	266	426	100.0	43.8

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

Notes: 1. All percentages are calculated on the total number of deaths.
2. Rates of death for infants under 28 days, between 28 and 364 days and total deaths under 1 year are calculated per 1000 live births.

86 Updated data were not available at publication. Data given here are the same as those presented in *Children and Young People in Queensland: A snapshot 2005*.

87 Updated data were not available at publication. Data given here are the same as those presented in *Children and Young People in Queensland: A snapshot 2005*. Details of Supported Accommodation Assistance Program statistics are included in the 2006 Snapshot report.

The majority of all child deaths (263 deaths, 61.7%) were of children under 1 year of age. Over 73% of these (192 deaths) occurred within the first 28 days of life. The second-highest number of deaths occurred in the 1–4 year age group with 55 deaths (12.9% of all deaths). Fifteen to 17 year olds recorded the next highest number of deaths (44 deaths, 10.3% of all deaths), followed by 5–9 year olds (34 deaths, 8.0% of all deaths). Ten to 14 year olds had the lowest number of deaths in the 12-month period examined (30 deaths, 7.0%).

Coronial findings

Of the 426 total deaths in the 2005–06 reporting period, 169 were reportable.⁸⁸ At the time of reporting, coronial findings were available for 52 of these. Autopsy notices only were available in a further 100 cases. The official cause of death was pending in 17 cases.

All causes of child death

Tables 4.2 and 4.3 list all causes of child death in the 12-month period by ICD-10 chapter level, broken down by gender and age category respectively.

Table 4.2: All causes of child death per ICD-10 chapter classifications by gender (2005–06)

ICD-10 chapter descriptions	Female	Male	Total	Total
	<i>n</i>	<i>n</i>	<i>n</i>	%
Natural causes				
Certain conditions originating in the perinatal period (P00–P96)	62	85	147	34.5
Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99)	18	42	60	14.1
Neoplasms (C00–D48)	10	14	24	5.6
Diseases of the nervous system (G00–G99)	3	13	16	3.8
Endocrine, nutritional and metabolic diseases (E00–E90)	6	6	12	2.8
Certain infectious and parasitic diseases (A00–B99)	3	9	12	2.8
Diseases of the respiratory system (J00–J99)	5	5	10	2.3
Diseases of the circulatory system (I00–I99)	2	5	7	1.6
Diseases of the genitourinary system (N00–N99)	1	1	2	0.5
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50–D89)	1	1	2	0.5
Diseases of the digestive system (K00–K93)	1	1	2	0.5
Mental and behavioural disorders (F00–F09)	1	0	1	0.2
Diseases of the ear and mastoid process (H60–H95)	0	1	1	0.2
Diseases of the musculoskeletal system and connective tissue (M00–M99)	0	1	1	0.2
Disease of the eye and adnexa (H00–H59)	0	0	0	0.0
Diseases of the skin and subcutaneous tissue (L00–L99)	0	0	0	0.0
Pregnancy, childbirth and the puerperium (O00–O08)	0	0	0	0.0
Total number of deaths from natural causes	113	184	297	69.7

⁸⁸ A reportable death is defined by the *Coroners Act 2003* as one in which the identity of the person is unknown; a death which was violent or otherwise unnatural; happened in suspicious circumstances; was not a reasonably expected outcome of a health procedure; was a death in care or a death in custody; or a cause of death certificate has not been and is not likely to be issued. Information on reportable deaths is received by the Commission via the Police Report of Death to a Coroner (Form 1).

Table 4.2 (cont.): All causes of child death per ICD-10 chapter classifications by gender (2005–06)

ICD-10 chapter descriptions	Female	Male	Total	Total
	<i>n</i>	<i>n</i>	<i>n</i>	%
SIDS and undetermined causes				
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)	8	11	19	4.5
External causes				
External causes of morbidity and mortality (V01–Y98)	32	61	93	21.8
Cause of death pending ⁸⁹	7	10	17	4.0
Grand total	160	266	426	100.0

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

Note: 1. Causes of death are sorted by frequency and are not in chapter order.

Table 4.3: All causes of child death per ICD-10 chapter classifications and age group (2005–06)

ICD-10 chapter descriptions	Under 28 days	Between 28 and 364 days	1–4 years	5–9 years	10–14 years	15–17 years	Total <i>n</i>	Total %
Natural causes	187	37	24	22	18	9	297	69.7
SIDS and undetermined causes								
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99)	2	14	1	1	1	0	19	4.5
External causes								
External causes of morbidity and mortality (V01–Y98)	0	9	28	10	11	35	93	21.8
Cause of death pending	3	11	2	1	0	0	17	4.0
Grand total	192	71	55	34	30	44	426	100

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

Natural causes

Certain conditions originating in the perinatal period were the most common natural cause of death, accounting for 147 of 297 deaths (49.5% of natural causes). Congenital malformations, deformations and chromosomal abnormalities also accounted for a significant proportion of natural deaths (60 deaths, 20.2%). More males than females died of natural causes (184 and 113 deaths respectively). Two hundred and twenty-four natural cause deaths (75.4%) were of children under 1 year of age (4.3 per 1000 live births, 433.6 per 100,000 children under 1 year in Queensland), with 83.5% of these being of

children aged under 28 days. Children over the age of 1 year died at a rate of 7.9 per 100,000 children and young people aged 1–17 years in Queensland (73 deaths).

External causes

Of the 93 children who died from external causes between July 2005 and June 2006, 61 were male (65.6%) and 32 were female (34.4%). Nine were under 1 year of age (9.7%, 0.2 per 1000 live births, 1.7 per 100,000 children under 1 year), while 84 were 1 year of age or over (90.3%, 9.11 per 100,000 population). External deaths comprised 21.8% of all child deaths.

⁸⁹ Includes the following causes of death: “Autopsy Notice given – cause of death not yet determined”, “Not yet determined pending test results”, and “Not yet established, tests required”. There is a routine time lapse in coronial findings being made available. As a result, the cause of death is not able to be determined in those cases unless autopsy findings are available.

Causes of death by research category

The Commission has categorised all external cause deaths into the categories listed by age group in Table 4.4.

Table 4.4: Research categories by age group⁹⁰ (2005–06)

Research category	Under 28 days	Between 28 and 364 days	1–4 years	5–9 years	10–14 years	15–17 years	Grand total	Rate per 100,000
Transport								
Pedestrian injured in transport accident (V01–V09)	0	0	4	2	3	0	9	
Pedal cyclist injured in transport accident (V10–V19)	0	0	0	0	1	1	2	
Motorcycle rider injured in transport accident (V20–V29)	0	0	0	1	0	1	2	
Car occupant injured in transport accident (V40–V49)	0	4	1	1	1	17	24	
Pedestrian injured in transport accident (V01–V09)	0	0	1	0	0	0	1	
Car occupant injured in transport accident (V40–V49)	0	0	0	0	0	2	2	
Water transport accidents (V90–V94)	0	0	0	1	0	0	1	
Transport total	0	4	6	5	5	21	41	4.2
Drowning								
Accidental drowning and submersion (W65–W74)	0	3	15	0	0	0	18	
Drowning total	0	3	15	0	0	0	18	1.8
Suicide								
Intentional self-harm (X60–X84)	0	0	0	0	3	3	6	
Event of undetermined intent (Y10–Y34)	0	0	0	0	2	7	9	
Suicide total	0	0	0	0	5	10	15	1.5
Other non-intentional injury								
Falls (W00–W19)	0	0	0	0	0	1	1	
Exposure to inanimate mechanical forces (W20–W49)	0	0	0	1	1	1	3	
Exposure to animate mechanical forces (W50–W64)	0	0	1	0	0	0	1	
Other accidental threats to breathing (W75–W84)	0	2	2	0	0	0	4	
Contact with venomous animals and plants (X20–X29)	0	0	0	1	0	0	1	
Complications of medical and surgical care (Y40–Y84)	0	0	0	1	0	0	1	
Other non-intentional injury total	0	2	3	3	1	2	11	1.1

⁹⁰ The research categories are based on information gathered by police as reported in the Police Report of Death to a Coroner (Form 1). Although a medical cause of death as established by autopsy may be pending (these cases are shown in Table 4.2), from the information received in the Form 1 these cases are able to be included in the research categories.

Table 4.4 (cont.): Research categories by age group (2005–06)

Research category	Under 28 days	Between 28 and 364 days	1–4 years	5–9 years	10–14 years	15–17 years	Total <i>n</i>	Rate per 100,000
Fatal assault								
Feetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00–P04)	1	0	0	0	0	0	1	
Ill-defined and unknown causes of mortality (R95–R99)	0	0	0	0	1	0	1	
Contact with heat and hot substances (X10–X19)	0	0	1	0	0	0	1	
Assault (X85–Y09)	0	0	2	1	0	2	5	
Pending	0	1	0	0	0	0	1	
Fatal assault total	1	1	3	1	1	2	9	0.9
Fire								
Exposure to smoke, fire and flames (X00–X09)	0	0	1	1	0	0	2	
Fire total	0	0	1	1	0	0	2	*
Total	1	10	28	10	12	35	96	9.9

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

* Rates are unable to be calculated for numbers less than 4.

Note: 1. Rates of death are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Table 4.5 shows those deaths which were undetermined or were pending an official cause of death and could not be classified as any of the above research categories.

Table 4.5: Undetermined cause of death by age group (2005–06)

Research category	Under 28 days	Between 28 and 364 days	1–4 years	5–9 years	10–14 years	15–17 years	Total <i>n</i>	Rate per 100,000
Undetermined ≥ 1 year								
Ill-defined and unknown causes of mortality (R95–R99)	0	0	0	1	0	0	1	
Undetermined ≥ 1 year total	0	0	0	1	0	0	1	*
Unknown – pending test results								
Ill-defined and unknown causes of mortality (R95–R99)			1		0	0	1	
Pending	2	3	2	1	0	0	8	
Unknown – pending test results total	2	3	3	1	0	0	9	0.9
Total	2	3	3	2	0	0	10	1.0

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

* Rates are unable to be calculated for numbers less than 4.

Note: 1. Rates of death are calculated per 100,000 children and young people aged 0–17 years in Queensland.

Transport incidents were the leading external cause of fatality among all children and young people (41 deaths, 44.1%), followed by drowning (18 deaths, 19.4%). Suicide and other non-intentional injury were the next most common causes, with 15 and 11 deaths respectively.

Gender differences were more pronounced for transport, suicide and other non-intentional injury.

Transport incidents were the most frequent external cause of death for infants under 1 year of age (4 deaths). Drowning accounted for the greatest number of deaths in the 1–4 year age group (15 deaths), while 5–9 year olds most frequently died as a result of transport incidents (5 deaths). Suicide and transport incidents were the leading causes of death for 10–14 year olds (5 deaths each), and the highest number of deaths in the 15–17 year age group was the result of transport incidents (21 deaths).

Sudden unexpected death in infancy

Sudden unexpected death in infancy (SUDI) is defined as the death of an infant less than 1 year of age in which no cause of death is immediately obvious. SUDI is not a cause of death. Rather, a death is classified as a SUDI if, when initially reported (prior to investigation and autopsy), the death was of an infant under 12 months of age, was sudden in nature and unexpected, and occurred after the infant had been placed to sleep. SUDI therefore includes the deaths of infants where a medical cause of death is later established. Deaths due to unrecognised illness, anatomical or developmental abnormalities, sleep accidents due to unsafe sleep environments and deaths later found to be the result of intentional injury are included within the SUDI classification. Also included are deaths due to sudden infant death syndrome (SIDS) and other undetermined or ill-defined causes.

Once coronial findings are completed, a definitive cause of death can be assigned.

Sudden unexpected death in infancy, like external cause deaths, is a reportable death,⁹¹ and is therefore considered as a research category for analysis. As mentioned previously, this is an initial classification – the definitive cause of death is established later. SUDI cases are counted under the research category (or natural cause) that best represents their cause of death. However, these deaths share many similarities and they are grouped together for the purpose of analysis in Chapter 12 of this report.

In the 12-month period examined, the deaths of 36 infants were classified as SUDI. The cause of death for these infants is given in Table 4.6.

Table 4.6: SUDI cases by cause of death (2005–06)

Cause of death	Total <i>n</i>
SIDS and other ill-defined causes of mortality	
Sudden infant death syndrome	11
Undetermined	5
External causes of non-intentional injury	
Accidental suffocation and strangulation in bed	2
Natural causes	
Acute bronchiolitis, unspecified	1
Acute epiglottitis	1
Anoxic brain damage, not elsewhere classified	1
Enteroviral encephalitis	1
Gastro-oesophageal reflux disease without oesophagitis	1
Myocarditis, unspecified	1
Otitis media, unspecified	1
Sepsis of newborn due to <i>Staphylococcus aureus</i>	1
Streptococcal infection, unspecified	1
Streptococcal meningitis	1
Pending test results	8
Total	36

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

91 A reportable death is defined by the *Coroners Act 2003* as one in which the identity of the person is unknown; a death which was violent or otherwise unnatural; happened in suspicious circumstances; was not a reasonably expected outcome of a health procedure; was a death in care or a death in custody; or a cause of death certificate has not been and is not likely to be issued. Information on reportable deaths is received by the Commission via the Police Report of Death to a Coroner (Form 1).

Sudden infant death syndrome (SIDS) and undetermined causes

During the 12-month period analysed, 11 of the 36 SUDI cases were certified as due to SIDS (0.2 per 1000 live births, 21.3 per 100,000 infants under 1), while 5 children died of undetermined causes (0.1 per 1000 live births, 9.7 per 100,000 infants under 1). Males were more likely to die from SIDS than females, accounting for 63.6% of cases (7 deaths). Studies have consistently shown that males are at a statistically increased risk of SIDS.

Most common causes/categories of death by age group

The five most common causes/categories of death for each age group are illustrated in Tables 4.7 to 4.12. ICD-10 chapter levels are given for natural causes, while external causes are categorised into transport, drowning, suicide, other non-intentional injury-related deaths, fatal assault and fire, as discussed previously. SUDI deaths are not shown here but have been allocated to their respective research categories, based on their ICD-10 chapter levels. Natural causes are further discussed in Chapter 5. Chapters 6 to 12 of this report analyse external causes of death in detail.

Under 28 days

As shown in Table 4.7, conditions originating in the perinatal period (132 deaths, 68.8%) were the most frequent cause of death for infants under the age of 28 days.⁹² This was followed by congenital malformations, deformations and chromosomal abnormalities, with 47 deaths (24.5%). The cause of death was pending in 3 cases, while infectious diseases; endocrine, nutritional and metabolic diseases; and signs and symptoms not elsewhere classified⁹³ each accounted for 2 deaths. Fatal assault accounted for 1 death in this age group, as did diseases of the circulatory system; diseases of the musculoskeletal system and connective tissue; and diseases of the nervous system.

Table 4.7: Most common causes of death for infants under 28 days (2005–06)

Cause/category of death	<i>n</i>	%	Rate per 1000 live births
Certain conditions originating in the perinatal period	132	68.8	2.6
Congenital malformations, deformations and chromosomal abnormalities	47	24.5	0.9
Cause of death pending	3	1.6	*
Certain infectious and parasitic diseases	2	1.0	*
Endocrine, nutritional and metabolic diseases total	2	1.0	*
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified total	2	1.0	*

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

* Rates are unable to be calculated for numbers less than 4.

Note: 1. This table does not include all causes of death. Consequently, the percentage column does not add to 100%. The percentage of deaths refers to the proportion of all infants aged less than 28 days who died.

Between 28 and 364 days

Table 4.8 shows that symptoms and findings not elsewhere classified (SIDS and undetermined causes) was the most frequent cause of death in infants between the ages of 28 and 364 days (14 deaths, 19.7%). Ten deaths were the result of perinatal conditions and an additional 10 were still awaiting an official cause of death (14.1%). Congenital malformations/deformations accounted for 8 deaths, and infectious diseases accounted for 5. Four deaths in this age group were the result of transport incidents, and 4 resulted from respiratory diseases. Diseases of the nervous system and drowning accounted for 3 deaths each, while non-intentional injury and neoplasms each accounted for 2 deaths.

92 One of these deaths was the result of an assault on the mother. This death has also been counted in Chapter 11, Fatal Assault.

93 The ICD-10 chapter 'Signs, symptoms and abnormal clinical and laboratory findings, not elsewhere classified' incorporates causes of death such as sudden infant death syndrome (SIDS) and other undetermined deaths.

One natural cause death was recorded for each of the following five categories: diseases of the blood, blood-forming organs and certain disorders involving the immune mechanism; diseases of the circulatory system; diseases of the digestive system; diseases of the ear and mastoid process; diseases of the genitourinary system.

Table 4.8: Most common causes of death for infants 28 to 364 days (2005–06)

Cause/category of death	<i>n</i>	%	Rate per 1000 live births
Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	14	19.7	0.3
Certain conditions originating in the perinatal period	10	14.1	0.2
Cause of death pending	10	14.1	0.2
Congenital malformations, deformations and chromosomal abnormalities	8	11.3	0.2
Certain infectious and parasitic diseases	5	7.0	0.1

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

Note: 1. This table does not include all causes of death. Consequently, the percentage column does not add to 100%. The percentage of deaths refers to the proportion of all infants aged between 28 and 364 days who died.

1–4 years

As shown in Table 4.9, the leading cause of death in 1–4 year olds was drowning (15 deaths, 27.3%). This was followed by neoplasms (8 deaths, 14.5%) and transport incidents (6 deaths, 10.9%). Four deaths were the result of a disease of the nervous system, and 3 resulted from infectious or parasitic diseases. Congenital malformations, non-intentional injury and fatal assault also accounted for 3 deaths each. Two deaths were the result of diseases of the respiratory system, and the cause of death was pending for an additional 2 deaths.

One natural cause death occurred in each of the following five categories: certain conditions originating in the perinatal period; diseases of the circulatory system; diseases of the genitourinary system; mental and behavioural disorders; and symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. Fire also accounted for 1 death in this age group.

Table 4.9: Most common causes/categories of death for toddlers 1–4 years (2005–06)

Cause/category of death	<i>n</i>	%	Rate per 100,000
Drowning	15	27.3	7.4
Neoplasms	8	14.5	4.0
Transport	6	10.9	3.0
Diseases of the nervous system	4	7.3	2.0
Certain infectious and parasitic diseases	3	5.5	*

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. This table does not include all causes of death. Consequently, the percentage column does not add to 100%. The percentage of deaths refers to the proportion of all children aged 1–4 years who died.

2. Rates are calculated per 100,000 children aged 1–4 years in Queensland.

5–9 years

Table 4.10 shows that 5–9 year olds were most likely to die of neoplasms in 2005–06 (8 deaths, 23.5%). Five deaths (14.7%) were caused by diseases of the nervous system and transport incidents, while endocrine, nutritional and metabolic diseases accounted for 4 deaths (11.8%). Other non-intentional injury accounted for 3 deaths, and infectious and parasitic diseases were responsible for 1 death.

One natural cause death occurred in each of the following four categories: certain conditions originating in the perinatal period; diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism; diseases of the respiratory system; and symptoms, signs and clinical and laboratory findings, not elsewhere classified. One death was caused by fatal assault, and 1 by fire. The cause of death in 1 case was pending.

Table 4.10: Most common causes/categories of death for children 5–9 years (2005–06)

Cause/category of death	<i>n</i>	%	Rate per 100,000
Neoplasms	8	23.5	3.0
Diseases of the nervous system	5	14.7	1.9
Transport	5	14.7	1.9
Endocrine, nutritional and metabolic diseases	4	11.8	1.5
Other non-intentional injury	3	8.8	*

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. This table does not include all causes of death. Consequently, the percentage column does not add to 100%. The percentage of deaths refers to the proportion of all children aged 5–9 years who died.

2. Rates are calculated per 100,000 children aged 5–9 years in Queensland.

10–14 years

As can be seen from Table 4.11, suicide and transport incidents were the leading causes of death in 10–14 year olds, accounting for 5 deaths each (16.7%). Three deaths were recorded for diseases of the circulatory system; diseases of the nervous system; endocrine, nutritional and metabolic diseases; and neoplasms.

Two deaths were recorded for each of the 3 categories that follow: certain conditions originating in the perinatal period; congenital malformations, deformations and chromosomal abnormalities; and diseases of the respiratory system. Fatal assault and non-intentional injury also accounted for 1 death each.

Table 4.11: Most common causes/categories of death for children 10–14 years (2005–06)

Cause/category of death	<i>n</i>	%	Rate per 100,000
Suicide	5	16.7	1.8
Transport	5	16.7	1.8
Diseases of the circulatory system	3	10.0	*
Diseases of the nervous system	3	10.0	*
Endocrine, nutritional and metabolic diseases	3	10.0	*
Neoplasms	3	10.0	*

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. This table does not include all causes of death. Consequently, the percentage column does not add to 100%. The percentage of deaths refers to the proportion of all children aged 10–14 years who died.

2. Rates are calculated per 100,000 children aged 10–14 years in Queensland.

15–17 years

Table 4.12 shows that almost half of the deaths of 15–17 year olds were the result of transport incidents (21 deaths, 47.7%). Suicide was the next leading cause with 10 deaths (22.7%). Endocrine, nutritional and metabolic diseases and neoplasms each accounted for 3 deaths (6.8%), while other non-intentional injury and fatal assault each accounted for 2 deaths.

One death was recorded for each of the following: diseases of the circulatory system; diseases of the digestive system; and diseases of the respiratory system.

Table 4.12: Most common causes/categories of death for children 15–17 years (2005–06)

Cause/category of death	n	%	Rate (per 100,000)
Transport	21	47.7	12.6
Suicide	10	22.7	6.0
Endocrine, nutritional and metabolic diseases	3	6.8	*
Neoplasms	3	6.8	*
Other non-intentional injury	2	4.5	*

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. This table does not include all causes of death. Consequently, the percentage column does not add to 100%. The percentage of deaths refers to the proportion of all children aged 15–17 years who died.

2. Rates are calculated per 100,000 young people aged 15–17 years in Queensland.

Aboriginal and Torres Strait Islander deaths

Forty-eight of the 426 children and young people who died in the reporting period were identified as Aboriginal or Torres Strait Islander; 42 were identified as Aboriginal, 4 as Torres Strait Islander and 2 as both Aboriginal and Torres Strait Islander. Over 11% of all deaths during this period were of Indigenous children.

In a further 3 cases the Police Report of Death to a Coroner (Form 1) indicated that the children were Indigenous (2 Aboriginal and 1 Torres Strait Islander). This brings the percentage of Indigenous child deaths to 12.0% of all child deaths.

Table 4.13 outlines the causes of death by age group for the total 51 children and young people identified as Aboriginal and/or Torres Strait Islander. Of the Indigenous children who died during the reporting period, the greatest proportion were under 28 days of age (21 deaths, 41.2%). In comparison, 45.2% (171 deaths) of the non-Indigenous children who died in the same period were in this age group. The second-highest number of Indigenous child deaths occurred among children between 28 and 364 days, accounting for 14 deaths (27.5%).

Table 4.13: Aboriginal and Torres Strait Islander child deaths by cause of death and age group (2005–06)

Cause/category of death	Under 28 days	Between 28 and 364 days	1–4 years	5–9 years	10–14 years	15–17 years	Total n	Total %	Rate per 100,000
Natural causes	20	6	2	0	2	0	30	58.8	46.3
SIDS and undetermined causes	1	2	0	0	0	0	3	5.9	*
Research category									
Transport	0	2	1	2	1	0	6	11.8	9.3
Suicide	0	0	0	0	1	2	3	5.9	*
Drowning	0	1	2	0	0	0	3	5.9	*
Other non-intentional injury	0	0	0	1	0	0	1	2.0	*
Fire	0	0	1	0	0	0	1	2.0	*
Subtotal of research categories	0	3	4	3	2	2	14	27.5	21.6
Cause of death pending	0	3	0	1	0	0	4	7.8	6.2
Grand total	21	14	6	4	4	2	51	100.0	78.7

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. Rates are calculated per 100,000 Indigenous children and young people aged 0–17 years in Queensland.

2. Rates for SIDS and undetermined causes are calculated per 100,000 Indigenous children under the age of 1 in Queensland.

Causes of death for non-Indigenous children are given in Table 4.14.

Table 4.14: Non-Indigenous child deaths by cause of death and age group (2005–06)

Cause/category of death	Under 28 days	Between 28 and 364 days	1–4 years	5–9 years	10–14 years	15–17 years	Total <i>n</i>	Total %	Rate per 100,000
Natural	166	31	22	22	16	9	266	70.9	29.3
SIDS and undetermined causes	1	12	0	0	0	0	13	3.5	26.9
Research categories									
Transport	0	2	5	3	4	21	35	9.3	3.9
Drowning	0	2	13	0	0	0	15	4.0	1.7
Suicide	0	0	0	0	4	8	12	3.2	1.3
Other non-intentional injury	0	2	3	2	1	2	10	2.6	1.1
Fatal assault	1	1	3	1	1	2	9	2.4	1.0
Fire	0	0	0	1	0	0	1	0.3	*
Subtotal of research categories	1	7	24	7	10	33	82	21.9	9.0
Undetermined ≥ 1 year	0	0	0	1	0	0	1	0.3	*
Pending	3	7	3	0	0	0	13	3.5	1.4
Total	171	57	49	30	26	42	375	100.0	41.3

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. Rates are calculated per 100,000 non-Indigenous children and young people aged 0–17 years in Queensland.

2. Rates for SIDS and undetermined causes are calculated per 100,000 non-Indigenous children under the age of 1 in Queensland.

Indigenous children died at a higher rate than non-Indigenous children for all causes of death. While non-Indigenous children died at a rate of 41.3 per 100,000 non-Indigenous children and young people aged 0–17 years, Indigenous children died at a rate of 78.7 per 100,000 Indigenous children.

Natural causes

58.8% of Aboriginal and Torres Strait Islander child deaths were due to natural causes (30 deaths). In contrast, natural causes accounted for 70.9% of non-Indigenous child deaths. Indigenous children were, however, more likely to die from natural causes than non-Indigenous children, with a rate of death of 46.3 per 100,000 Indigenous children 0–17 years, compared with 29.3 per 100,000 for non-Indigenous children.

Conditions originating in the perinatal period were the most common natural cause of death for both Indigenous and non-Indigenous children, with 17 and 130 deaths respectively. This was followed by congenital malformations, deformations and chromosomal abnormalities, with 3 Indigenous child deaths and 57 non-Indigenous child deaths.

External causes

Fourteen Aboriginal and Torres Strait Islander children died from external causes during the reporting period (27.5% of Indigenous child deaths). External causes accounted for 21.9% of non-Indigenous child deaths (82 deaths). External cause deaths occurred at a higher rate in Indigenous children (21.6 per 100,000 children, compared with 9.0 per 100,000 for non-Indigenous children).

Transport incidents were the leading external cause of death for both Indigenous and non-Indigenous children (6 and 35 deaths respectively). Suicide and drowning were the next most common external cause of death in Indigenous children (3 deaths each). Similar patterns emerged for non-Indigenous children, with drowning accounting for 15 deaths, and suicide 12 deaths.

Sudden unexpected death in infancy (SUDI)

Of the 12 Aboriginal and Torres Strait Islander child deaths classified as SUDI, 1 was later certified as being a result of SIDS, while 2 were undetermined. A further 3 cases are pending test results. Because of the low numbers of Indigenous infant deaths due to SIDS and undetermined causes, rates were not able to be calculated, and therefore cannot be compared with the number of non-Indigenous SIDS deaths. The remaining 6 cases were classified as diseases of the nervous system (1 death); diseases of the respiratory system (2 deaths); diseases of the digestive system (1 death); certain conditions originating in the perinatal period (1 death); and diseases of the ear and mastoid process (1 death).

These figures are given in Table 4.15.

Table 4.15: Region of child deaths by research category (2005–06)

Research category	Metropolitan		Regional		Remote		N/A	Grand total
	<i>n</i>	Per 100,000	<i>n</i>	Per 100,000	<i>n</i>	Per 100,000		
Natural	185	34.5	91	24.2	13	21.4	7	296
SIDS and undetermined	8	27.2	8	42.4	0	*	0	16
Research category								
Transport	11	2.1	21	5.6	6	9.9	3	41
Drowning	10	1.9	6	1.6	2	*	0	18
Suicide	5	0.9	8	2.1	2	*	0	15
Other non-intentional injury	5	0.9	3	*	2	*	1	11
Fatal assault	3	*	5	1.3	1	*	0	9
Fire	0	*	1	*	1	*	0	2
Subtotal research category	34	6.3	44	11.7	14	23.1	4	96
Undetermined ≥ 1 year	1	*	0	*	0	*	0	1
Pending	10	1.9	4	1.1	3	*	0	17
Grand total	238	44.4	147	39.1	30	49.4	11	426

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. Eleven children were not classified as their usual residence was outside Queensland. For further details, see Appendix 4.1.

2. Rates are calculated per 100,000 children and young people aged 0–17 years in metropolitan, regional and remote areas of Queensland.

3. The rate of death for SIDS and undetermined causes is calculated per 100,000 children under 1 year living in regional, metropolitan and remote areas of Queensland.

Geographical distribution (ARIA+)

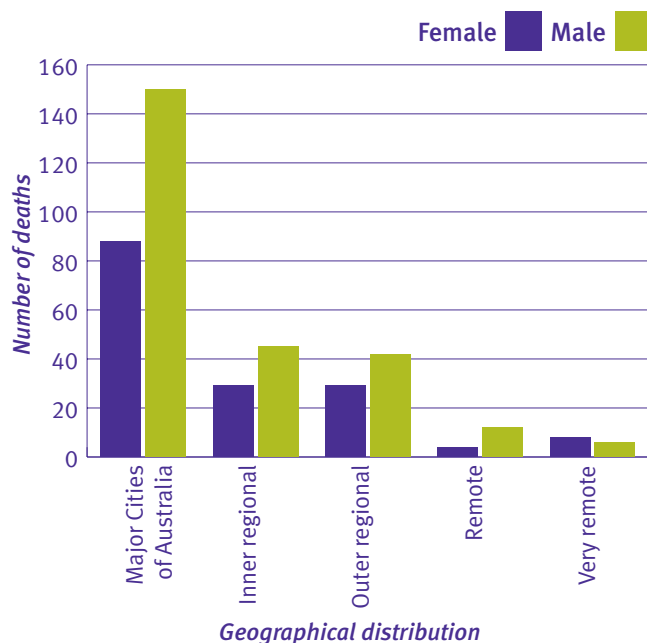
The greatest rate of child death was found in remote areas of Queensland, with 49.4 per 100,000 children aged 0–17 living in remote areas (30 deaths). Metropolitan regions recorded the next highest rate of child death (44.4 deaths per 100,000 children in metropolitan areas, 238 deaths). Regional areas had the lowest rate of child death at 39.1 per 100,000 children living in regional areas (147 deaths).

Natural cause deaths occurred with the greatest frequency in metropolitan areas (34.5 per 100,000 children), compared with regional and remote areas with 24.2 and 21.4 per 100,000 children respectively. External cause deaths were more frequent in remote areas (a rate of 23.1 per 100,000), compared with 11.7 per 100,000 in regional areas and 6.3 per 100,000 in metropolitan areas. Transport deaths were the most common external cause in all areas.

Rates of death from SIDS and undetermined causes were higher in regional areas than metropolitan areas (remote areas did not record any SIDS deaths).

Figure 4.1 illustrates the breakdown for each region by gender

Figure 4.1: Region of child deaths by gender (2005–06)



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

Notes: 1. Eleven children were not classified as their usual residence was outside Queensland. For further details, see Appendix 4.1.
2. Represents the actual number of child deaths, not rates.

Queensland was not the usual place of residence for 11 of the 426 children and young people who died in Queensland during the 12-month period examined. See Appendix 4.1 for further details.

Socio-economic status (SEIFA)

As outlined in Table 4.16, children living in higher socio-economic regions recorded the highest rate of child deaths (45.1 deaths per 100,000 children aged 0–17 living in high to very high socio-economic areas of Queensland, 165 deaths). However, this rate was only marginally higher than that found in low to very low socio-economic areas (44.5 per 100,000 children living in low socio-economic areas, 179 deaths). Moderate socio-economic areas recorded the lowest rate of child death at 34.4 per 100,000 children (71 deaths).

Natural cause deaths were more common in high to very high areas (35.8 per 100,000 children, compared with 28.9 per 100,000 in low areas and 20.4 per 100,000 in moderate areas). External cause deaths, however, were more common in low and moderate socio-economic areas, with 11.7 and 11.6 deaths per 100,000 children respectively. Transport deaths were the leading external cause in all areas. The next most common external cause was suicide in low areas, and drowning in moderate and high socio-economic areas.

Low socio-economic areas had a higher rate of SIDS and undetermined infant deaths than high areas, with 39.1 per 100,000 in low areas, compared with 29.7 per 100,000 in high areas (rates were not able to be calculated for SIDS deaths in moderate areas because of the low numbers of deaths).

Table 4.16: Socio-economic status of child deaths by research category (2005–06)

Research category	Low to very low		Moderate		High to very high		N/A	Grand total
	<i>n</i>	Per 100,000	<i>n</i>	Per 100,000	<i>n</i>	Per 100,000		
Natural	116	28.9	42	20.4	131	35.8	7	296
SIDS and undetermined	8	39.1	2	*	6	29.7	0	16
Research category								
Transport	23	5.7	9	4.4	6	1.6	3	41
Drowning	7	1.7	6	2.9	5	1.4	0	18
Suicide	8	2.0	5	2.4	2	*	0	15
Other non-intentional injury	4	1.0	3	*	3	*	1	11
Fatal assault	4	1.0	1	*	4	1.1	0	9
Fire	1	*	0	*	1	*	0	2
Subtotal of research categories	47	11.7	24	11.6	21	5.7	4	96
Undetermined ≥ 1 year	0	*	0	*	1	*	0	1
Pending	8	2.0	3	*	6	1.6	0	17
Grand total	179	44.5	71	34.4	165	45.1	11	426

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

* Rates are unable to be calculated for numbers less than 4.

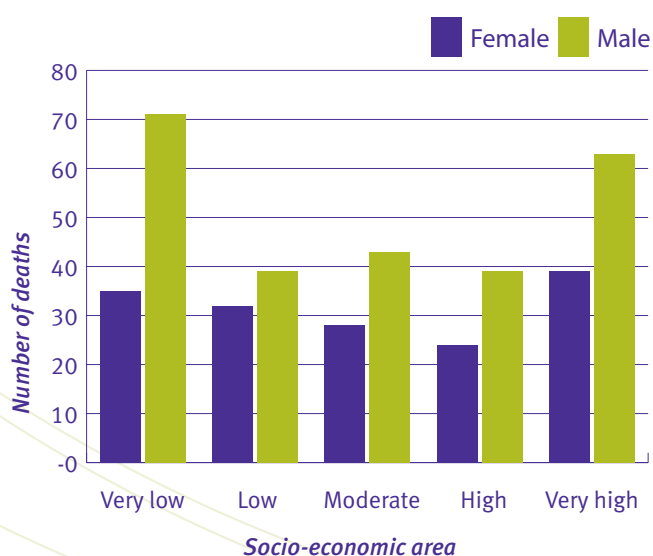
Notes: 1. Eleven children were not classified as their usual residence was outside Queensland. For further details, see Appendix 4.1.

2. Rates are calculated per 100,000 children and young people aged 0–17 years in metropolitan, regional and remote areas of Queensland.

3. The rate of death for SIDS and undetermined causes is calculated per 100,000 children under 1 year living in regional, metropolitan and remote areas of Queensland.

Deaths per region by gender are shown in Figure 4.2.

Figure 4.2: Socio-economic status of child deaths by gender (2005–06)



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

Notes: 1. Eleven children were not classified as their usual residence was outside Queensland. For further details, see Appendix 4.1.
2. Represents the actual number of child deaths, not rates.

Child protection population

Forty-eight⁹⁴ children and young people whose deaths were registered in the 12-month period examined were known to the DChS, representing 11.3% of all child deaths. Since 1 August 2004, the Department has been required to conduct a review of the service delivery provided to a child if the child was known to the Department within the three years before death. The Department is required to provide a report to the Child Death Case Review Committee (CDCRC) within six months of becoming aware of a child’s death. The CDCRC is an independent committee responsible for considering the Department’s reviews.

94 Source: Qld Child Death Register – caution needs to be exercised in relation to the interpretation of Table 4.17 because of the relatively small numbers involved. The numbers may also differ slightly from those of the Child Death Case Review Committee’s Annual Report 2005–06, as the Committee reports on deaths that occurred in the financial year where children are known to the DChS, while the Child Death Annual Report 2005–06 reports on deaths that are registered in Queensland with the Registry of Births, Deaths and Marriages each financial year.

The CDCRC reviewed 15 of the deaths that were registered in Queensland in the 2005-06 reporting period. The remaining cases will be reviewed by CDCRC in 2006–07.

Twenty-six of the 48 children were male (54.2%) and 22 were female (45.8%). Twelve of these children were Aboriginal or Torres Strait Islander (25.0%).

Table 4.17 outlines the cause of death by age group for children known to the Department.

Table 4.17: Cause of death of children known to the DChS by age group (2005–06)

Cause/category of death	Under 1 year	1–4 years	5–9 years	10–14 years	15–17 years	Total <i>n</i>	Rate per 100,000 in child protection population	Rate per 100,000 all Queensland children
Natural	10	5	4	4	0	23 ⁹⁵	38.1	32.4
Research category								
Transport	0	0	2	3	3	8	13.3	4.2
Fatal assault	2	2	1	0	1	6	9.9	0.9
Suicide	0	0	0	2	3	5	8.3	1.5
Drowning	2	2	0	0	0	4	6.6	1.8
Other non-intentional injury related	0	0	0	0	0	0	*	*
Fire	0	0	0	0	0	0	*	*
Subtotal research categories	4	4	3	5	7	23	38.1	9.9
Pending	1		1			2	*	0.9
Total	15	9	8	9	7	48	79.6	43.8

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

* Rates are unable to be calculated for numbers less than 4.

Notes: 1. Rates are based on the number of distinct children with notifications with the DChS for the 3-year period between 1 July 2002 and 30 June 2005.
2. Natural represents all deaths from diseases and morbid conditions, including deaths from SIDS and undetermined causes.

Of the children known to the DChS in the 3 years before their death, 47.9% died as a result of natural, SIDS and undetermined causes, while 16.6% died in transport-related incidents; 12.5% died as a result of fatal assault, 10.4% were suspected suicides and 8.3% died due to drowning.

Children known to the Department are an at-risk cohort and were over-represented across all causes of death, with a rate of 79.6 deaths per 100,000 children in the child protection population, compared with 43.8 deaths per 100,000 for all Queensland children.⁹⁶

Specifically:

- Children known to the DChS were 11 times more likely to have been fatally assaulted than all Queensland children, with 9.9 deaths per 100,000 children in the child protection population compared with 0.9 deaths per 100,000 Queensland children
- Children known to the DChS were 5.5 times more likely to suicide, with 8.3 deaths per 100,000 children in the child protection population compared with 1.5 deaths per 100,000 Queensland children (23.3 suicides per 100,000)

95 One foetal death coded as per ICD-10 as due to a disease or morbid condition occurred in the context of an assault on the child's mother. For research purposes this has been analysed as a fatal assault in this table.

96 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.

children in the child protection population aged 10–17 years, compared with 3.3 suicides for children 10–17 years per 100,000 Queensland children)

- Children known to the DChS were 3.6 times more likely to have drowned, with 6.6 deaths per 100,000 children in the child protection population compared with 1.8 deaths per 100,000 Queensland children (19.9 drowning deaths per 100,000 children in the child protection population aged 0–4 years, compared with 7.1 drownings for children 0–4 years per 100,000 Queensland children), and
- Children known to DChS were 3.2 times more likely to die in a transport incident, with 13.3 deaths per 100,000 children in the child protection population compared with 4.2 deaths per 100,000 Queensland children.

The Department of Child Safety’s Child Death Reviews

The Commission has identified a further 4 cases⁹⁷ through the Police Report of Death to a Coroner (Form 1) and/or the Commission’s records indicating a history of departmental involvement with the deceased child’s siblings only. In 2 cases the cause of death falls into the ‘natural’ research category, while 1 was a ‘drowning’. One cause of death has been analysed as a ‘sudden unexplained infant death’ as the coronial findings have not been finalised and the cause is not immediately obvious.

These cases have not been subject to a statutory review because the deceased children, although in high-risk families, were not technically known to the DChS.

Case study 1

The deceased infant (aged less than 1 month) had been co-sleeping with a sibling and their parent. The infant’s parent asked the eldest sibling to watch the younger two for a short time (5–10 minutes) while she showered. The eldest sibling noticed that the infant was purple in colour, with blood coming from the nose.

A domestic violence order was put in place before the birth of the child. The other siblings had been the subject of a number of notifications over the previous 4 years. Emotional and physical abuse notifications were substantiated 2 years previously, but sexual abuse allegations were not. The mother was identified by a health service as being at ‘high risk’ at the birth of the infant because of domestic violence, maternal and/or financial problems.

Coronial findings indicate the cause of death as being due to natural causes.

This case was not subject to a statutory review by the DChS (or the CDCRC).

In the 4 cases identified, as there was no DChS contact recorded with the deceased child in question, the Department’s involvement with the child’s family was not required to be the subject of review in accordance with Chapter 7A of the *Child Protection Act 1999*.

It is unlikely that these 4 cases represent an exhaustive list, as the Commission is only able to identify such cases where DChS involvement with the deceased child’s family is detailed on the Police Report of Death to a Coroner (Form 1), or when the Commission’s datasets reveal that a child’s siblings were ‘in care’ or the subject of a complaint.

The Commission has identified the following 3 scenarios where the sibling/s of a deceased child may be the subject of DChS involvement without the deceased child actually being recorded on departmental systems.

Scenario 1: failure to identify and/or record the deceased child as a subject child

The deceased child was alive at the time a notification concerning the child’s sibling/s was received. However, because of a lack of effective information gathering and/or record-keeping, the deceased child was not identified and/or recorded as a subject child.

⁹⁷ In addition to these 4, there is 1 other case that has been identified. In this instance the death has not been registered by the family. The Commission is working with the Registry of Births, Deaths and Marriages in relation to the registration of this death and the DChS in relation to the review of this death. Refer to Chapter 2, ‘Methodology’, for further information.

Part 2.17 (Investigation and assessment outcomes) of the Child Safety Practice Manual requires that “any additional children [not originally recorded as subject children in the notification] identified as being harmed or at risk of harm during the investigation and assessment should be added as subject children to the ‘relevant persons table’ of the investigation and assessment document and assessed accordingly”.⁹⁸

The quality of the decisions made during the intake and investigation and assessment phases is affected by the quality of information gathered by the Child Safety Officer (CSO) about the child, the child’s family and the child protection concerns. Every effort must be made to gather accurate information about the subject children and other relevant persons, including given names, surnames, aliases, nicknames, ages and dates of birth, gender, cultural identity, addresses and relationships.

Scenario 2: failure to identify risk to an unborn child

The deceased child was an unborn child during a period of active DChS involvement with the child’s mother or siblings, but because of a practice error the child was not recorded as being at risk of harm after s/he was born.

Case study 2

The deceased (aged less than 1 year) and the child’s toddler sibling had been placed in a running shower and left unattended. A parent returned after a brief period and found clothes and toys covering the bottom of the bath, with the infant lying face down in about 10 cm of water. The sibling was playing with the toys in the bath.

In this case there had been a number of notifications regarding physical and emotional abuse and neglect of the toddler sibling, and on one occasion the mother was charged with assaulting the sibling. The mother was approximately 7 months pregnant at the time of the most recent notification on the deceased child’s toddler sibling.

Part 10 (Unborn children) of the Child Safety Practice Manual states that concerns about an unborn child who is reasonably suspected to be at risk of harm after he or she is born, because of the current behaviour or circumstances of the parent, should be screened in as a notification.

Section 246A(2) of the *Child Protection Act 1999* also requires that a review be conducted if “the child was born and before the child was born the chief executive reasonably suspected that the child might be in need of protection after he or she was born”.

If child protection concerns co-exist in a family at a time when the mother is known to be pregnant, then the environment of the pregnant woman could indicate future risk for the child. Departmental officers should be aware of and document this risk.⁹⁹

Scenario 3: the deceased child’s siblings were known to the Department before the deceased child’s birth or conception

The deceased child was the sibling of a child who (before the deceased child’s birth or conception) was the subject of DChS involvement.

In scenarios 1 and 2 there appears to be an existing requirement for a review of DChS involvement with the deceased child’s family under Chapter 7A of the *Child Protection Act 1999*. This is because the child was not recorded as a subject child as the result of administrative/practice issues, not because the Department was ‘unaware’ of the child protection concerns existing in the deceased child’s family. As the focus of the review is on the appropriateness of departmental involvement with a child and their family (as opposed to the cause of the child’s death), a failure to identify or record the deceased child as a subject constitutes a case practice issue that warrants examination.

98 Part 2.17 (Information requirements) similarly requires that “during an investigation and assessment, the CSO check the details of the subject children and other relevant persons provided by the notifier with the children and family to ensure that departmental records are accurate and kept up-to-date. Where information received is not correct, the CSO is responsible for ensuring that client profiles are amended and updated.”

99 With respect to unborn children, child death case reviews are not undertaken where a child is stillborn or the pregnancy is miscarried.

Therefore, in accordance with Part 14.1 (Child death case reviews) of the Child Safety Practice Manual, an external review may need to be conducted in these cases.¹⁰⁰ However, the Commission is of the view that the Practice Manual could benefit from clarification of the jurisdiction in this regard.

For cases that fall within the scope of scenario 3, as there was no current departmental involvement with the family/deceased child, such cases are not currently required to be the subject of review. However, the DChS may wish to consider extending its current practice to require reviews of its involvement in such circumstances, with a view to:

- identifying risk factors to inform future practice
- identifying potential points of intervention to inform future practice, and
- determining criteria for reassessment of family circumstances and support needs, particularly where further siblings are born.

From the information available to the Commission, it is possible that some of the cases identified in the 2005–06 reporting period involved ongoing child protection concerns (rather than an isolated incident), and that the very young age of the children may offer a partial explanation of why they had not come to the attention of the DChS.¹⁰¹ Moreover, in the 2004–05 financial year, notifications on infants (aged less than 1 year) accounted for only 8% of the total notifications, although this age group is identified as at the greatest risk of death or serious injury from abuse.¹⁰² In Australia the rate is 2.68 deaths per 100,000 population in this age group. For females, this is the highest rate across the entire life-course spectrum. (The risk to infants comes predominantly from their physical vulnerability – so violent acts are more likely to have fatal outcomes.)

Therefore, there may be the potential for organisational learning to be generated through an examination of cases where a deceased child's sibling/s were known to the Department (this could be achieved through an administrative process, such as amending the scope of child death reviews in the DChS Practice Manual). However, regardless of the approach, it is likely that there would be an issue in relation to the DChS learning that the deaths have occurred, and the Commission would be able to help in this regard.

In a Ministerial Statement of 11 May 2004, the Honourable Mike Reynolds MP, Minister for Child Safety stated that DChS child death inquiries were to “apply to a very wide range of children”, including cases where “just one phone call has been made to the department”. In the second reading of the Child Safety Legislation Amendment Bill (16 June 2004) he further stated that the amendments which legislated DChS death review requirements and the role and functions of the CDCRC would ensure that “the Department of Child Safety and the system of child safety and child protection that we have in Queensland [is] as open, as transparent, and as accountable as we possibly can make it”.

The Commission considers that there is scope for DChS reviews to include deceased children whose siblings were the subject of departmental involvement. This would accord with the Minister for Child Safety's intention “to have a very high standard of accountability, transparency and openness”.

Precedents for reviews of cases where a deceased child's siblings have had recent involvement with child protective services have been established in other Australian jurisdictions and internationally.

100 External reviews should be undertaken when “it is apparent that there are specific issues regarding the management of the case that require particular scrutiny with a view to informing departmental policy and practice”. In addition to reading of all case documentation, preparing a chronology of departmental involvement with the child, detailing and analysing departmental responses to the issues of the case and identifying any policy, procedural or practice gaps, external reviews involve interviewing current departmental staff and ex-departmental officers and staff from other entities as appropriate.

101 In the 4 cases identified in the 2005–06 reporting period, the deceased child was aged 1 year or less, and in 3 of the 4 cases the deceased was a very young infant.

102 Notifications on children in the 1–4 year age group accounted for 25% of the total notifications, the 5–9 year age group for 31% and the 10–14 year age group 28%. Source: Department of Child Safety, *Child Protection Queensland: 2004–05 Performance Report*.

New South Wales

Under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* the Ombudsman is required to monitor, review and formulate recommendations in relation to deaths of certain children, including a child who died within 3 years of being the subject of a risk of harm report to the Department of Community Services or was a sibling of such a child.¹⁰³

South Australia

Under Part 7C of the *Children's Protection Act 1993*, the Child Death and Serious Injury Review Committee should review certain cases of child death or serious injury, including cases where there had been, within 3 years before the incident resulting in the death or serious injury, a notification to the Department of Families and Communities of suspected abuse or neglect of the child or a member of the child's family.

Tasmania

Child and Family Services (a division of the Department of Health and Human Services) must conduct a Critical Case Review when a child or young person dies from possible abuse or neglect and there is current or recent involvement by Child and Family Services with the child, young person or any of his or her siblings over the previous 12-month period.¹⁰⁴

Internationally

There are similar child death review processes in many Canadian provinces/territories. In Manitoba, for example, if parents, siblings or a deceased child received services from a child welfare agency 2 years before a child's death, the case is reviewed.

Recommendation 3

The Commission recommends that the Department of Child Safety review the Child Safety Practice Manual with a view to clarifying the application of the child death review requirements in relation to the deaths of siblings of children who were known to the Department within the previous 3 years.

103 http://www.austlii.edu.au/au/legis/nsw/consol_act/csrama1993583/s36.html

104 *Memorandum of Advice to Minister of Health and Human Services – The Need for a Child Death Review System in Tasmania*, Patmalar Ambikapathy, Commissioner for Children, Tasmania, April 2004.