

Executive summary

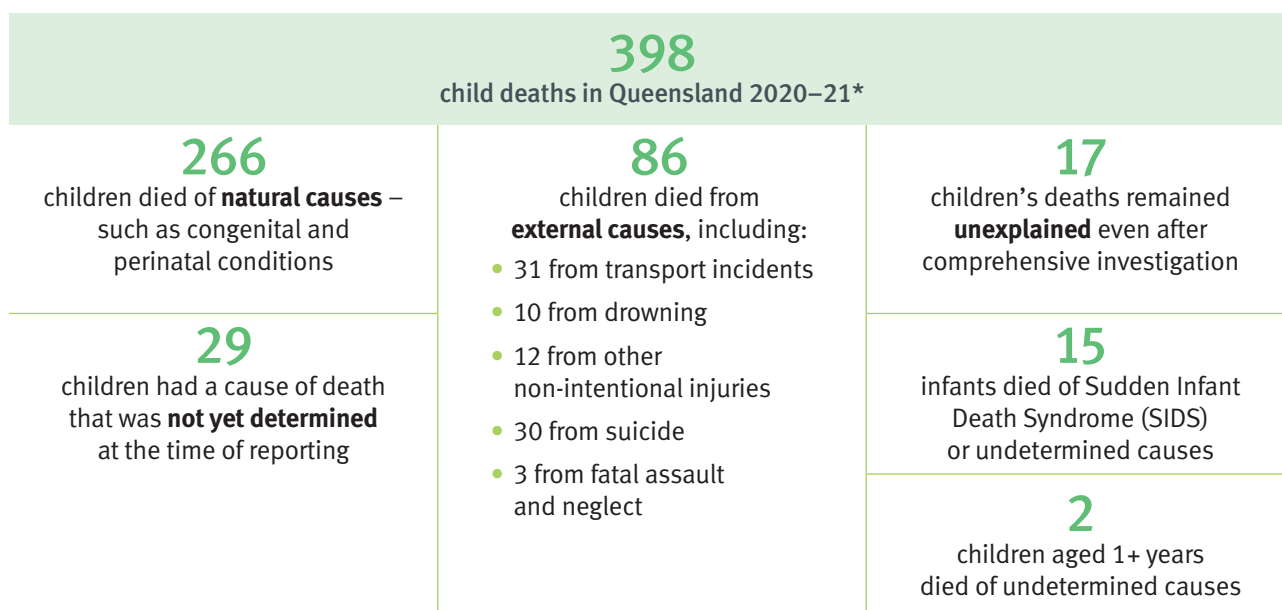
The Queensland Family and Child Commission records information about the deaths of all children and young people under 18 years of age in Queensland in the Child Death Register. The Register captures information about a child's demographics, cause and circumstances of death and, where known, certain characteristics or vulnerabilities. The Register has been in existence since 2004. It is an important resource for informing child death prevention activities and measures.

In the 12-month period from 1 July 2020 to 30 June 2021, the deaths of 398 children and young people aged 0–17 years were registered in Queensland.²

Deaths from natural causes (diseases and morbid conditions) accounted for a large proportion of child deaths, with these most likely to occur in the first days and weeks of life.

Child mortality from external causes includes deaths from injuries, either non-intentional (accidental) injuries such as transport incidents or drowning, or from intentional injuries, which includes suicide and fatal assault and neglect. Due to the relatively small numbers involved, caution should be exercised in interpreting year-to-year changes.

Child deaths in Queensland, 2020–21



* By date of death registration.

Trends in child mortality

The number of child deaths and mortality rates have generally declined over the 17 years the Register has been in existence, driven to a large extent by decreases in deaths from natural causes. The overall child mortality rate has decreased 2.7% per year on average.

Transport-related child mortality has decreased 6.6% per year on average. While year to year changes should not be interpreted as indicating trends, 19 motor vehicle crash fatalities in 2020–21 was well above the preceding 5-year average of 10.6.

In contrast to overall trends in most other areas of child mortality, child mortality from suicide showed a slow increasing trend (2.4% per year on average). Thirty suicides in 2020–21 is the second highest annual number recorded since 2004, after 37 suicides in 2018–19.

2 The Queensland Child Death Register is based on death registrations recorded by the Queensland Registry of Births, Deaths and Marriages. Deaths in this Annual Report are counted by date of death registration and may therefore differ from child death data based on date of death.

Leading cause by age

The leading causes of death changes with age, largely in line with the risks faced at each development stage. The leading external causes of death for 5–9 year olds was transport and for 10–14 year olds was suicide.

Age category		Leading cause ^a
Infants	0–27 days	Perinatal conditions
	28–364 days	SIDS and undetermined causes
	1–4 years	Drowning
	5–9 years	Neoplasms (cancers and tumours)
	10–14 years	Neoplasms (cancers and tumours)
	15–17 years	Suicide

a In the 5-year period 2016–17 to 2020–21.

Vulnerable groups

Some children are more vulnerable to experiencing adversity—including experiences that increase risk of death—than others. Aboriginal and Torres Strait Islander children and those children who are known to the child protection system (Child Safety)³ often experience multiple vulnerabilities and are consistently and significantly over-represented in child mortality statistics.

Seventy-one deaths in 2020–21 were of Aboriginal and Torres Strait Islander children, 41 died from natural causes (diseases and morbid conditions), 16 from external causes, 3 were unexplained deaths and 11 were pending a cause at the time of reporting.

Aboriginal and Torres Strait Islander children were over-represented in child deaths. The mortality rate for Indigenous children was 69.6 deaths per 100,000 Indigenous children aged 0–17 years, compared to 29.6 deaths per 100,000 non-Indigenous children (3-year average). The Indigenous mortality rate was 2.3 times the rate for non-Indigenous children for all causes. For external causes of death the Indigenous mortality rate was 3.0 times the non-Indigenous rate (5-year average).⁴

Of the 398 children and young people who died in 2020–21, 53 were known to Child Safety in the 12 months before they died. Causes of death for the 53 children at the time of reporting were:

- natural causes, 17
- transport incidents, 5
- drowning, 5
- other non-intentional injury, 6
- suicide, 4
- fatal assault and neglect, 2
- unexplained deaths, 5
- cause pending, 9.

The mortality rate for children known to Child Safety was almost twice the Queensland child mortality rate (5-year average). For external causes of death, the mortality rate for children known to Child Safety was four times the rate for all children in Queensland.

3 Department of Children, Youth Justice and Multicultural Affairs.

4 Rates are calculated as 3-year averages for major groups and 5-year averages for data which is further disaggregated.

This and previous annual reports have found child mortality rates for children known to Child Safety to be consistently higher than the rates for all children, especially for deaths from external causes. This is explained, to an extent, by the significant disadvantage, abuse and neglect these children experience prior to coming to the attention of the child protection system, as well as the often multiple risk factors present in their families.

Areas of focus

COVID-19

The QFCC will continue to monitor trends in child deaths, including any impacts or effects on suicidal behaviours, throughout the next phase of the COVID-19 pandemic.

Youth suicide remains an area of deep concern. A slow increasing trend in suicide over time continues to be evident. Adverse childhood experiences can contribute to increased vulnerability to poor mental health, and multiple family stressors including family violence were commonly present for young people who have taken their own lives.

Sudden unexpected infant deaths continue to represent a significant group of infant deaths. Adopting safe sleep practices from birth offers the best protections to reduce the risk of SIDS and sleep accidents. The families of infants dying suddenly during sleep were often complex and vulnerable. The Pépi-Pod® Program has shown encouraging results in improving the sleep safety of at-risk infants in vulnerable families.

The family factors which lead to children becoming known to the child protection system – child neglect and abuse, domestic violence and substance misuse – are also factors which present an increased risk of fatal injury in children. The Queensland Child Death Review Board (CDRB) is responsible for conducting systemic reviews following the death of a child connected to the child protection system. The CDRB's focus is on opportunities to improve the child protection system and prevent future deaths. The inaugural report of the CDRB will be tabled in Parliament during 2021–22.

New Child Death Register for Queensland

The QFCC launched its new Child Death Register, Coda, in March 2021. The replacement database has enhanced functionality and captures quality information in a more structured way. It enables the delivery of public education campaigns, government policy and design programs to help reduce preventable child deaths.

Data for prevention activities

The QFCC works with researchers and government agencies to raise community awareness and develop prevention programs and policies, by identifying risk factors, trends and emerging safety hazards.

The QFCC can provide detailed child death data to genuine researchers and organisations at no cost. Email child_death_prevention@qfcc.qld.gov.au

Resources available online

QFCC's 16-years data analysis report, *Counting lives, changing patterns*

Annual report resources:

- 17-year summary tables
- fact sheets
- Australian and New Zealand child death statistics.

This report includes chapters on categories of death and annual child death data for 2020–21. It identifies trends and contains a number of findings that may require further review. The QFCC will pursue opportunities to collaborate with researchers and other interested stakeholders.