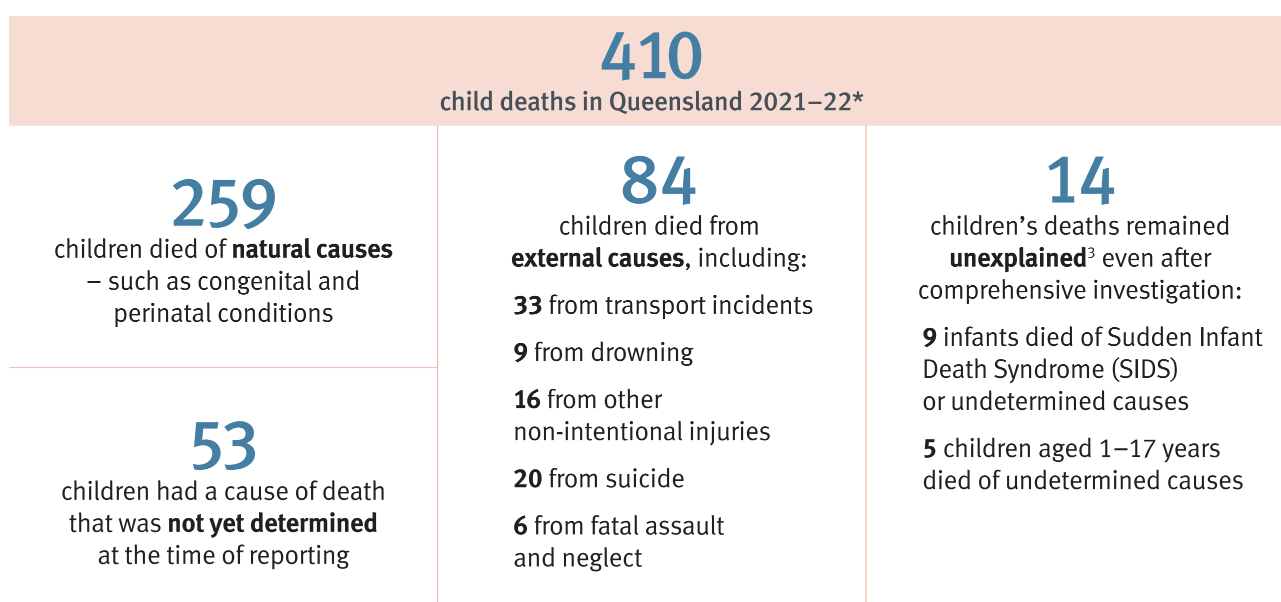
Executive summary

In the 12-month period from 1 July 2021 to 30 June 2022, the deaths of **410** 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, 2021–22



** By date of death registration.*

Trends in child mortality

While the last 2 years have seen a slight increase in the number of child deaths, there has been an overall decrease in child mortality rates since the Child Death Register commenced operation in 2004 (down 2.9% per year on average). The trend has been driven, to a large extent, by decreases in deaths from natural causes.

Transport-related child mortality has decreased 4.9% per year on average. However, higher numbers of transport deaths in the last 2 years have seen these rates begin to increase. In fact, the 33 transport deaths in 2021–22 is the highest transport total in the last 10 years, and mirrors increases in the road toll in Queensland and other jurisdictions.

The slowly increasing trend in the rate of youth suicide has continued. However, the 20 suicides recorded in 2021–22 was a decrease from the worryingly high numbers seen in 2018–19 (37) and 2020–21 (30). Further analysis suggests the suicide rate has increased more in young females than in young males.

Discouragingly, we have also seen increased numbers of sudden unexpected deaths in infancy (SUDI). In 2021–22 there were 44 sudden unexpected infant deaths in Queensland—the highest number of SUDIs in 8 years. These deaths continue to represent a considerable proportion of infant deaths.

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.

3 Where a cause of death could not be determined even after thorough investigation. It includes deaths from SIDS and undetermined causes.

Leading cause by age

The leading causes of death vary with age, largely in line with the risks faced by children at each stage of development.

Age category		Leading causes*		
		1	2	3
Infants	0–27 days	Perinatal conditions	Congenital anomalies	SIDS and undetermined causes
Infants	28–364 days	SIDS and undetermined causes	Congenital anomalies	Perinatal conditions
	1–4 years	Drowning	Transport	Cancers and tumours; Congenital anomalies
	5–9 years	Cancers and tumours	Transport	Drowning; Nervous system diseases
	10–14 years	Cancers and tumours	Suicide	Transport
	15–17 years	Suicide	Transport	Cancers and tumours

** In the 5-year period 2017–18 to 2021–22.*

Vulnerable groups

Some children are more vulnerable to experiencing adversity—including experiences that increase risk of death—than others. First Nations children and those children who are known to the child protection system (Child Safety)[4] often experience multiple vulnerabilities and are consistently and significantly over-represented in child mortality statistics.

Aboriginal and Torres Strait Islander children were over-represented in child deaths. Seventy deaths in 2021–22 were of Aboriginal and Torres Strait Islander children. Of these, 32 died from natural causes (diseases and morbid conditions), 21 from external causes, 3 were unexplained deaths and 14 were pending a cause of death at the time of reporting.

The mortality rate for Indigenous children was 2.4 times higher than for non-Indigenous children (71.7 deaths per 100,000 Indigenous children aged 0–17 years, compared with 30.0 deaths per 100,000 non-Indigenous children (5-year average)). For external causes of death specifically, the Indigenous mortality rate was 3.0 times the non-Indigenous rate (5-year average).

Sixty-nine of the 410 children who died in 2021–22 were known to Child Safety in the 12 months prior to their deaths, an increase from 53 deaths in 2020–21. Children are considered known to Child Safety if they were the subject of an intake call or intervention in the preceding 12 months. The population of children known to the child protection system has increased over the last 5 years, although this growth does not fully account for the increase in child deaths observed in the latest year.

The mortality rate for children known to Child Safety was almost twice the Queensland child mortality rate (5-year average). Children known to Child Safety were almost 4 times more likely to die of external causes than the total child population in Queensland.

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 may have experienced prior to coming to the attention of the child protection system, as well as the multiple risk factors often present in their lives.

4 Department of Children, Youth Justice and Multicultural Affairs.

Child death prevention activities

During 2021–22, the QFCC responded to 21 external requests for child death data, including to support:

- Australian Competition and Consumer Commission's (ACCC) review of infant inclined products
- Australian Government Department of Infrastructure, Transport, Regional Development, Communications and the Arts' review of vehicle reversing aid technologies
- ACCC's assessment of regulatory options to prevent injury and death from toppling furniture
- Workplace Health and Safety Queensland's consultation on quad bikes and side-by-side vehicles used in the workplace
- ACCC's discussion paper on helium balloon kit safety.

The QFCC also participated as an active member of a range of advisory groups, such as:

- Australian and New Zealand Child Death Review and Prevention Group
- Consumer Product Injury Research Advisory Group
- Interim Queensland Government Suicide Prevention Network
- QPQC Infant Mortality Sub-Committee
- QPQC Steering Committee
- Queensland Government Births and Deaths Working Group
- Road Safety Research Network
- SUDI multiagency advisory meeting.

The QFCC continued to monitor and support the response to, and prevention of, suicide deaths of young people including through a crucial information sharing process with the Department of Education. This process informs student wellbeing policy development and supports suicide postvention in affected schools. The QFCC also contributed to SUDI prevention projects resulting in publications including the ***Queensland Clinical Guidelines: Safer infant sleep***[5], and ***Best practice guide for the design of safe infant sleeping environments***.[6]

Safer pathways through childhood framework 2022–2027

The *Safer pathways through childhood* framework sets the direction of the QFCC's child death prevention functions over the next 5 years. The Action Plan for the coming year can be found at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**.

Collaborative partnerships

This report includes chapters on categories of death and identifies trends and findings that may require deeper investigation. The QFCC values the expertise of others and would welcome opportunities to work with stakeholders undertaking related initiatives.

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 at www.qfcc.qld.gov.au/about-us/publications/child-death-reports-and-data

Annual report resources

- 18-year summary tables
- fact sheets
- Australian and New Zealand child death statistics 2020
- Appendices B to G

Safer pathways through childhood framework 2022–2027

5 www.childrens.health.qld.gov.au/chq/health-professionals/qpqc

6 www.productsafety.gov.au/about-us/publications/best-practice-guide-for-the-design-of-safe-infant-sleeping-environments