Safer Pathways Through Childhood

Action Plan 2025–26

A message from the Principal Commissioner

The Queensland Family and Child Commission's *Safer pathways through childhood* framework (SPTC framework), sets the direction of our child death prevention functions through to 2027.

Every child death is a devastating loss, and our work is grounded in deep respect for the children who have died, their families, friends and community.

As a society we have made significant ground in reducing childhood mortality; however, data in the Child Death Register (the Register) continues to reflect that many child deaths are potentially preventable.

The SPTC framework is informed by a socio-ecological model that recognises the historical, cultural, social and economic circumstances that can create barriers to some groups of children experiencing optimal health outcomes.

Actions of the past year have helped us to share our learnings involving child deaths concerning motor vehicles, electric devices and youth suicide, with the aim to drive change to help eliminate these preventable deaths.

These actions continued alongside our focused work on child deaths from natural causes including infections involving Sepsis, and those deaths where infants die suddenly, usually during sleep, with no immediately obvious cause – sudden unexpected death in infancy (SUDI).

We cannot do this work alone. I thank our partners who are also dedicated to creating safer pathways through childhood by contributing evidence-based research and data on causes and risk factors for child deaths and injuries.

Through our combined research efforts, we gain a broader and deeper understanding of the factors in child deaths that are preventable or amenable to change. We then optimise on these insights to inform system improvements and drive change.

Over the next year – our fourth year of actions, we will remain focused on identifying prevention and intervention measures to reduce child mortality, specifically for preventable deaths. We will look to maximise the impact of our legislated child death prevention functions as part of our role in managing the Register in Queensland, which now holds over 20 years of data.

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

QUEENSLAND Family & Child Commission

Queensland Government

Safer Pathways Through Childhood

Priority populations

The Safer Pathways Through Childhood (SPTC) framework has prioritised activities aimed at producing findings to help identify ways to reduce health inequity among certain groups: children known to statutory systems such as the child protection and youth justice systems, First Nations children, children with disability, children living in remote or low socio-economic areas, and children under 5 years of age. The focus on these groups is evident throughout the projects outlined in each action plan.

Impact areas

There are four main ways our work under the SPTC framework makes an impact on reducing child deaths:

1. **Data quality:** We produce high quality data and contribute to improvements in related datasets.
2. Expertise: We value specialist knowledge and collaborate with expert stakeholders and the community.
3. **Research into action:** We seek opportunities to use our data and expertise to reduce the likelihood of child deaths.
4. **Continuous improvement:** We monitor data to identify emerging trends, system improvements and effective prevention initiatives.

We achieve these impacts in the context of collaborative partnerships.

Focus areas

Our work under the SPTC framework aims to contribute to the evidence-base about:

- disadvantage, adversity and social vulnerability
- risk-taking (by both children and parents)
- appropriate supervision across childhood
- help-seeking behaviour and access to services
- reducing risk through design, product safety and regulation
- improving data about First Nations children
- youth suicide prevention
- incidence and risk factors for sudden unexpected death in infancy (SUDI)
- preventable mortality.

2024–25

Completed actions

Unregistered child deaths

There is an increasing trend in child deaths that remain unregistered for more than 60 days, a period more than four times the statutory timeframe for death registration.

Last year we linked data with Registry of Births Deaths and Marriages (RBDM) and Queensland Health (QH) to quantify the under registration of child deaths. For children who had neither their birth nor their death registered, there is virtually no public record of their lives.

We identified approximately nine in ten unregistered deaths were infants, with infants who were born and died on the same day accounting for almost three quarters of all unregistered deaths. Almost two thirds of unregistered deaths were identified only in QH data. There is a possibility that there are, as yet, unidentified stillbirths in the group of children who were born and died on the same day.

As part of our normal operations, we will monitor the number of unregistered deaths and continue to escalate the records to RBDM for timely resolution. We will work together with RBDM and QH to identify ways to reduce the number of unregistered deaths in the future. This will help to ensure child death data in the Register is as accurate as possible.

Sudden unexpected death in infancy (SUDI)

SUDI remains a leading cause of post-neonatal deaths in Queensland, occurring at a higher rate than the national average.

SUDI remained a key focus of our child death prevention work in 2024–25. We provided data to support the Infant Mortality Subcommittee, Queensland Paediatric Quality Council, *Sudden and unexpected infant deaths during sleep in Queensland 2013-2016: Risk factors and opportunities for prevention* paper, released in April 2025. We also established an agreement with QH, First 2000 Days program, to provide regular SUDI data to support their ongoing work and research in this area.

We will continue to routinely apply an evidence-based classification system to classify cases of SUDI according to the likelihood of suffocation so we can better monitor the role of dangerous sleep environments and sleep accidents in SUDI. We will also continue to identify gaps in investigation and inform risk minimisation strategies as part of our normal operations.

Seatbelt and child car restraint use

123 children in Queensland have died in road crashes in the 20 years from 2004 to 2023.

In October 2024, we published the *Seatbelt and child restraint use in children 0–12 years* report. The report analyses the use of seatbelts and child restraints for children aged 0–12 years who died while passengers in motor vehicle crashes in Queensland between 2004–2023.

Although child death data suggests improved road safety outcomes for children travelling in motor vehicles, one in four children who died were not using any type of restraint, including an adult seatbelt, during travel. Nearly 60 per cent of the children who were unrestrained were Aboriginal and Torres Strait Islander children.

Approximately 75 per cent of fatally injured children, who were restrained during travel, were not restrained in accordance with best practice for their age. Australian laws relating to child restraint use and position of travel of children in the vehicle do not reflect evidence-based safest practice and lag notably behind other high resource countries internationally.

Narrowing the gap between legislation and best practice can help to improve passenger safety for infants and children.

As a result of this research, the Queensland Family and Child Commission (the Commission) was invited to sit as a member of the Child Restraint Review Expert Advisory Group, National Transport Commission. This group continues to meet and will make recommendations to Ministers on how the current model Australian Road Rules can be improved so the child restraint rules are up to date with the latest safety research and best practice guidelines and offer the best level of protection for all children.

www.qfcc.qld.gov.au/sites/default/files/202412/QFCC%20Seatbelt%20and%20car%20restraint%20use%20in%20children%20-%20road%20crash%20deaths%202004-2023.pdf

Annual child death review conference

Leaders in their fields shared their knowledge and expertise with conference participants.

In May 2025, we hosted the annual Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) Conference for a third year.

Leaders in their fields presented on a range of topics to deepen our understanding of risk factors around child death and strengthen prevention strategies. Sessions from the conference can be viewed on our website.

www.qfcc.qld.gov.au/2025/ANZCDRPG-Conference

Insights Papers

In 2025, we released the first insights paper in a series on the causes and factors that contribute to child fatalities in Queensland.

E-scooters and e-bikes

Children accounted for 25 per cent of all road crash deaths involving personal mobility devices and bicycle riders and pillions in Queensland, in 2024.

In June 2025, we published *Improving safety when young people ride e-scooters and e-bikes* Insights Paper. Evidence shows that road incidents involving e-scooters and e-bikes are becoming more frequent and more severe.

Child injury and death data suggests that children are often not riding in line with the road rules for example, children aged 12–15 years are not being supervised by an adult when riding an e-scooter and riders of all ages on e-scooters and e-bikes are often without a securely fitted and fastened approved helmet.

The paper makes a number of recommendations to improve safety outcomes, including the introduction of a minimum age of 16 years to lawfully ride e-scooters in Queensland.

The insights paper informed the Commission's submission to the Parliamentary Inquiry into e-mobility safety and use in Queensland.

www.qfcc.qld.gov.au/sites/default/files/2025-06/Improving-safety-when-young-people-ride-e-scooters-and-e-bikes.pdf
www.qfcc.qld.gov.au/sector/policy-submissions

Paediatric vehicular heatstroke

There have been 14 heat stress-related child deaths in vehicles in Queensland between 2004–2024.

This paper is pending release. The paper explores the circumstances that can increase the risk of a child becoming hidden, trapped or left unattended inside a vehicle, including a psychological condition, known as Forgotten Baby Syndrome.

The paper will present several key messages for prevention including, ***never leave a child unattended in a vehicle*** and ***always lock an unattended vehicle but firstly, look before you lock.***

The paper recommends a number of engineering, enforcement and education measures that are essential for effectively preventing children from being left unattended or becoming hidden, trapped or locked in vehicles.

2025–26

Continuing projects

Data linkage

Data linkage is a valuable way to enhance data in the Register, increasing its utility for informing child death prevention research and policy development.

Last year we maintained our focus on data linkage partnerships and explored new connections to help enhance child death data in the Register.

Data linkage partnerships (existing or explored) include:

- Registry of Births Deaths and Marriages (RBDM)
- Queensland Health (QH)
- Queensland Ambulance Service (QAS)
- Education Queensland
- Department of Housing.

We will continue to build our data linkage partnerships to increase our understanding of preventable child deaths and help to make a significant contribution to the research evidence on child mortality and potential prevention mechanisms.

Queensland Health

In September 2024, we established a memorandum of understanding (MOU) for data sharing with QH. We then provided a child death dataset to Health for data linkage.

This year, we will focus on linked perinatal, hospital admissions and emergency presentations data and linked ambulance call out and attendance data.

This will be an iterative process, requiring regular reviews by both agencies of the detailed data requirements as the project progresses. The aim is to routinely receive this linked data as part of our normal operations.

Research translation – paediatric sepsis

Sepsis in children is the biggest single cause of preventable death in childhood in Queensland.

We have partnered with the Queensland Paediatric Sepsis Program (QPSP) (Children's Health Queensland) since 2022.

Last year we continued our support to help QPSP action items in the five key areas outlined in the *Queensland paediatric sepsis mortality study*, published in February 2024.

We wrote to Hospital and Health Services across Queensland seeking their cooperation to help improve the identification of sepsis on cause of death certificates by developing a workflow and education package. We also made enhancements to the Register to capture additional information for infections.

This year we will continue to support QPSP by promoting their sepsis awareness campaigns through our social media channels, partner with Queensland University of Technology on post sepsis care research and maintain a spotlight on sepsis-related child deaths in our annual report.

www.qfcc.qld.gov.au/sites/default/files/2024-03/Paediatric%20Sepsis%20Mortality%20Study.pdf

Redefining assault and neglect

We are concerned that, consistent with international research, some child deaths due to abuse and neglect may be under-captured in the Register.

Last year we continued to enhance how we define and screen for fatal assault and neglect cases in the

Register. The intent is to have a sound, evidence informed, set of definitions and screening criteria for identifying all child maltreatment and neglect cases.

This year we will continue to refine our practice and bring together experts to help inform a classification system, with clearly delineated criteria, to identify all child deaths where maltreatment is the most probable cause, as well as those that occur in suspicious circumstances.

A broader, child-centred research classification will better facilitate the identification of factors common to multiple deaths, as well as opportunities for early intervention and prevention.

National child death data collection

There is a long-recognised need for comparable and consistent national information on the causes and circumstances of child deaths and risk factors for these deaths.

In March 2025, we provided data to the Australian Institute of Health and Welfare (AIHW) as part of their work piloting a national child death data collection.

A national data collection based on detailed data from Australian state and territory child death registries will provide richer data on causes and contributing factors in child deaths than is currently available in the National Mortality Dataset.

This year we will continue to monitor progress and support the efforts by AIHW.

Preventable mortality

There may be value in determining the range of conditions causing deaths considered to be preventable and categorising deaths to align with the focus of prevention initiatives.

In 2024–25 we continued our interest in further exploring alternative and/or complementary approaches to the classification and reporting of child deaths, particularly those due to diseases and morbid conditions (natural cause deaths).

The concept of preventable child mortality is also an area of interest highlighted by the Child Death Review Board (the Board). This year we will present information on this concept, the strengths and challenges of this approach, particularly for deaths due to diseases and morbid conditions (natural cause deaths), and preliminary data, to the Board for discussion.

Defined scope 2025–26

Aboriginal and Torres Strait Islander youth suicide

Mortality rates for Aboriginal and Torres Strait Islander children were more than 3 times higher than the non-Indigenous child mortality rates for suicide, 2023–24.

In 2024–25 we entered into a partnership with the Australian Institute for Suicide Research and Prevention (AISRAP), Griffith University, following Dr Amanda Gibson's success in securing a research funding grant.

This year we will provide child death data and in-kind support for Dr Gibson's research to explore the buffering effects of cultural connection on the relationship between experiences of racism on suicidality and help-seeking pathways for Aboriginal and Torres Strait Islander children.

This research is expected to span across several years. We look forward to contributing to this research and supporting the identification of opportunities for targeted suicide prevention for Aboriginal and Torres Strait Islander children.

Insights Papers

In 2025–26 we will publish additional Insights Papers on selected topics and factors that contribute to child fatalities in Queensland. Topics include:

- child deaths involving quad bikes and side-by-side vehicles
- child deaths by falls or drowning at waterfalls and rock pools
- incidences of child deaths from animal bites and stings.

These papers will contribute to the evidence-base about disadvantage, adversity and social vulnerability, risk-taking (by both children and parents), appropriate supervision across childhood, reducing risk through design, product safety and regulation, and child death prevention and awareness.

Discovery pieces

Youth suicide information paper

There has been a gradual, but statistically significant rise in youth suicide rates over time.

We have been considering ways to optimise research on trends and risk factors for youth suicide in Queensland over the past 20 years, to enhance its value for prevention, intervention, innovation and impact.

The Queensland Mental Health Commission's (QMHC's) *Every Life: The Queensland Suicide Prevention Plan 2019-2029 – Phase two*, seeks to '*consolidate existing data on issues affecting children and young people to identify trends and risk factors and provide timely access to that data to all relevant agencies*'.

In early 2025, we met with the QMHC to discuss our mutual interest in research that intersects mental health, the presence of child abuse and neglect, and suicide prevention. Both agencies have agreed to explore opportunities to scope future joint work to drive reform and improve the reliability of data regarding suicide.

www.qmhc.qld.gov.au/sites/default/files/documents/qmhc_every_life_phase_2_plan.pdf

This work will complement the Commission's current partnership with the Australian Catholic University on a comprehensive research project. This research aims to address the disparity between mental health care needs and service provision for children and young people who have experienced childhood maltreatment to build research evidence and identify practice solutions.

Fulfilling our legislative obligations

In addition to the specific prevention projects outlined in this action plan, in 2025–26 we will continue to fulfil our child death prevention functions under Part 3 of the *Family and Child Commission Act 2014*, including:

- maintaining a register of all child deaths in Queensland
- analysing and reporting on data in the Register in our Annual Report: Deaths of children and young people, Queensland
- responding to stakeholders' request for information and advice to support their prevention initiatives
- providing feedback on policies and programs
- releasing data to child death prevention researchers.

The Commission would welcome contacts from researchers and agencies interested in partnering on child death prevention initiatives. To discuss opportunities for collaboration or to make a request for child death information, email child_death_prevention@qfcc.qld.gov.au.

Child Death Review Board

In addition to our broader child death prevention functions, the Commission provides secretariat support to the Child Death Review Board (CDRB). The CDRB is an independent board established to carry out system reviews following the deaths of children connected to the child protection system.

These reviews identify opportunities to improve the child protection system and prevent future deaths. The CDRB uses agency information, research and data to make system-wide findings and recommendations for systemic improvements to help prevent deaths that may have been avoidable. Information about the CDRB, its reports and research publications, is available on our website.

www.cdrb.qld.gov.au/

Table of actions

Action	Category of death	Priority population	Focus area	Impact area
Continuing projects				
Data linkage Link administrative datasets to build the evidence base on precipitating factors to child deaths.	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Fostering expertise • Collaborative partnerships
Research translation – paediatric sepsis Translating the findings and recommendations of the sepsis study into practice.	Natural cause deaths	All priority population groups	• Building capacity and monitoring trends	• Data quality • Continuous improvement • Collaborative partnerships
Redefining assault and neglect Seek expert advice to identify deaths due to, or suspicious of, assault and neglect, including supervisory neglect.	Assault and neglect	All priority population groups	• Building capacity and monitoring trends • Risk-taking • Supervision • Help-seeking and access to services • Family-level adversity	• Data quality • Fostering expertise • Collaborative partnerships
National child death data collection Collate richer data on causes and contributing factors in child deaths.	All causes	All priority population groups	• Building capacity and monitoring trends	• Data quality • Fostering expertise • Collaborative partnerships
Preventable childhood mortality Defining preventable causes of death for children.	Preventable deaths	All priority population groups	• Building capacity and monitoring trends • Help-seeking and access to services • Family-level adversity	• Data quality • Fostering expertise • Continuous improvement • Collaborative partnerships
Aboriginal and Torres Strait Islander youth suicide Explore the buffering effects of cultural connection on the relationship between experiences of racism on	Suicide	Fist Nations children (except children under 9 years)	• Help-seeking and access to services • Family-level adversity	• Research into action • Continuous improvement • Collaborative partnerships

Action	Category of death	Priority population	Focus area	Impact area
suicidality and help-seeking pathways for First Nations children.				
Defined scope projects				
Insights papers Provide insights into selected causes and factors that contribute to child fatalities in Queensland.	Preventable deaths	All priority areas	• Building capacity and monitoring trends • Risk-taking • Supervision • Environmental hazards, product safety and regulation	• Research into action • Continuous improvement • Collaborative partnerships
Discovery pieces				
Youth suicide information paper Identifying trends and risk factors for youth suicide over 20 years.	Suicide	All priority population groups (except children under 5)	• Building capacity and monitoring trends • Family level adversity	• Research into action • Collaborative partnerships