1 Child deaths in Queensland

In 2024–25, 427 children tragically lost their lives in Queensland. By closely examining the circumstances surrounding each death, we aim to identify patterns, inform policy, and implement preventative measures to safeguard the lives of children in the future. By identifying key trends and areas for further investigation we can better address overlapping risks in children's lives. Through our collaborative partnerships we aim to influence change to service delivery for at-risk children and their families.

We ensure the Queensland Child Death Review Board (the Board) is supported in their role to improve systems by providing access to timely and comprehensive information on causes and contributing factors in child deaths, especially for deaths of children known to the child protection system. In the last year we contributed to thematic analysis of issues involving school engagement and student behaviour, and housing instability and family and domestic violence.

Through the insights in our 21-year analysis of mortality in Aboriginal and Torres Strait Islander children, we contribute to Queensland Government's Closing the Gap report—measuring progress in improving outcomes for Aboriginal and Torres Strait Islander peoples.

The Commission hosted the Australian and New Zealand Child Death Review and Prevention Conference for the third year, as well as the annual meeting of the specialist child death review teams in each jurisdiction. The conference included presentations from leaders in their fields on a range of topics to deepen our understanding of risk factors around child death and strengthen prevention strategies. It attracted over 200 participants from across Australia and New Zealand from child protection, injury prevention, health, coronial, and research sectors.

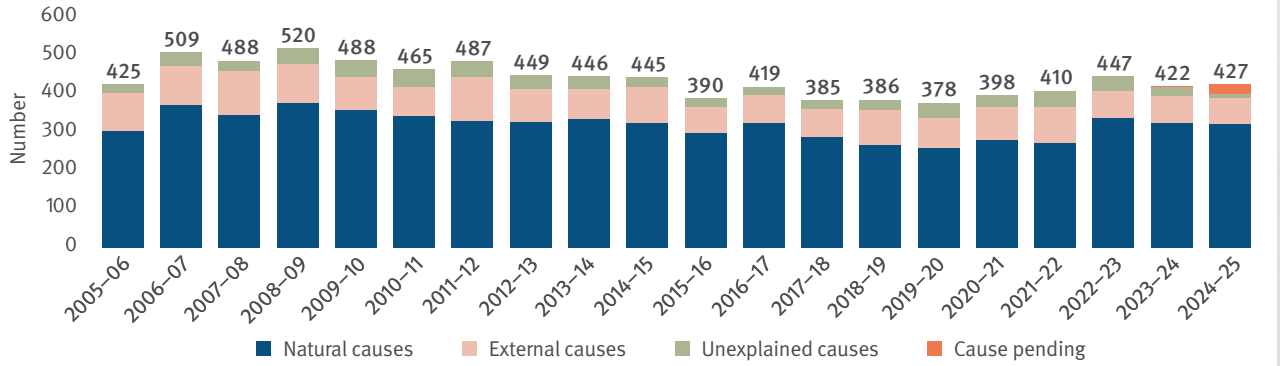
There is a long-recognised need for comparable and consistent national information on the causes and circumstances of child deaths and risk factors for these deaths. We are supporting work to achieve this and contributed data for a pilot by the Australian Institute of Health and Welfare (AIHW) of a national data collection.

Our analysis of child deaths is helping to deepen understanding of the complex risk factors contributing to child mortality in other jurisdictions. For example, we provided the NSW Ombudsman with data on the prevalence of child deaths where there is a parental history of methamphetamine or other stimulant use, to support their investigation of the issue in their jurisdiction.

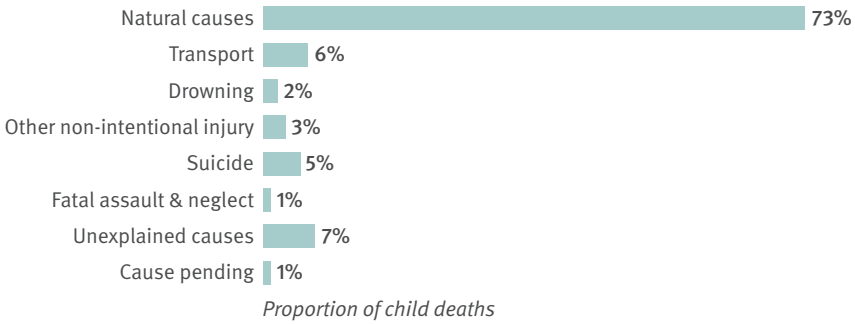
We continue to invite researchers to harness the rich and diverse data within the Child Death Register (the Register) to drive innovative, evidence-based research. By leveraging this resource, researchers can uncover new insights, inform policy, and contribute to meaningful advancements across systems. Our commitment to data accessibility and research collaboration ensures that the Register serves as a valuable foundation for impactful, real-world outcomes.

Key facts on child deaths in Queensland

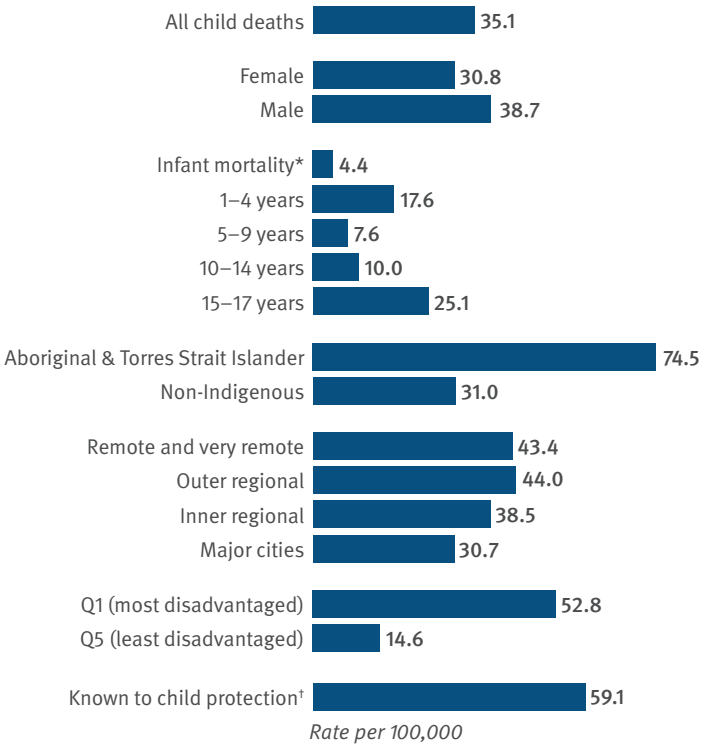
2005 to 2025



5-year summary (2020–2025) | Cause of death category



Demographics



Leading cause by age

0–27 days	**Perinatal conditions** 2.3 per 1,000 births
28–364 days	**SIDS and undetermined** 0.4 per 1,000 births
1–4 years	**Cancers and tumours** 3.3 per 100,000
5–9 years	**Cancers and tumours** 2.1 per 100,000
10–14 years	**Suicide** 2.1 per 100,000
15–17 years	**Suicide** 7.6 per 100,000

Notes: Counting is by date of death registration. Percentages may not add to 100 due to rounding.
** rate per 1,000 births.*
† in the 12 months prior to death.

Key findings

Between 1 July 2024 and 30 June 2025, the deaths of 427 children and young people were registered in Queensland. The child mortality rate over the last 5 years was 35.1 deaths per 100,000 children aged 0–17 years and the infant mortality rate was 4.4 per 1,000 births.[3] Queensland's child mortality rate is high compared with other Australian states and territories. In 2022, Queensland's child mortality rate was 36.3 per 100,000 children aged 0–17 years, a mid to high-range value compared to other Australian jurisdictions which ranged between 22.5 (Victoria) and 67.9 (Northern Territory).[4]

A summary table of child deaths by cause and key characteristics can be found in **Table A.1** in **Appendix A**.

Natural causes (diseases and morbid conditions) accounted for 75% of deaths of children and young people in 2024–25, occurring at a rate of 25.6 deaths per 100,000 (5-year average).[5]

Sixty-eight deaths were from external causes (which include transport, drowning, other non-intentional injury, suicide and fatal assault and neglect). External causes accounted for 16% of child deaths in 2024–25 and occurred at a rate of 6.6 deaths per 100,000 (5-year average).

Other than natural causes, the leading causes of deaths in 2024–25 were suicide (24), transport incidents (23), unexplained causes (13), followed by drowning (10). Seven children died from other non-intentional injuries and 4 children died as a result of fatal assault and neglect.

Causes of death are often not available until the outcomes of autopsy and coronial investigations are final. For this reason, some deaths are reported as 'cause pending'. Final outcomes are usually available within 1–2 years, at which point the Register is updated to reflect the official cause. Of the 427 deaths of children and young people in 2024–25, 6% (25 deaths) were recorded as 'cause pending'. The majority pending a cause are infant deaths and are often found to be from unexplained causes (based on outcomes in previous periods).

Trends

Higher numbers of deaths from natural causes in the last 3 years have contributed to higher totals in child deaths. Natural cause deaths in the last 3 years ranged between 321 and 337. By comparison, natural cause deaths in the previous 5 years ranged between 267 and 289.

In contrast, the 68 deaths from external causes in 2024–25 was second lowest after 2015–16 (67) for any year since 2004–05.

Child mortality rates; however, have generally declined over time. Broad trends in rates over the period 2004 to 2025 are illustrated in Figure 1.1 using 5-year rolling rates.[6] Key findings on changes between 2004–09 and 2020–25 include:

- the child mortality rate decreased 2.2% per year on average
- the overall trend is driven by decreases in child deaths from natural causes, which constituted the majority of child deaths, and decreased by 2.2% per year on average
- deaths from external causes decreased by 2.3% per year on average.[7]

The upturn in the mortality rates for all causes and natural cause reflect the higher numbers in the totals for the last 3 years.

3 For a summary of the population data used to calculate rates, see **Appendix B—Methodology** available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

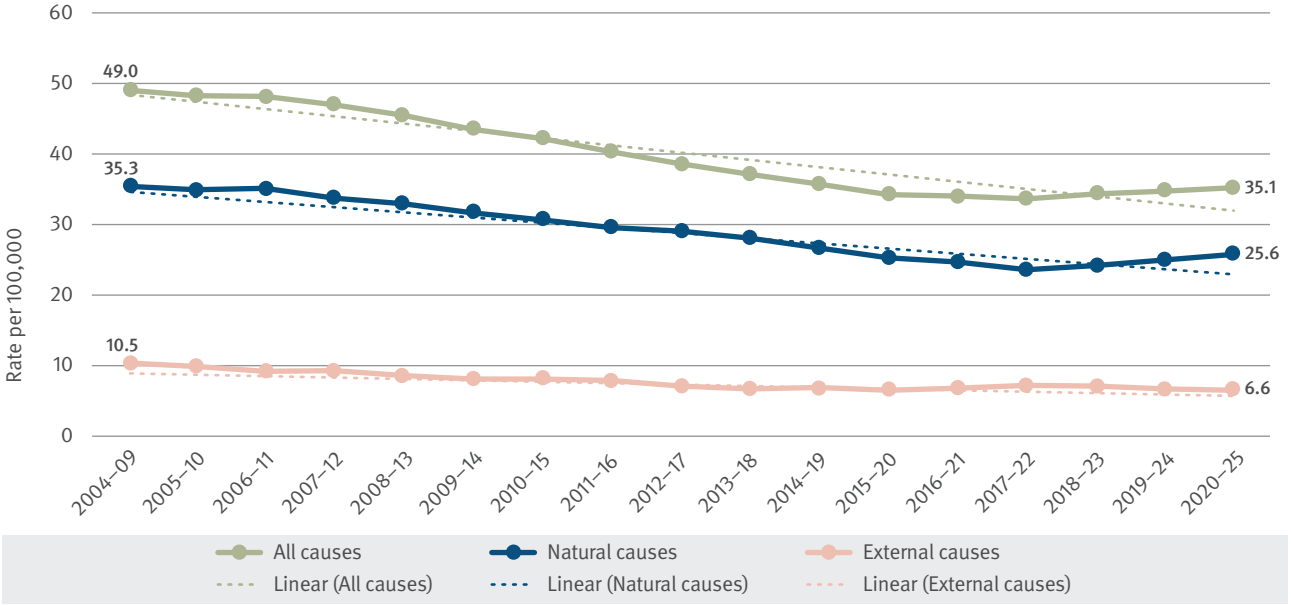
4 QFCC (Queensland Family and Child Commission) (2025) *Australian and New Zealand child death statistics 2022*, **www.qfcc.qld.gov.au/sector/child-death/child-death-statistics-anz**

5 Detailed tables with data on cause of death and other demographics can be found in **Appendix A**.

6 Tables with data for 2004–2025 are available online at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

7 Average annual changes are based on the applicable changes in the trend line.

Figure 1.1: Child deaths by major cause group (5-year rolling rate), 2004–09 to 2020–25



Notes: Rates calculated per 100,000 population aged 0–17 years, averaged over 5 years.

The child mortality rates for the primary causes of death are illustrated in Figures 1.2 and 1.3.

Transport had been the leading external cause of child death up until 2016, with rates at least twice those for other external causes. The transport trend line decreased 3.7% per year on average between 2004–09 and 2020–25. Notwithstanding the overall decrease since 2004, higher numbers of transport deaths especially from 2020 to 2023 have led to the rates to increase and plateau.

In contrast, the suicide mortality rate has slowly increased across most of the periods (trend line up 1.2% per year on average),[8] such that between 2014–19 and 2016–21 the rates of suicide exceeded the rates of transport deaths. High numbers of suicides recorded in 2018–19 and 2020–21 (37 and 30 respectively) contributed to an increase in rates, but with lower numbers in the last 4 years the suicide rate has decreased in the most recent periods.

Figure 1.2 also shows the mortality rate for deaths from unexplained causes. As indicated in the figure, child deaths from unexplained causes have exceeded deaths from transport and suicide in almost all periods since 2008–13. The trend line for mortality from unexplained causes decreased by 2.2% per year on average.[9] Most deaths in this group are infant deaths certified as sudden infant death syndrome (SIDS) or undetermined causes. The dip in numbers and rates in the most recent period is most likely due to the deaths which are pending a cause at the time of reporting, as opposed to an actual decrease.

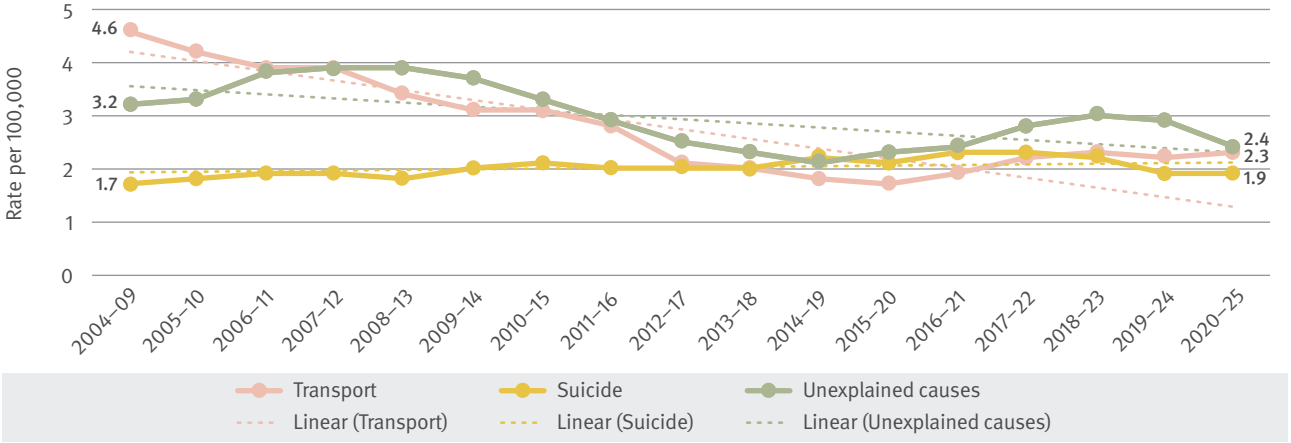
Mortality rates for drowning, other non-intentional injury and fatal assault and neglect, shown in Figure 1.3, decreased between 2004–09 and 2020–25, with the trend lines decreasing 3.0%, 1.9% and 1.7% respectively per year.[10]

8 The increase between 2004–09 and 2020–25 did not reach statistical significance.

9 The decrease between 2004–09 and 2020–25 did not reach statistical significance.

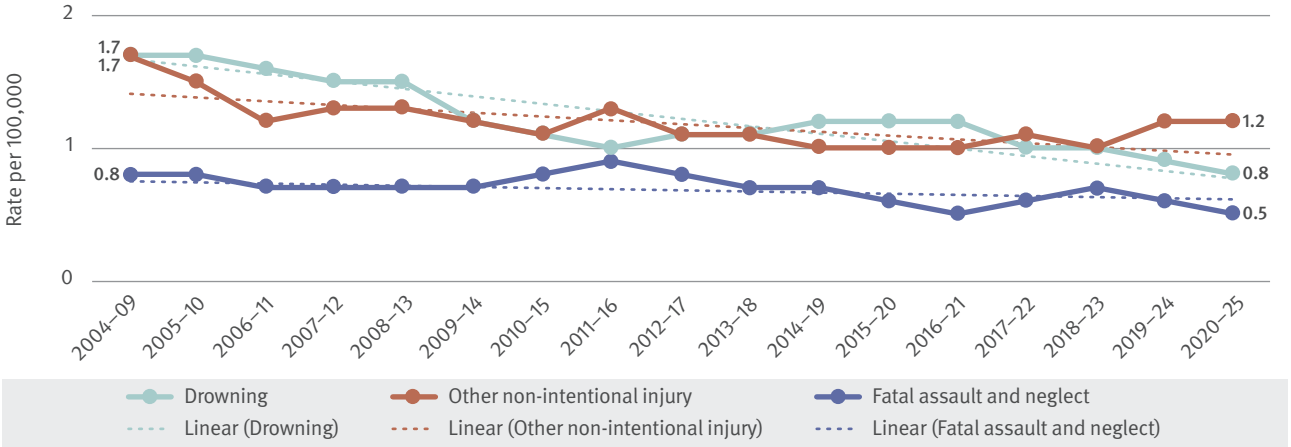
10 The decreases between 2004–09 and 2020–25 in other non-intentional injury and fatal assault and neglect did not reach statistical significance.

Figure 1.2: Transport, suicide and unexplained causes (5-year rolling rate), 2004–09 to 2020–25



Notes: Rates calculated per 100,000 population aged 0–17 years, averaged over 5 years.

Figure 1.3: Drowning, other non-intentional injury and fatal assault and neglect (5-year rolling rate), 2004–09 to 2020–25



Notes: Rates calculated per 100,000 population aged 0–17 years, averaged over 5 years.

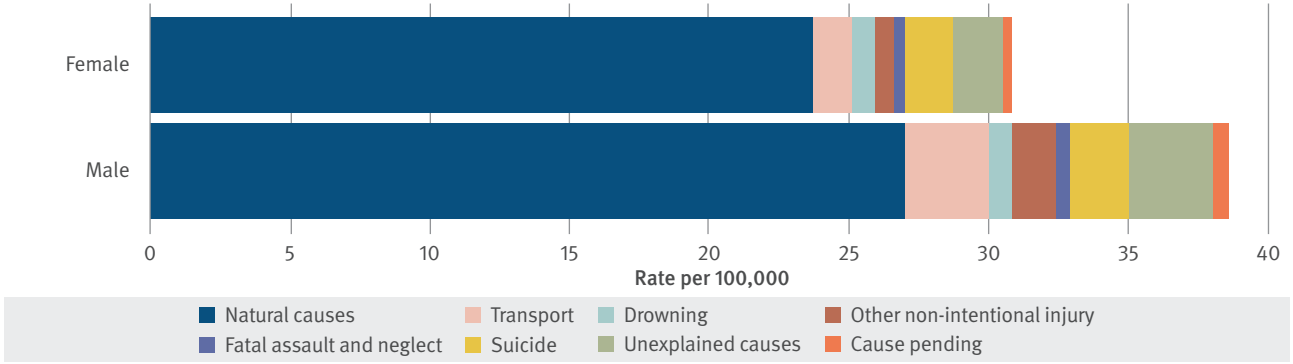
Demographics

Sex

In 2024–25, 59.5% of deaths were male children while 40.0% were female children. Two deaths (0.5%) were infants of indeterminate sex.[11] The 5-year mortality rates per 100,000 population aged 0–17 years were 38.7 for males and 30.8 for females.

Males were over-represented across most categories of death, particularly in deaths from transport incidents and other non-intentional injuries.

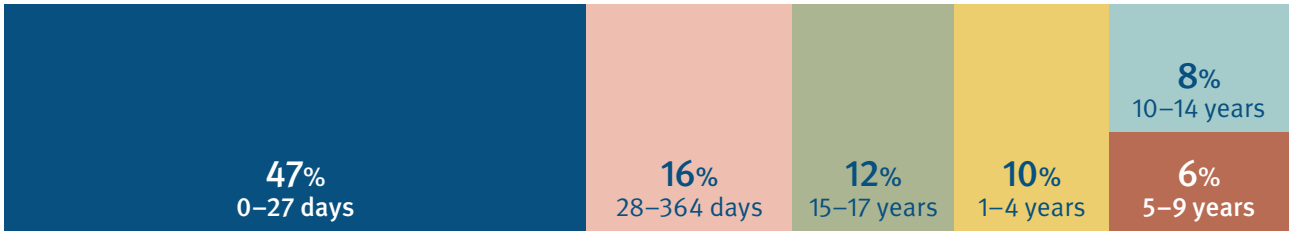
Figure 1.4: Deaths by sex and cause of death (rate), 2020–21 to 2024–25



Age

Figures 1.5 to 1.7 reveal the considerable differences in child deaths by age and cause. As shown in Figure 1.5, over the last 5 years, 47% of all child deaths occurred in the first days and weeks of life (0–27 days), and a further 16% were post-neonatal infants (28–364 days).

Figure 1.5: Deaths by age (proportion), 2020–21 to 2024–25



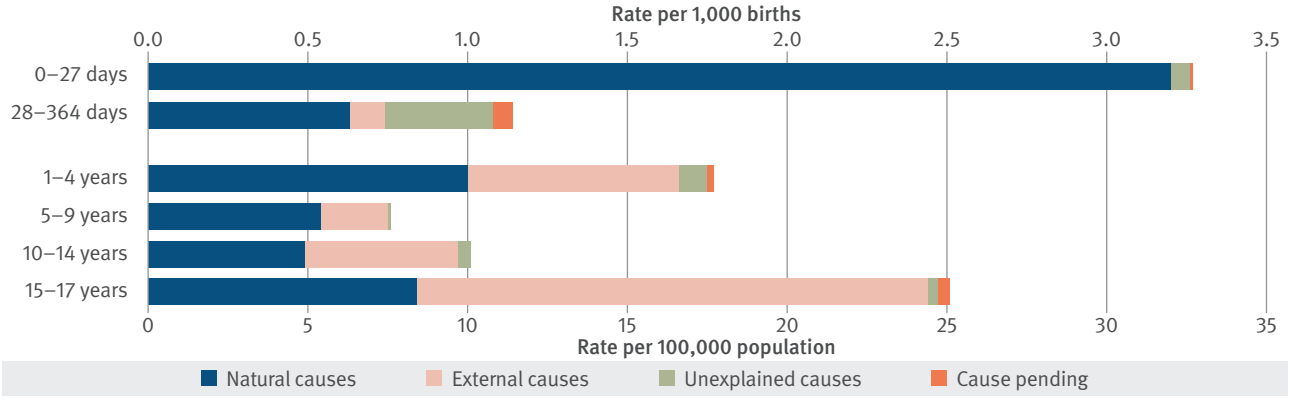
Notes: Percentages may not add to 100 due to rounding.

In Figure 1.6, rates of death are presented as per 1,000 live births for infants and per 100,000 population for older age groups. Almost all deaths in the 0–27 days age group were from natural causes, with a rate of 3.2 natural-cause deaths per 1,000 live births and the total mortality rate was also 3.2 per 1,000. In all other age groups between one-third and two-thirds of the deaths were from natural causes.

External causes were larger contributors to overall mortality in older age groups. This was most marked for children aged 15–17 years (64% from external causes), followed by 10–14 years (47% from external causes). Unexplained causes made a greater contribution to the overall mortality rate for infants aged 28–364 days than in any other age group (30%).

11 Arises in births of extreme prematurity.

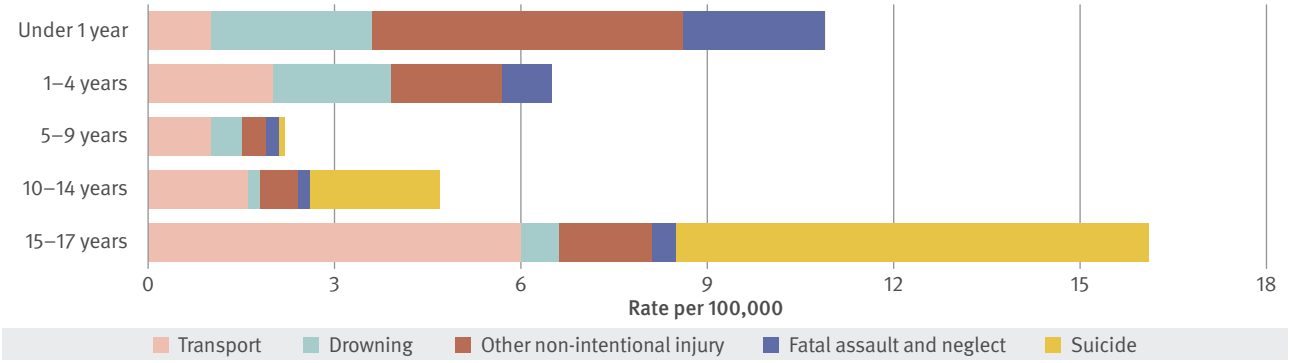
Figure 1.6: Deaths by age and major cause group (rate), 2020–21 to 2024–25



Notes: Rates for 0–27 days and 28–364 days calculated per 1,000 live births and, for age 1–17 years, per 100,000 population in each age category, averaged over 5 years.

Patterns in rates of external-cause deaths by age are indicated in Figure 1.7. Children aged 15–17 years and infants under 1 year had the highest rates of death from external causes, followed by children aged 1–4 years. Suicide was the leading external cause for children aged 10–14 and 15–17 years, while drowning was the leading external cause for children aged 1–4 years. The leading external causes for infants under 1 year were other non-intentional injuries, drowning, and fatal assault and neglect.

Figure 1.7: External-cause deaths by age (rate), 2020–21 to 2024–25



Notes: Rates for age groups, including under 1 year, are calculated per 100,000 population, averaged over 5 years.

Leading causes of death

Table 1.1 indicates the leading causes of death in each age category, based on deaths in the last 5 years. The table uses categories from the *International Classification of Diseases and Related Health Problems, tenth revision* (ICD-10). Further detail on causes of death by age can be found in **Appendix D** (available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**).

The leading causes of death for infants 0–27 days were perinatal conditions followed by congenital anomalies. For infants 28–364 days, the leading cause was SIDS and undetermined causes (as a group).

Cancers and tumours and transport incidents were among the top 3 leading causes for each age category from 1–17 years. Cancers and tumours were the leading cause of death for children aged 1–4 years and 5–9 years.

Suicide and transport were leading causes of death for children aged 15–17 years and for those aged 10–14 years.

Young children aged 1–4 years are more vulnerable to external causes of death. After cancers and tumours, transport, drowning and other non-intentional injuries were leading causes in this age group.

Table 1.1: Top 4 leading causes of death by age (rate per 1,000/100,000), 2020–21 to 2024–25

Age category	1	2	3	4
0–27 days	Perinatal conditions (2.3)	Congenital anomalies (0.8)	SIDS and undetermined causes (0.06)	Nervous system diseases (0.02)
28–364 days	SIDS and undetermined causes (0.4)	Congenital anomalies (0.3)	Perinatal conditions (0.2)	Nervous system diseases (0.05)
Under 1 year	Perinatal conditions (2.5)	Congenital anomalies (1.0)	SIDS and undetermined causes (0.4)	Nervous system diseases (0.1)
1–4 years	Cancers and tumours (3.3)	Transport (2.0)	Drowning (1.9)	Other non-intentional injury (1.8)
5–9 years	Cancers and tumours (2.1)	Transport (1.0)	Nervous system diseases (1.0)	Congenital anomalies (0.7)
10–14 years	Suicide (2.1)	Cancers and tumours (1.9)	Transport (1.6)	Nervous system diseases (1.3)
15–17 years	Suicide (7.6)	Transport (6.0)	Cancers and tumours (2.5)	Nervous system diseases (2.0)
0–17 years	Perinatal conditions (12.8)	Congenital anomalies (5.9)	Cancers and tumours (2.4)	SIDS and undetermined causes (2.4)

SIDS Sudden infant death syndrome.
Notes: The ICD-10 chapter classifications for diseases and morbid conditions (rather than the broader categories of death reported elsewhere) is used in this table and may therefore differ from other cause of death comparisons within the report. Rates are averaged over 5 years and calculated per 1,000 births for infants under 1 year and per 100,000 population in age categories 1–17 years.

Table 1.2 highlights the leading non-natural causes of death among children (5-year average). Unexplained causes (SIDS and undetermined causes) ranks as the leading cause of non-natural death in the 0–17 years age group. Transport-related deaths are a close second leading non-natural cause of death in children followed by suicide.

Table 1.2: Top 4 leading causes of death from non-natural causes (rate per 100,000), 2020–21 to 2024–25

Age category	1	2	3	4
0–17 years	SIDS and undetermined causes (2.4)	Transport (2.3)	Suicide (1.9)	Other non-intentional injury (1.2)

Regional and remote areas

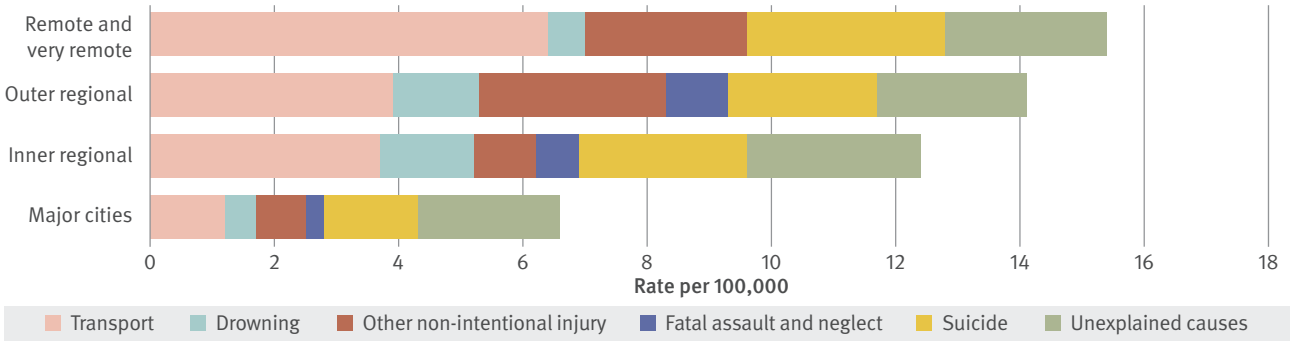
The child mortality rate from all causes was highest in outer regional areas and remote and very remote areas of Queensland, with rates of 44.0 and 43.4 per 100,000 respectively, compared with 38.5 in inner regional areas and 30.7 in major cities (5-year average).[12,13]

Figure 1.8 illustrates that rates of deaths from external and unexplained causes, taken together, increase with increasing remoteness from population centres and services. In particular, the differences in transport death rates between major cities and other areas were found to be statistically significant.

12 Analysis based on the Accessibility/Remoteness Index of Australia Plus (ARIA+) for the child's place of usual residence. ARIA+ is a measure of remoteness that ranks locations based on their distance by road to a centre that provides services. www.qgso.qld.gov.au/about-statistics/statistical-standards-classifications/accessibility-remoteness-index-australia

13 Rates exclude deaths of children whose usual residence was outside Queensland. See the *21-year data tables* available on the report home page for detailed data www.qfcc.qld.gov.au/about-us/publications/child-death-reports-and-data

Figure 1.8: ARIA+ of usual place of residence by selected causes of death (rate), 2020–21 to 2024–25



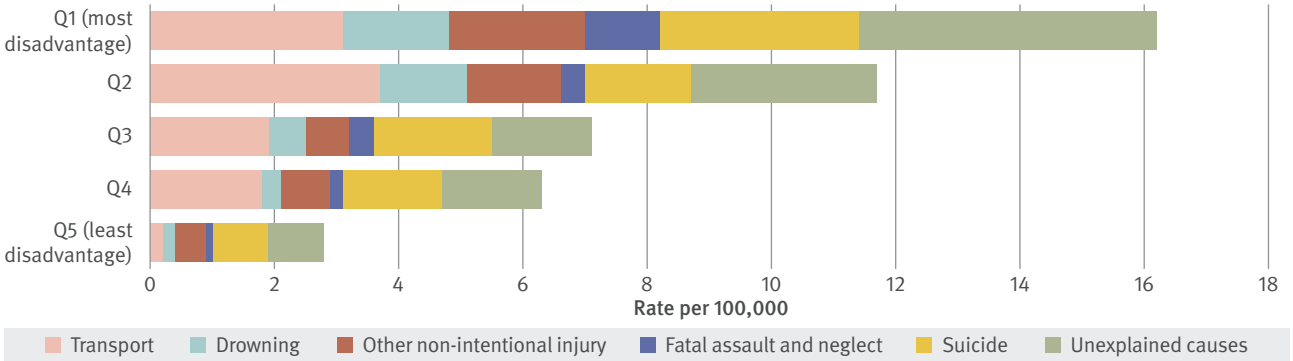
Notes: Rates calculated per 100,000 population aged 0–17 years in each ARIA+ category, averaged over 5 years. Excludes the deaths of children whose usual place of residence was outside Queensland.

Socio-economic disadvantage

The child mortality rate from all causes was highest in areas with the greatest levels of socio-economic disadvantage.[14] The rate of child deaths in quintile 1 areas (most disadvantaged) was 52.8 per 100,000 children aged 0–17 years, compared with 32.7 in quintile 3 areas and 14.6 in quintile 5 areas (least disadvantaged) (5-year average).[15]

Figure 1.9 illustrates that rates of death from external and unexplained causes, taken together, increase with increasing socio-economic disadvantage. The differences in rates of death between areas of greatest and least disadvantage were statistically significant for transport, drowning, suicide, and unexplained causes (although the raw numbers for quintile 5 were low).

Figure 1.9: SEIFA quintile of usual place of residence by selected causes of death (rate), 2020–21 to 2024–25



Notes: Rates calculated per 100,000 population aged 0–17 years in each SEIFA quintile, averaged over 5 years. Excludes the deaths of children whose usual place of residence was outside Queensland.

14 Analysis is based on the Socio-Economic Indexes of Australia (SEIFA) score for the child's place of the usual residence. SEIFA is allocated to geographic areas to represent their level of advantage or disadvantage from Census data. www.abs.gov.au/websitedbs/censushome.nsf/home/seifa

15 Rates exclude deaths of children whose usual residence was outside Queensland. See the *21-year data tables* available on the report home page for detailed data.

Aboriginal and Torres Strait Islander children

The deaths of 88 Aboriginal and Torres Strait Islander children were registered in 2024–25, of which:

- 66 were from natural causes
- 12 were external causes
- 5 were unexplained causes
- 5 deaths were pending a cause at the time of reporting.

Aboriginal and Torres Strait Islander children are over-represented in child deaths. The mortality rate for Aboriginal and Torres Strait Islander children was 74.5 deaths per 100,000 Aboriginal and Torres Strait Islander children aged 0–17 years, compared with 31.0 deaths per 100,000 non-Indigenous children (5-year average). The Aboriginal and Torres Strait Islander mortality rate was 2.4 times the rate for non-Indigenous children for all causes.[16]

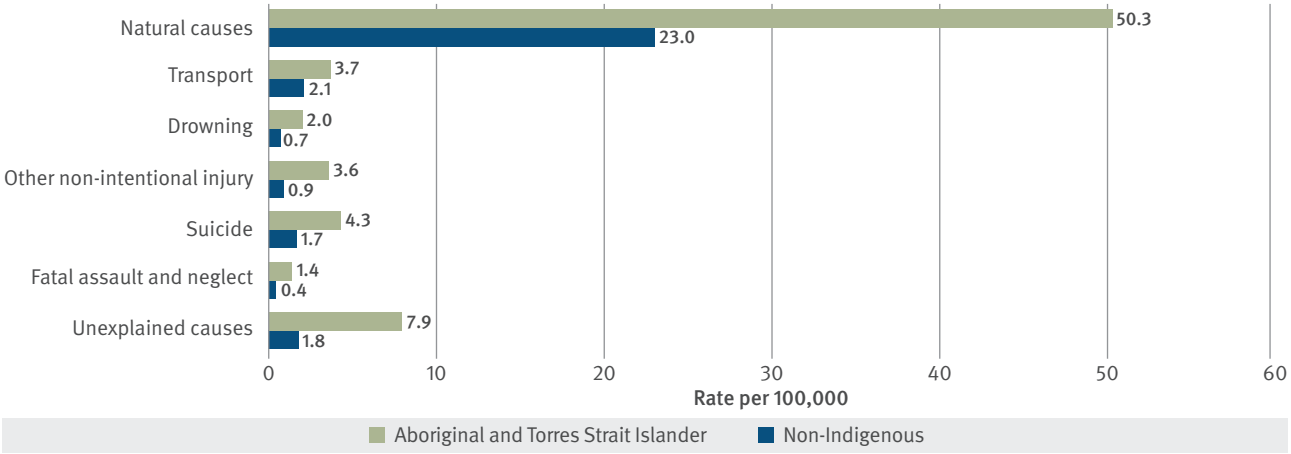
The Aboriginal and Torres Strait Islander infant mortality rate was 7.5 deaths per 1,000 Aboriginal and Torres Strait Islander births, compared with 4.0 deaths per 1,000 non-Indigenous births (5-year average).

The level of over-representation was higher for certain causes of death, as illustrated in Figure 1.10. The differences between rates were statistically significant for natural causes, other non-intentional injury, and unexplained causes. Mortality rates for Aboriginal and Torres Strait Islander children were 4 (or more) times higher than the non-Indigenous child mortality rates for:

- other non-intentional injury
- unexplained causes.

Aboriginal and Torres Strait Islander infants were also over-represented in sudden unexpected death in infancy with a mortality rate 4 times that for non-Indigenous infants (1.7 and 0.4 per 1,000 births, respectively).

Figure 1.10: Cause of death by Aboriginal and Torres Strait Islander status (rate), 2020–21 to 2024–25



Notes: Rates calculated per 100,000 Aboriginal and Torres Strait Islander and non-Indigenous children aged 0–17 years, averaged over 5 years.

The structural inequalities experienced by First Nations families are profound. They stem from the legacy of colonisation and forced removals of children, and have resulted in the loss of cultural traditions, language, and family structure, producing intergenerational trauma. Historical and continued marginalisation of Indigenous culture and knowledge systems have created persistent socio-economic and educational inequalities. These contribute to higher rates of social risk factors for current generations including unemployment, poverty, substance misuse, family violence, residential instability and ill health.[17] Together, these factors can increase the risk of childhood injury and death.

16 See Appendix A, Table A.2 for detailed data.

17 McNamara B, Gubhaju L, Jorm L, Preen D, Jones J, Joshy G, Shepherd C, McAullay D, and Eades S (2018) 'Exploring factors impacting early childhood health among Aboriginal and Torres Strait Islander families and communities: Protocol for a population-based cohort study using data linkage (the 'Defying the Odds' study)', *BMJ Open*, 8, doi.org/10.1136/bmjopen-2017-021236

Trends

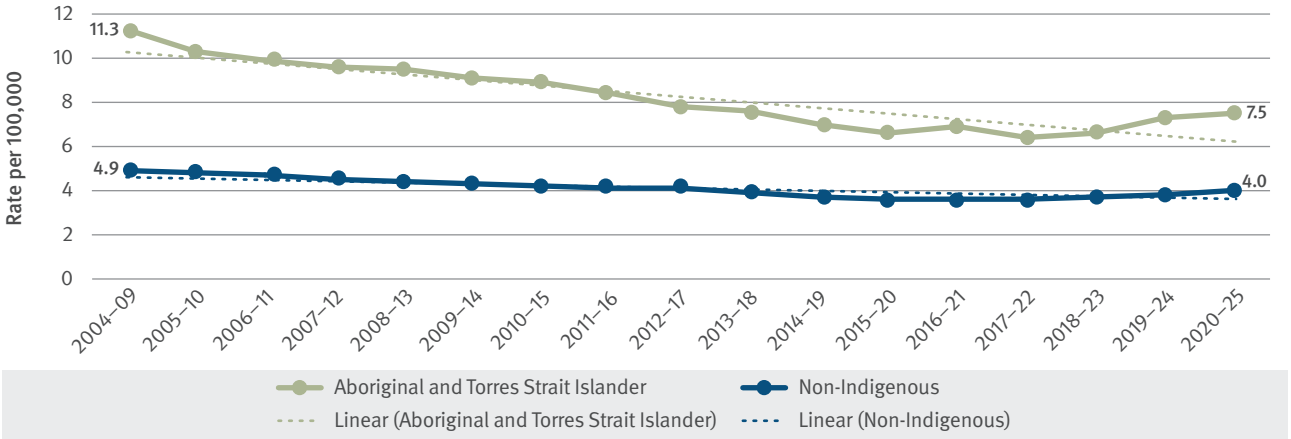
Aboriginal and Torres Strait Islander population estimates

Calculations of mortality rates for Aboriginal and Torres Strait Islanders in this report use as a denominator the estimated resident population (ERP), excepting for the age group under 1 year where the number of live births is used as the denominator. In July 2024, the Australian Bureau of Statistics (ABS) released the 2021 Census-based estimates and projections for Aboriginal and Torres Strait Islander Australians for 2011 to 2031.[18] Analyses of mortality rates by Indigenous status which use the population estimates as a denominator are only available from 2011, as estimates for earlier years are not available in the latest release.

The infant mortality rate for Aboriginal and Torres Strait Islanders decreased since 2004 at a faster rate compared to the non-Indigenous rate, as shown in Figure 1.11. Between 2004–09 and 2020–25 the Indigenous infant mortality rate decreased 2.5% per year on average while the non-Indigenous rate decreased 1.6% per year (as indicated in the trend lines). Increased rates are apparent in both categories in the last 3 periods.

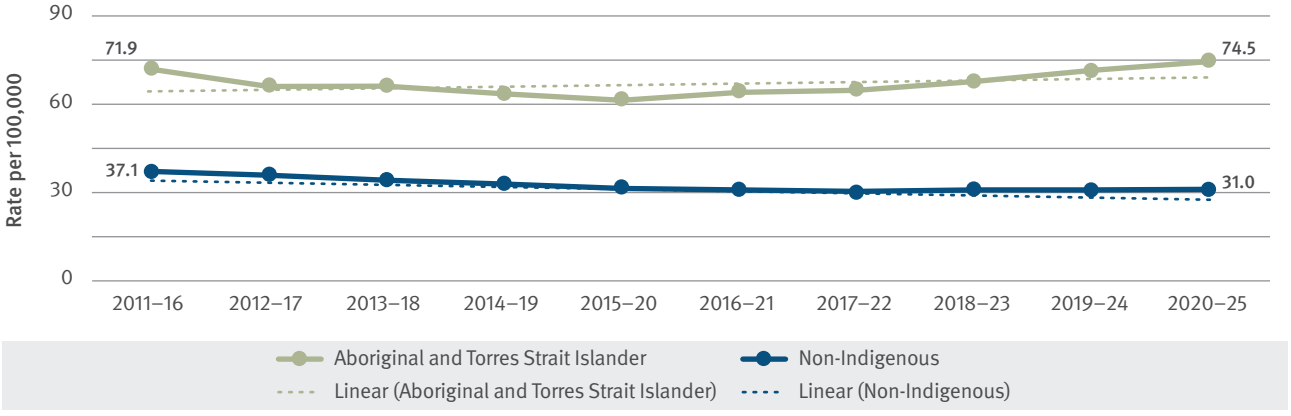
The trends in the child mortality rate (0–17 years) by Indigenous status between 2011–16 to 2020–25 are illustrated in Figure 1.12. No notable changes in mortality rates were apparent in either of the categories, with the slight increasing trend in the Aboriginal and Torres Strait Islander rate and the slight decreasing trend in the non-Indigenous rate not representative of changes which were statistically significant.

Figure 1.11: Infant deaths by Aboriginal and Torres Strait Islander status (5-year rolling rate), 2004–09 to 2020–25



Notes: Rates calculated per 1,000 Aboriginal and Torres Strait Islander and non-Indigenous live births, averaged over 5 years.

Figure 1.12: Child deaths (0–17 years) by Aboriginal and Torres Strait Islander status (5-year rolling rate), 2011–16 to 2020–25



Notes: Rates calculated per 100,000 Aboriginal and Torres Strait Islander and non-Indigenous children aged 0–17 years, averaged over 5 years.

18 ABS (2024) *Estimates and projections of the Aboriginal and Torres Strait Islander population for 2011 to 2031*, https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-and-projections-aboriginal-and-torres-strait-islander-australians/latest-release

Children known to the child protection system

The Department of Families, Seniors, Disability Services and Child Safety (the department) administers the child protection system in Queensland. For this report, a child is deemed to have been known to child protection if, within 12 months before the child's death:

- the department was notified of concerns of alleged harm or risk of harm, or
- the department was notified of concerns before the birth of a child and reasonably suspected the child might be in need of protection after their birth, or
- the department acted under the *Child Protection Act 1999* relating to the child, or
- the child was in the custody or guardianship of the Chief Executive.

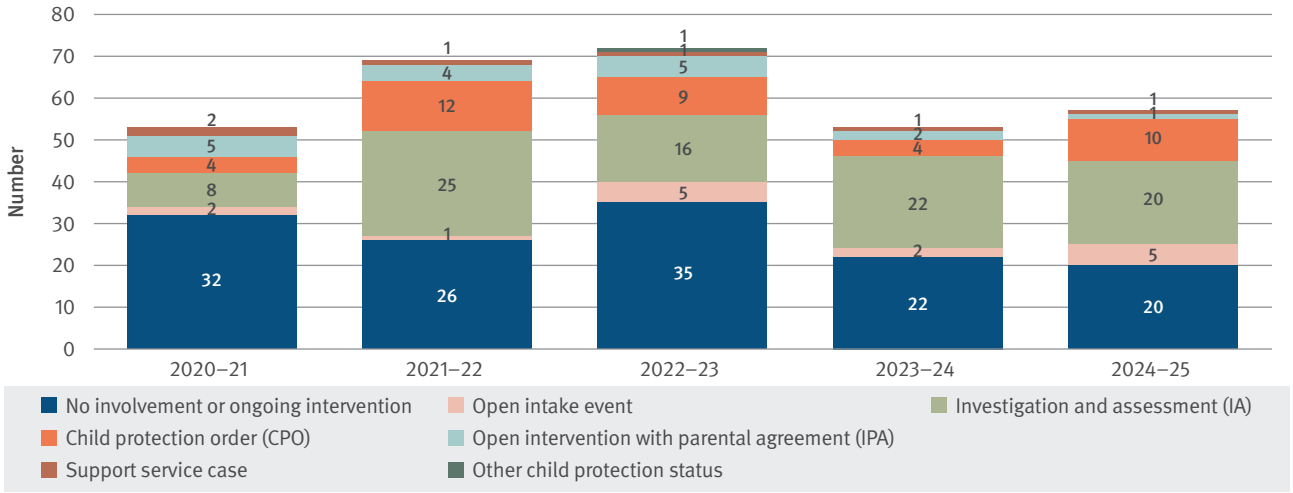
Fifty-seven children who died in 2024–25 were known to child protection in the 12 months prior to their deaths, an increase from 53 deaths in 2023–24. Twenty-one of these children died from natural causes, 16 from external causes, 10 from unexplained causes and 10 deaths were pending a cause at the time of reporting.

On occasion, children not previously known to child protection may come to the attention of the child protection system due to an incident causing critical injuries and subsequently died in hospital from their injuries. In 2024–25, 3 of the 57 children who were known to child protection at the time of death did not have a child protection history prior to the incident, or had a protection history but the contact was more than 12 months before the incident. The causes of death for these 3 children were fatal assault and neglect, unexplained causes and cause pending.

'Known to child protection' refers to a broad cohort of children and is a proxy indicator for family wellbeing. Figure 1.13 provides, for the last 5 years, the child protection status recorded at the time of death showing:

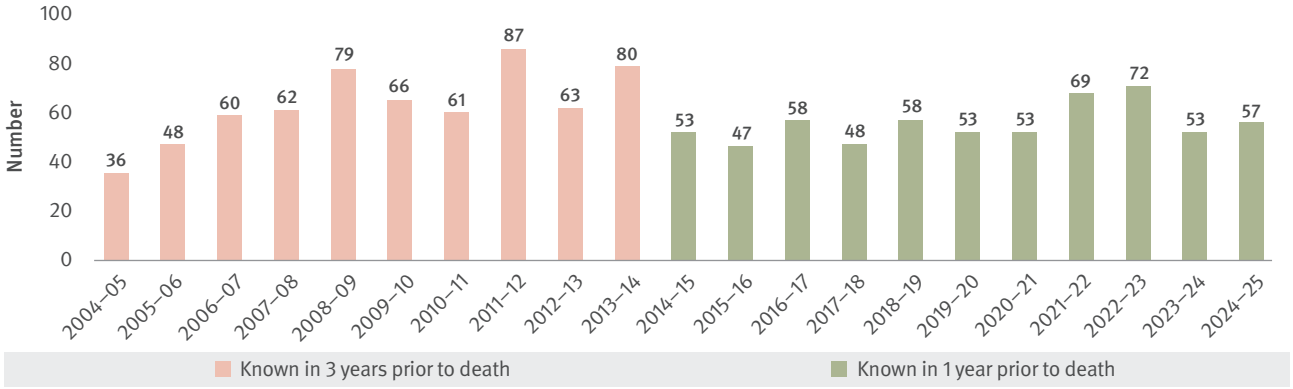
- 44% – no involvement or ongoing intervention
- 30% – investigation and assessment (IA)
- 13% – child protection order (CPO)
- 6% – intervention with parental agreement (IPA)
- 5% – open intake event.

Figure 1.13: Deaths of children known to the child protection system by status at the time of death (number), 2020–21 to 2024–25



The trends in deaths of children known to the child protection system are presented in Figure 1.14. From 2004–05 to 2013–14, statutory reviews were required for children known to child protection in the 3 years prior to their death. Following legislative changes implemented as a result of the Queensland Child Protection Commission of Inquiry's recommendations, reviews since 2014–15 are only completed for children known to the child protection system in the 12 months prior to their death.[19]

Figure 1.14: Deaths of children known to the child protection system (number), 2004–05 to 2024–25



The mortality rate for children known to child protection was more than 1.5 times the Queensland child mortality rate (59.1 deaths per 100,000 and 35.1 deaths per 100,000 respectively, averaged over 5 years).[20,21]

Figure 1.15 illustrates the over-representation of children known to child protection in deaths from external and unexplained causes (noting these figures include reference to those children who came to the attention of child protection due to an incident causing critical injuries and subsequent death). Over the last 5 years, mortality rates for children known to child protection have been more than 3 times higher than the Queensland child mortality rates for:

- fatal assault and neglect
- other non-intentional injury
- drowning
- unexplained causes.

Children known to the child protection system were also over-represented in sudden unexpected infant deaths, with a mortality rate 4 times the rate for all Queensland infants (respectively 2.5 and 0.6 per 1,000).

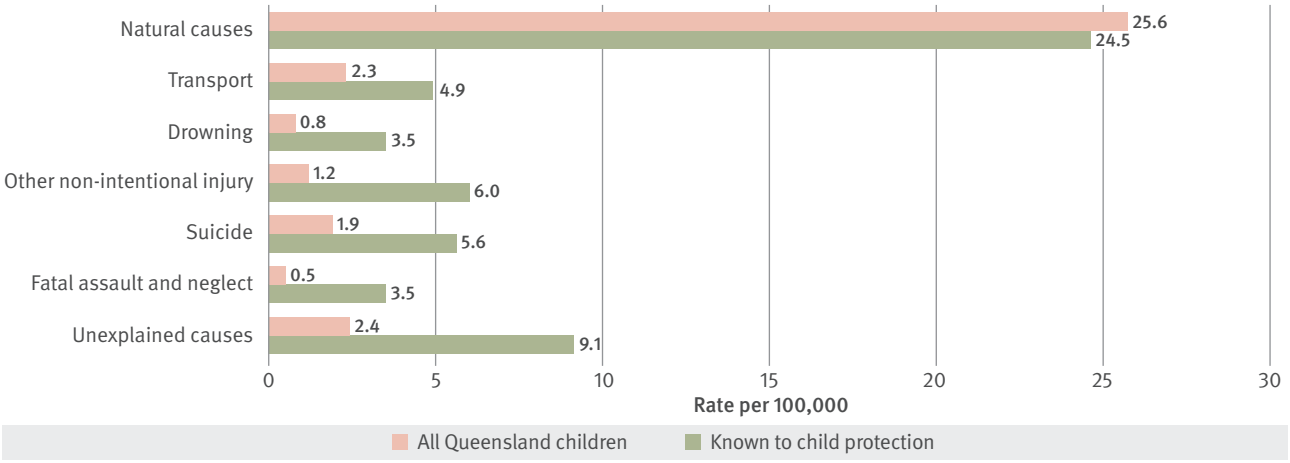
Children who are at increased risk of child maltreatment are often from families with high levels of socio-economic disadvantage, unmet parental needs including mental health, domestic and family violence, and problematic substance use and housing instability. All of which are risks for adverse childhood outcomes—including death. Therefore, it is not contact with the child protection system that increases the probability of death, but rather the significant disadvantage and unmet needs of families that result in the abuse and neglect of children that brings them to the attention of the child protection system.

19 www.childprotectioninquiry.qld.gov.au

20 The population used as a denominator for 'children known to child protection' is the number of children known to child protection services (as the subject of, or mentioned in, a child concern report, intake enquiry, notification, investigation and assessment, ongoing intervention, child protection orders or placements or any other action taken under the *Child Protection Act 1999*) in the 12 months before the relevant year (e.g. the denominator for 2024–25 is the number of children known to child protection services during 2023–24).

21 See **Appendix A**, **Table A.3** for detailed data.

Figure 1.15: All Queensland deaths and children known to child protection by cause of death (rate), 2020–21 to 2024–25



Notes: Rates calculated per 100,000 children known to child protection in the year prior to 30 June and per 100,000 population aged 0–17 years, averaged over 5 years.

Children in care

A child in care in Queensland refers to a child or young person who is subject to statutory child protection intervention and placed under the custody or guardianship of the Chief Executive of the department. This includes placements in foster care, kinship care, residential care, or other approved out-of-home care arrangements.

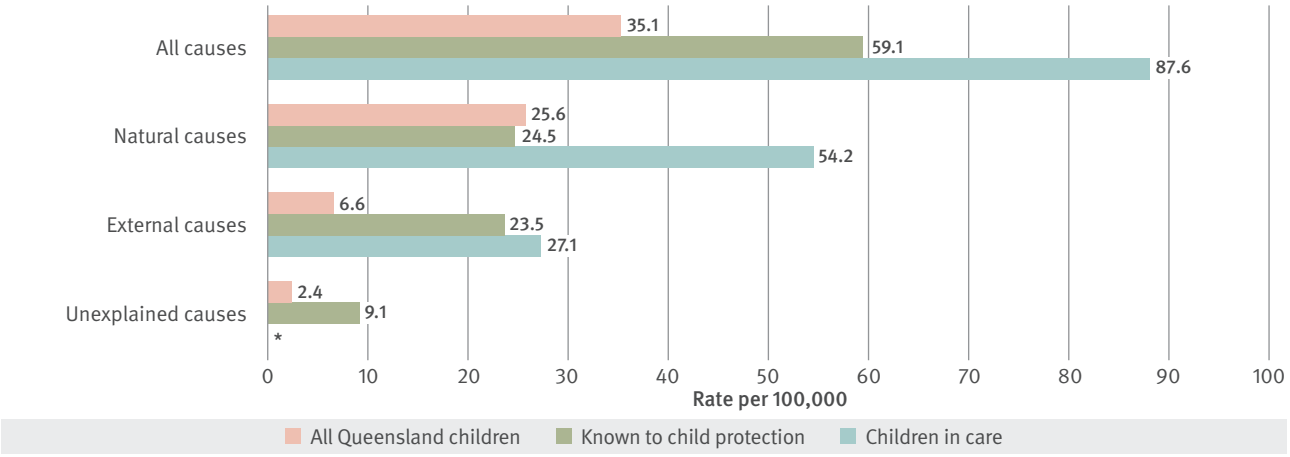
Ten children who died in 2024–25 were in care at the time of death. In the last 5 years, 42 children were in care at the time of their death, representing 14% of the 304 deaths of children known to the child protection system.

Figure 1.16 illustrates the mortality rate in the cohorts of all Queensland children, known to child protection and children in care at the time of death. Children in care had the higher total mortality rate of 87.6 per 100,000 compared to the cohort known to child protection (59.1 per 100,000), and the general child population (35.1 per 100,000).

The natural causes mortality rate for children in care (54.2) was twice the rate for the cohort known to child protection (24.5) and the general child population (25.6).

For external causes of death, children in care and children known to child protection had mortality rates more than 3 times the rate for all Queensland children.

Figure 1.16: Deaths by major cause group by child protection cohort (rate), 2020–21 to 2024–25



** Rate not calculated for numbers less than 4.*

Notes: Rates calculated per 100,000 children in out-of-home care at 30 June, known to child protection in the year prior to 30 June and population aged 0–17 years, averaged over 5 years.

Children reported missing

Reporting on deaths where the child or young person had been reported missing arose from the Commission review ***When a child is missing: Remembering Tiahleigh***—a report into Queensland's children missing from out-of-home care.[22]

During 2024–25, 5 children in total had been reported missing to the police in relation to their death, 3 of the deaths were from drowning and 2 were from suicide. Of these 5 children, one child was known to child protection but was not a child in care.

22 QFCC (2016) *When a child is missing: Remembering Tiahleigh—a report into Queensland's children missing from out-of-home care*, Queensland Government, www.qfcc.qld.gov.au/sector/child-death/system-reviews-after-child-death

Learnings

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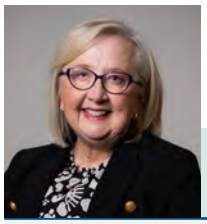

Improving the safety and wellbeing of vulnerable children: A consolidation of systemic recommendations and evidence

Anne Hollonds
National Children's Commissioner

At the 2025 Australian and New Zealand Child Death Review and Prevention Conference, hosted by the Queensland Family and Child Commission (the Commission) in May, National Children's Commissioner, Anne Hollonds shared key insights from a report called **Improving the safety and wellbeing of vulnerable children** that analysed recommendations from Royal Commissions and inquiries between 2010 and 2022 on child protection and child justice systems. The report was prepared by the Australian Institute of Family Studies to inform the National Children's Commissioner's landmark report tabled in Parliament in 2024: ***'Help Way Earlier!' How Australia can transform child justice to improve safety and wellbeing***. It brings together 3,005 recommendations from 61 reports over this period, aimed at enhancing protections for vulnerable children across Australia. The report identified numerous recommendations that continue to be repeated indicating persistent gaps and lack of implementation of evidence-based recommendations designed to address child safety risks and improve wellbeing outcomes.

The presentation outlined major contributing factors to vulnerability, including exposure to domestic and family violence, neglect, poverty, and service fragmentation, and highlighted how these intersect across health, education, child protection, and justice systems.

The report calls for improved early identification of risk, to ensure practices are culturally safe, particularly for Aboriginal and Torres Strait Islander children, and to invest in multi-agency collaboration to deliver targeted, trauma-informed support. The report summarises systemic recommendations repeated over the 12-year period into 6 key themes:

- inadequate cross-system information sharing, collaboration and coordination across child protection and youth justice systems
- limited First Nations partnership and self-determination across child protection and youth justice systems
- lack of mechanisms for oversight, monitoring and transparency across child protection and youth justice systems
- limited child protection and youth justice workforce capacity and support
- inadequate levels of investment across child protection and youth justice systems
- limited opportunities for child voice and participation within child protection and youth justice systems.

The presentation concluded by reinforcing that by consolidating evidence and actionable strategies, the report serves as a roadmap for improving outcomes for vulnerable children and strengthening Queensland's child protection systems. In addition, it underscores the urgency of systemic change and the collective responsibility of government, services, and community stakeholders in safeguarding our youngest citizens, especially children in vulnerable circumstances.

View the presentation: www.qfcc.qld.gov.au/2025/ANZCDRPG-Conference

Read more:
https://humanrights.gov.au/our-work/childrens-rights/publications/improving-safety-and-wellbeing-vulnerable-children

https://humanrights.gov.au/our-work/childrens-rights/publications/help-way-earlier

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The South Australian Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People

Judith Lovegrove
Director, Aboriginal Practice Department for Child Protection/Member of the Authority

Judith Lovegrove presented at the 2025 Australian and New Zealand Child Death Review and Prevention Conference on behalf of the South Australian Aboriginal Authority—an independent body composed of Aboriginal leaders, advocates, and community members, who are dedicated to reviewing and responding to the deaths of Aboriginal children in South Australia. The aim of the Authority is to build a culturally grounded child death review model that amplifies Aboriginal voices and strengthens accountability across the systems that serve Aboriginal families.

The Authority drew upon years of lived experience and cultural knowledge to confront issues of systemic neglect, institutional bias, and disconnection from community. Their evolving model centres community ownership, cultural safety, and truth-telling as foundations for change. The model moves beyond traditional government-led review methods to prioritise healing, advocacy, and prevention through Aboriginal-led processes.

Key insights include:

- the **benefits** of placing Aboriginal leadership at the centre, fostering trust, inclusion and meaningful outcomes
- the **challenges** of navigating institutional resistance, securing policy support, and confronting structural inequities.

The presentation concluded with a call to action—one that urges government and stakeholders to support Aboriginal-designed mechanisms for oversight and advocacy, and to ensure that every Aboriginal child is protected with dignity, respect and care.

View the presentation: www.qfcc.qld.gov.au/2025/ANZCDRPG-Conference