9 Child death prevention activities

In February 2025, we published the 20th annual report to be produced on child deaths in Queensland – *Annual Report: Deaths of children and young people Queensland 2023–24*. This was a sobering moment as we reflected on the over 9,000 children who have died in childhood over the past 20 years. It underscored the profound responsibility we hold as custodians of the Register and the critical role it plays in understanding and preventing child deaths. We remain committed to promoting the utilisation of this vital resource—both nationally and internationally—to reduce risks, inform prevention strategies, and help create safer environments for all children.

Our *Safer pathways through childhood framework* (SPTC framework), sets the direction of our child death prevention functions through to 2027. We transitioned some of our projects under the 2024–25 Action Plan to be part of our normal operations, including, monitoring unregistered child deaths and routinely applying an evidence-based classification system to classify cases of SUDI.

Finalised reports and submissions are made available through our website with many of these receiving significant media coverage. Under the SPTC framework we have published on topics including, seatbelts and child restraints, e-scooters and e-bikes, sepsis, and swimming pool immersions. We also used our social media channels to advocate for change and raise awareness of child safety hazards and prevention messages.

This year we prepared a report featuring Australian child death statistics from all 8 states and territories on behalf of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). We also proudly hosted the ANZCDR&PG annual meeting and held the ANZCDR&P Conference for a third consecutive year.

Our information sharing process continued with the Department of Education to inform student wellbeing policy development and support suicide postvention in affected schools.

We actively engage and support researchers through access to data held in the Register to inform research, public education, policy development and program design. On 29 occasions throughout the year, we shared critical information from the Register with partner organisations, researchers, and community groups. We also worked closely with 9 advisory committees, working groups, and networks.

Our work is grounded in equity, ensuring that all children, regardless of background, are protected through informed, inclusive, and proactive approaches to risk reduction.

Maintaining the Child Death Register

The Queensland Family and Child Commission (the Commission) is responsible for maintaining and reporting on the Queensland's Child Death Register, in accordance with Part 3 of the *Family and Child Commission Act 2014*. The Commission is responsible for several functions relating to child deaths in Queensland, including:

1. maintaining a register of all child deaths in Queensland based on notifications from the Registrar of Births, Deaths and Marriages and details of all child deaths reported to the Coroners Court of Queensland
2. researching the risk factors associated with child deaths and making recommendations to prevent such deaths occurring
3. preparing an Annual Report on child deaths.

The Child Death Register was established in 2004 and currently contains over 9,500 records that have been classified by cause of death, demographic and incident characteristics. It allows the Commission to extract information from its 21 years of recorded data, highlighting risk factors and trends that can inform research, support policy improvement and community safety initiatives to help reduce the likelihood of child deaths.

Publications

Deaths of children and young people Annual Report

In February 2025, the *Annual Report: Deaths of children and young people Queensland 2023–24* was tabled in Parliament. This was the 20th annual report to be produced on child deaths in Queensland. The electronic version of the annual report can be accessed on the **Queensland Parliament website** (authorised version).[102]

Resources associated with the annual report, including the 21-year summary tables, **Appendices B to G**, and fact sheets, can be found at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

Australian child death statistics 2022

The Commission published in March 2025 the report ***Australian child death statistics 2022***, prepared on behalf of the members of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). The report is available at **www.qfcc.qld.gov.au/sector/child-death/child-death-statistics-anz**

Seatbelt and child restraint use in children 0–12 years

In October 2024, the Commission released ***Seatbelt and child restraint use in children 0–12 – Road crash child passenger deaths Queensland 2004–2023***. The report, drawing from the Child Death Register, is an analysis of motor vehicle accidents and shows 123 children have died in road crashes over the last 20 years. The analysis found concerning trends around the use of child seats and seatbelts in Queensland. The findings highlighted an urgent need for targeted education campaigns, improved access to affordable restraints, and culturally informed outreach—particularly in First Nations communities and remote regions.

The report gained significant national media attention, featuring in 126 news stories and reaching nearly 2.3 million people. Following its release, the Commission was invited to join the National Transport Commission's Child Restraint Review Expert Advisory Group. This group is developing recommendations to update the Australian Road Rules to align with current safety research and best practice, with the goal of protecting all children more effectively.

The report is published under *Safer Pathways Through Childhood 2022–2027*, can be found at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

102 www.parliament.qld.gov.au/Work-of-the-Assembly/Tabled-Papers/Online-Tabled-Papers

Improving safety when young people ride e-scooters and e-bikes

Improving safety when young people ride e-scooters and e-bikes compiles the evidence around injuries and fatalities for children and young people resulting from e-scooters and e-bikes, risk factors, and how Queensland's road rules and laws surrounding their use compares to other jurisdictions. Published under *Safer Pathways Through Childhood 2022–2027*, the paper makes recommendations to improve safety outcomes, including the introduction of a minimum age of 16 years to lawfully ride these devices in Queensland.

The report can be found at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

Submissions

Poisons safety

In February 2025, the Commission in collaboration with Dr Ruth Barker and Poisons Information Centres nationally, supported a submission to the National Drugs and Poisons Scheduling Committee requesting a rescheduling of highly caustic hydroxide agents. The poisons schedule had not sufficiently restricted access to hazardous substances, allowing them to remain readily available in domestic settings. This lack of control posed preventable risks that have led to serious injuries, long-term health issues, and fatalities in children. Inadequate regulation of their distribution and use had further intensified the problem. By implementing the change, the risk of accidental exposure and injuries from caustic substances will be significantly reduced. The restriction ensuring that only trained and authorised individuals handled, used, and stored these products, thereby protecting public health and safety.

E-mobility safety and use in Queensland

In June 2025, the Commission made a submission to the Inquiry into e-mobility safety and use in Queensland. The submission included information from the insights paper ***Improving safety when young people ride e-scooters and e-bikes***, which was included as part of the submission.

Australian and New Zealand child death review conference and meeting

Conference

In May 2025, the Commission hosted the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) conference for the third year. This online conference was a professional development opportunity for the specialist teams in each jurisdiction responsible for child death reviews and registers. The conference attracted over 200 participants from across Australia and New Zealand from child protection, injury prevention, health, coronial and research sectors.

Table 9.1: Australian and New Zealand child death review conference – session overview

Session 1: *Suicide Risk Factors and Prevention, Domestic and Family Violence*
Ms Grace Sholl, Suicidologist and lived experience advocate, explored the complex factors contributing to youth suicide and the urgent need for comprehensive, child centered, evidence-based interventions.
Professor Silke Meyer and Ms Maria Atienzar-Prieto from Griffith University, presented on a study examining the childhood experiences of domestic and family violence (DFV) among young people who died by suicide. It investigates the impact of early exposure to DFV on mental health, coping mechanisms, and long-term well-being.
Dr Holly Blackmore and Ms Anna Butler presented on a collaboration between Australia's National Research Organisation for Women's Safety (ANROWS) and the Australian Domestic and Family Violence Death Review Network, *Filicides in a domestic and family violence context 2010–2018*. The report explores the underlying patterns, risk factors, and systemic challenges associated with these tragic incidents. By analysing case data, the presentation aims to highlight the complex interplay between DFV, parental distress, and societal responses. Key themes include identifying warning signs, improving intervention strategies, and strengthening protective measures for children at risk.

Session 2: *Vulnerable Children and Culturally Responsive Practice*
Ms Judith Lovegrove spoke as a Community Member on the South Australian Aboriginal Authority's model for Aboriginal child death review. The South Australian Aboriginal Authority is a group of leaders and thinkers from the Aboriginal community who review the deaths of Aboriginal children in South Australia.
National Children's Commissioner, Anne Hollonds, delivered the findings of the report, *Improving the safety and wellbeing of vulnerable children – a consolidation of systemic recommendations and evidence*. The report is the result of a collaboration between the Australian Institute of Family Studies and the National Children's Commissioner (Australian Human Rights Commission).
Dr Julie McEniery from the Queensland Paediatric Quality Council delivered a presentation outlining key findings from the review of Queensland Sudden Unexpected Death in Infancy (SUDI) cases between 2013 and 2016. It examines patterns, contributing factors, and opportunities for prevention, drawing insights from case data to identify risks associated with infant sleep environments, health conditions, and social circumstances.

Session 3: *Drowning and Accident Prevention*
Professor Julie Brown, Injury Prevention Research Centre, examined restraint practices among fatally injured child passengers compared to the general child passenger population. It explored how factors such as proper seatbelt use, child restraint systems, and compliance with safety guidelines influence injury outcomes in vehicle accidents.
Ms Stacey Pidgeon, Royal Life Saving Society Australia, explored how coronial data has been used to shape the Australian Water Safety Strategy 2030, providing insights into drowning incidents and informing evidence-based prevention measures. It reflects on key lessons learned from examining fatal water-related cases, identifying trends, risk factors, and gaps in existing safety initiatives.

Session recordings can be found at **www.qfcc.qld.gov.au/2025/ANZCDRPG-Conference**

Annual meeting

In May 2025, representatives from child death review teams from each jurisdiction across Australia and New Zealand came together for the annual meeting, to share experiences, practices, barriers and priorities in relation to child death review and prevention.

The group discussed a range of emerging issues including suicide risk factors, culturally and linguistically diverse child deaths, at risk children with complex medical needs and/or disabilities, car seat safety for children, and mortality review models. One of the key focus areas for the group is the development of a national dataset to strengthen child death and injury prevention and research to inform practice and policy.

Dr Ruth Barker joined the group to discuss injury prevention, product safety advocacy activities and opportunities. Dr Barker, supported by evidence sourced from child injury and death data, has led national injury prevention efforts for over 20 years, most recently enacting change around button battery safety, clothing-related strangulation, caustic substance ingestion, playground fencing safety, and child restraint and car seat safety.

Safer pathways through childhood: Actions in 2024–25

The ***Safer pathways through childhood framework*** provides a roadmap for the Commission's child death prevention activities over the period 2022–27. Each year the Commission publishes its action plan of specific prevention activities to address priority areas in the coming year. The *Safer pathways through childhood framework*, annual action plans, and published reports can be found at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

Progress on activities during 2024–25 is summarised in the Action plan for 2025–26. This includes the following new and continuing projects: redefining fatal assault and neglect, preventable childhood mortality, child car seat restraints, sudden unexpected death in infancy (SUDI), e-scooter and e-bike safety, vehicular heat stress and data linkage.

Unregistered deaths

In the last financial year, data was linked between the Registry of Births, Deaths and Marriages (RBDM) and Queensland Health (QH) to assess the under-registration of child deaths. Most unregistered deaths were infants, especially those born and deceased on the same day. Nearly two-thirds were identified solely through QH data, with some cases potentially including unidentified stillbirths. The organisation will continue monitoring these cases and collaborate with RBDM and QH to improve registration processes and enhance the accuracy of child death records.

Insights papers

In 2025, the Commission released the first of a series of insights papers on the causes and factors that contribute to child fatalities in Queensland, ***Improving safety when young people ride e-scooters and e-bikes Insights Paper***[103]. The second paper, ***Protecting children from the dangers of heat in vehicles***[104], 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.

Queensland paediatric sepsis mortality study

The Queensland Family and Child Commission partnered with the Queensland Paediatric Sepsis Program to conduct the Queensland Paediatric Sepsis Mortality Study. This population-based research determined the true incidence of child deaths from sepsis across Queensland and identified risk factors in different demographic groups. Findings highlighted gaps in death certification, low parental awareness of sepsis symptoms, and inconsistent sepsis recognition guidance in primary care.

The second, translational phase—funded by the Commission and supplemented with in-kind support from Children's Health —aimed to:

- Ensure sepsis is accurately documented as a cause or contributor on death certificates
- Require death certifiers to record known pathogens on medical cause of death forms
- Develop localised workflows, educational materials, and implementation plans for all 16 Hospital and Health Services
- Introduce novel investigative practices within the Coroners Court of Queensland.

Continued over page...

103 https://www.qfcc.qld.gov.au/sites/default/files/2025-06/Improving-safety-when-young-people-ride-e-scooters-and-e-bikes.pdf
104 https://www.qfcc.qld.gov.au/sites/default/files/2025-08/Paper-protecting-children-from-the-dangers-of-heat-in-vehicles.pdf

Safer pathways through childhood: Actions in 2024–25

An education package on death certification and autopsy processes has been developed for Queensland Health and Primary Health Care clinicians. Early engagement with Hospital and Health Services and Primary Health Networks has informed a targeted dissemination strategy across hospital and primary care settings. These foundational resources meet the project's initial aims by improving clinician consistency in documenting sepsis and its causative pathogens.

As part of this effort, the Commission issued correspondence to Hospital and Health Services throughout Queensland, requesting their collaboration in improving the documentation of sepsis on cause of death certificates through the development of a standardised workflow and accompanying education package.

Additionally, targeted enhancements to the Child Death Register were undertaken to facilitate more comprehensive capture of infection-related data.

Indicators of red flags for fatal child assault and neglect

The Commission was invited to publish the findings of a collaborative study with the University of Queensland on the international digital publication Open Access Government. The site highlights policy developments, scientific research, and technological innovation for professionals in both the public and private sectors. The article shared the results of an analysis of 90 filicide events in Queensland between 2004 and 2020. The research identified key risk factors for fatal child assault and neglect, including domestic and family violence, substance misuse, parental separation, and repeated contact with child protection services.

The article is available at **www.openaccessgovernment.org/indicators-of-red-flags-for-fatal-child-assault-and-neglect/192035/**

Supporting youth suicide prevention

The Commission continued to monitor and support prevention of suicide deaths of children and young people. This included a crucial information sharing process with the Department of Education to inform student wellbeing policy development and support suicide postvention in affected schools. The Commission contributed to suicide prevention by:

- increasing awareness across government of trends in suicide numbers
- reporting on situational circumstances and risk factors affecting young people
- providing suicide data to government agencies to support development of mental health and wellbeing initiatives, including through the Queensland Government implementation plan for *Shifting minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan 2023–2028* (*Shifting minds*), which is led by the Queensland Mental Health Commission.

Researcher access to child death data

A key strategy to support child death and injury prevention is to make data held in the Child Death Register available for research, public education, policy development and program design. Data from the comprehensive dataset is available at no cost to genuine researchers.[105] Applications to obtain data can be made by emailing child_death_prevention@qfcc.qld.gov.au

In 2024–25, the Commission responded to 29 external requests for Child Death Register data. Data provided to genuine researchers may be either aggregated or presented as confidential unit records. Table 9.2 gives an overview of the key projects and agencies for which data was provided.

Table 9.2: Child death data requests by agency and purpose, 2024–25

Requesting agency	Purpose	Type of data
Type of data: *SUDI*		
Institute for Urban Indigenous Health	Institute for Urban Indigenous Health represents a network of Aboriginal and Torres Strait Islander Community Controlled Health Organisations operating across South East Queensland. The data requested is to better understand trends in SUDI in Aboriginal and Torres Strait Islander babies, to help inform service responses.	Non-confidential aggregate
Queensland Paediatric Quality Council	Queensland Paediatric Quality Council are developing a coronial nurses' questionnaire for infection, or genetic-related deaths or SUDI. Details of individual cases were provided for trialling the questionnaire.	Confidential unit records
Queensland Paediatric Quality Council	Proactive advice identifying a possible SUDI hotspot in the Ipswich region, to allow for consideration of emerging issues and possible actions.	Non-confidential aggregate
River's Gift	River's Gift, a community organisation, is planning to launch an infant safe sleep education program within childcare centres and organisations in regional Queensland. Regional SUDI data is requested to ascertain areas of higher prevalence of SUDI.	Non-confidential aggregate
First 2000 Days, Reform Office, Queensland Health	Regular provision of data is sought for ongoing monitoring of SUDI for the Pepi-Pod® program, an initiative within the Putting Queensland Kids First plan. The program has been identified as a priority initiative to address the higher rates of Queensland SUDI compared with other states in Australia.	Confidential unit records
Coroners Court of Queensland	A Queensland Coroner requests the data to support the State Coroner raising concerns about co-sleeping/unsafe sleeping of infants to Queensland Health, including variations in incidents between Hospital and Health Service regions.	Confidential unit records
Type of data: *Drowning*		
Royal Life Saving Society of Australia	Royal Life Saving Society of Australia is focused on reducing drowning in Australia through research, advocacy, education and leadership. Commission data is crucial to triangulate data received from other sources in the National Fatal Drowning Database. The database is used to produce the annual National Drowning Report and other research. This evidence is used to design and develop targeted, drowning prevention programs, such as the Australian Water Safety Strategy, as well as inform policy and practice. *Related release: National Drowning Report 2024.*	Confidential unit records

105 Under section 28 of the FCC Act, the Commission is able to provide child death information for genuine research, defined as research relating to childhood mortality or morbidity with a view to increasing knowledge of incidence, causes and risk factors relating to same. Genuine research includes policy and program initiatives to reduce child death or injury.

Requesting agency	Purpose	Type of data
Type of data: *Transport*		
Department of Transport and Main Roads	Rail crossing fatality data for Department of Transport and Main Roads to inform content of an online road safety education program.	Non-confidential aggregate
Department of Transport and Main Roads	E-scooter safety messages and Queensland Ambulance Service callout data to inform content of an online road safety education program. *Related release: "Journi" online road safety education program* https://www.qld.gov.au/transport/safety/road-safety/education/journi	Non-confidential aggregate
Type of data: *Non-intentional injury*		
Department of Primary Industries	The primary goal of the *Animal Management (Cats and Dogs) Act 2008* is to ensure the safety of the community. By collecting data on dog incidents, DPI can identify patterns and high-risk areas, allowing them to implement targeted measures to prevent future incidents.	Confidential unit records
Department of Housing, Local Government, Planning and Public Works	Fatality data related to toppling furniture, blind cords and windows will inform a framework to support renters and rental property owners regarding installation of safety modifications, where a category of modification to cover certain changes that do not require property owner approval, including wall anchoring devices, blind cord anchors and window safety devices. *Related release: Rental law changes to the process to request to make fixtures and structural changes commenced on 1 May 2025*.	De-identified unit records
Kidsafe Queensland	Kidsafe is an organisation which raises awareness of injury trends and provides practical, evidence-based injury prevention awareness. Data on child deaths from vehicular heat stress is for an interview with Australian Broadcasting Corporation on safety measures to prevent child deaths from heat stress.	Non-confidential aggregate
Queensland Injury Surveillance Unit	Queensland Injury Surveillance Unit sought playground related fatality data to inform review of standards. The current AS 4422 playground surface standard is an interim standard and needs revision and formal adoption.	Confidential unit records
Queensland Injury Surveillance Unit	Dr Ruth Barker, Director Queensland Injury Surveillance Unit, is a member of the CS-005 playground standards committee representing the Queensland Injury Surveillance Unit. Her role is to review the existing standard and contribute to improvements in the standards. A Northern Territory Coroner is investigating a case where a child became snagged on a fence at a childcare centre. Fatality data is required to inform advice to the Coroner on risks and prevention in fence design. The committee on the Australian Standard for playgrounds will shortly consider the matter.	Non-confidential aggregate
Queensland Injury Surveillance Unit	Information proactively provided to Dr Ruth Barker, a member of the national standards for child car restraints committee to inform understanding of risks for children with disabilities in design and use of car restraints.	Confidential unit records

Requesting agency	Purpose	Type of data
Type of data: *Children known to child protection*		
Child Death Review Board	Characteristics of school engagement and behaviour issues data to inform the Board's thematic Information paper *'School engagement levels in cases to date'* (Board meeting #25).	De-identified unit records
Child Death Review Board	Data on homeless and housing instability, and domestic violence to inform Summary Report titled *'Housing instability and family and domestic violence'* (Board meeting #27).	De-identified unit records
Type of data: *Fatal assault and neglect*		
Lumenia consultancy	The Commission has commissioned Lumenia to undertake research to review the Queensland Child Death Register definitions and screening criteria of child fatal assault and neglect, to ensure robust and reliable identification of cases. The data informs practice review and development of recommendations.	De-identified unit records
The Daily Mail	Data on deaths of children known to the child protection system, particularly external causes (assault and neglect) for a media story focussing on system changes in the ten years since the death of Tiahleigh Palmer.	Non-confidential aggregate
Type of data: *Diseases and morbid conditions*		
Queensland Paediatric Sepsis Program	Sepsis mortality study data by region is to support development of a public awareness campaign effective for Indigenous communities as part of the action plan from the Sepsis Mortality Study recommendations.	De-identified unit records
Type of data: *Interstate residents*		
Australian Capital Territory Government	Deaths of interstate residents were provided to the Australian Capital Territory Government for inclusion in the Australian Capital Territory Children & Young People Death Review Committee Biennial Report.	Non-confidential aggregate
Type of data: *All deaths*		
Australian Institute of Health and Welfare	Detailed data requested for a feasibility study to develop a national child death data collection based on data from the state and territory child death registries. The project was initiated at the request of the ANZCDR&PG and approved by the AIHW Ethics Committee on 17 September 2024.	De-identified unit records
Child Death Review Team, New South Wales Ombudsman	Deaths of children where there is parental history of methamphetamine or other stimulant use, for an issues paper in development as part of the New South Wales Biennial Report of the deaths of children in New South Wales in 2022–2023.	De-identified unit records

Notes: Not all requests are shown.

Prevention messaging

The Commission uses its social media channels to raise awareness of child safety hazards and prevention messages. During 2024–25, the Commission promoted prevention messaging via social media across a range of topics including: road safety, sepsis awareness, access to mental health services, suicide prevention, button battery safety, and water safety.

Participation in state and national advisory groups

As the custodian of the Child Death Register, the Commission shares its data and expertise to learn from children's deaths and enhance the safety and wellbeing of all Queensland children. It does this through collaboration with stakeholders and advisory groups, drawing on insights from the register to strengthen reporting systems and promote child death prevention efforts.

In 2024–2025, the organisation worked with:

- Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG)
- Australian National Child Death Data Collection Working Group
- Consumer Product Injury Research Advisory Group
- Child Restraint Expert Advisory Group, National Transport Commission
- Queensland Government Births and Deaths Working Group
- Queensland Paediatric Quality Council Steering Committee
- Queensland Paediatric Quality Council Infant Mortality Sub-committee
- Road Safety Research Network
- Shifting Minds Strategic Leadership Group.