Annual Report

Deaths of children and young people Queensland 2024–25

QUEENSLAND Family & Child Commission

Queensland Government

About this report

This report has been prepared under section 29 of the *Family and Child Commission Act 2014* (FCC Act). It describes information on the deaths of children and young people in Queensland registered in the period 1 July 2024 to 30 June 2025. The Queensland Family and Child Commission (the Commission) is a statutory body of the Queensland Government. Its purpose is to influence change that improves the safety and wellbeing of Queensland's children and their families. Under the FCC Act, the Commission has been charged by government to review and improve the systems that protect and safeguard Queensland's children.

Accessibility

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty understanding this report, you can contact Translating and Interpreting Service National on 13 14 50 to arrange for an interpreter to effectively explain it to you. Local call charges apply if calling within Australia; higher rates apply from mobile phones and payphones.

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QUEENSLAND
Family & Child
Commission

Queensland
Government

31 October 2025

The Honourable Deb Frecklington MP
Attorney-General and Minister for Justice and
Minister for Integrity
Department of Justice
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 29(1) of the *Family and Child Commission Act 2014*, I provide to you the Queensland Family and Child Commission's annual report analysing the deaths of Queensland children and young people.

The report analyses the deaths of all children and young people in Queensland registered in the period 1 July 2024 to 30 June 2025, with a particular focus on external and non-natural causes.

Yours sincerely,

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

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Acknowledgements

The Queensland Family and Child Commission (the Commission) acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians across the lands, seas and skies where we walk, live and work.

We recognise Aboriginal and Torres Strait Islander people as two unique peoples, with their own rich and distinct cultures, strengths and knowledge. We celebrate the diversity of Aboriginal and Torres Strait Islander cultures across Queensland and pay our respects to Elders past, present and emerging.

The Commission thanks the government and non-government agencies and individuals who contributed data and their expertise to the report. In particular, we express appreciation to the Australian Bureau of Statistics; the Coroners Court of Queensland; Department of Families, Seniors, Disability Services and Child Safety; Queensland Ambulance Service; Queensland Health; Queensland Paediatric Quality Council; Queensland Police Service; Queensland Treasury; Registry of Births, Deaths and Marriages; and the Royal Life Saving Society of Australia. The Victorian Department of Justice and Community Safety is also acknowledged as administrator of the National Coronial Information System.

The Commission would like to acknowledge the contribution of data from other Australian agencies and committees which perform similar child death review functions. This data has been compiled for an interjurisdictional overview representing further steps towards developing a nationally comparable child death review dataset.

This report may cause distress for some people. If you need help or support, please contact any of these services:

- **Lifeline** on 13 11 14
- **Beyond Blue** on 1300 22 4636
- **Kids Helpline** (for ages 5–25 years) on 1800 55 1800
- **13 YARN** (for Aboriginal and Torres Strait Islander people) on 13 92 76.

Principal Commissioner's message

Under the *Family and Child Commission Act 2014*, I am responsible for maintaining and reporting on the Queensland Child Death Register, which records the deaths of all children and young people under the age of 18 in Queensland.

This serious responsibility encompasses three core functions:

1. maintaining a comprehensive record of all child deaths notified by the Registrar of Births, Deaths and Marriages and reported to the Coroners Court of Queensland
2. conducting research into the risk factors associated with these deaths
3. preparing an Annual Report to inform prevention strategies and support public accountability.

The work carried out by the Commission staff is grounded in a commitment to listen, learn, and act to protect the health and wellbeing of Queensland's children. By strengthening our collective understanding of child mortality, we aim to drive coordinated, evidence-based responses that prevent future tragedies.

Over the past year, Queensland has recorded the loss of 427 children and young people. Each life was precious, and each loss deeply felt by families, friends, and communities across our state. To those who grieve, we extend our deepest condolences and reaffirm that every life matters.

Across the year we saw a 1.2% increase in child deaths (427 compared with 422 in 2023–24). Of these deaths, 321 were from natural causes and 68 from external causes such as transport incidents and other non-intentional injuries. Eighty-eight Aboriginal and Torres Strait Islander children died in 2024–25, compared with 91 the previous year. Fifty-seven of the children who died were known to the child protection system in the 12 months prior to their death, compared to 53 in 2023–24. Of these, 10 were in care and two had open cases; 25 had open investigations or intake events; and the remaining 20 had no ongoing involvement.

As custodian of the Child Death Register, we provide access to data and insights to strengthen prevention strategies. Over the year, we shared critical information from the Register on 29 occasions with partner organisations, researchers, and community groups. We also worked closely with 9 advisory committees, working groups, and networks. This collaboration ensures that our analysis translates into practical reforms —shaping policies, practices, and initiatives that reduce risks to children.

For example, our insights informed improvements in product safety and regulation, including:

- caustic substances (such as sodium and potassium hydroxide products)
- playground and play equipment
- rental laws allowing for safety fixtures
- animal management laws.

Our *Safer Pathways Through Childhood* program continues to turn knowledge into action. This includes bridging the gap between legislation and best practice in seatbelt and child restraint use; advocating for a minimum legal age of 16 years for e-scooter use in response to rising deaths; and developing guidance to prevent children from being left unattended, hidden, or trapped in vehicles.

Queensland also continues to play a leadership role nationally and internationally. In 2024–25, the Commission concluded its third consecutive year hosting the Australia and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). This collaboration of all state and territory review teams across Australia and New Zealand works to build nationally and internationally comparable data to strengthen child death prevention. Reflecting this role, in February 2025 we published the Australian *Child Death Statistics 2022* report—the only national compilation of infant deaths from Sudden Infant Death Syndrome and undetermined causes.

In May, we proudly hosted the Australia and New Zealand Child Death Review and Prevention Conference for the third consecutive year, bringing together over 200 participants from across jurisdictions. This event provided a powerful platform for knowledge-sharing and collaboration, with contributions from researchers, practitioners, lived experience advocates, and leaders. It also reinforced our shared commitment to preventing child deaths and ensuring safer futures for all children across Australia and New Zealand.

While our work is far from complete, our resolve remains unwavering. Every child deserves the chance to grow up safely, and through our research, reporting, and advocacy, we will continue to learn from loss, strengthen prevention, and strive for safer futures for Queensland's children.

In leading this work and preparing this report, I am struck by two contrasting realities. On one hand, the overall child mortality rates in Queensland show a gradual decline, reflecting fewer tragedies and progress in protecting our children and families. On the other hand, preventable deaths—particularly from suicide, fatal assault, and neglect—continue to occur, reminding us of the work that remains. The statistics in this report offer both hope and concern: hope that, through informed action and collaboration, we can create a safer world for our children, and concern that much more remains to be done to ensure that every child in Queensland is protected and able to thrive.

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

Executive summary

In the 12-month period from 1 July 2024 to 30 June 2025, the deaths of **427** children and young people aged 0–17 years were registered in Queensland.[1]

Deaths from natural causes (diseases and morbid conditions) accounted for a large proportion of child deaths, with these most likely to occur in the first days and weeks of life. Child mortality from external causes includes deaths from injuries, either non-intentional (accidental) injuries such as transport incidents or drowning, or from intentional injuries, which include suicide and fatal assault and neglect.

Child deaths in Queensland, 2024–25

427
child deaths in Queensland 2024–25*

321
children died of **natural causes** such as congenital and perinatal conditions

25
children had a cause of death that was **not yet determined** at the time of reporting

68
children died from **external causes**, including:

- **23** from transport incidents
- **10** from drowning
- **7** from other non-intentional injuries
- **24** from suicide
- **4** from fatal assault and neglect

13
children's deaths remained **unexplained**[2] even after comprehensive investigation:

- **9** from sudden infant death syndrome (SIDS)
- **4** from causes which could not be determined

29 infant deaths were in the research category **sudden unexpected deaths in infancy** (SUDI)

** By date of death registration.*

Emerging and continuing risks

Keeping infants safe during sleep

SIDS and undetermined causes were the leading cause of death for post-neonatal infants (0.4 deaths per 1,000 live births). Approximately two-thirds of SUDI deaths over the last 5 years occurred in infants before 4 months of age. Three-quarters of the SUDI deaths during this period occurred on non-infant sleep surfaces, with half occurring on adult beds, highlighting the provision of safe sleeping places for infants must remain a priority, along with understanding the factors which place infants at elevated risk. Among the SUDI that occurred in the context of shared sleeping during the 2020–25 period, nearly half of the infants were sharing a sleep surface with at least one person who smoked tobacco.

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

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

Potentially avoidable natural cause deaths

Medical conditions such as asthma, diabetes, anaphylaxis, and nutritional deficiencies can result in fatal outcomes when inappropriately managed. These deaths may reflect systemic gaps in healthcare access, caregiver knowledge, and early identification of risk factors. Deaths from conditions that can be mainly prevented through effective existing public health and primary prevention interventions and/or individualised care may be considered as potentially avoidable natural cause deaths.

Between 2015 and 2025, 24 children in Queensland died from treatable medical conditions, including asthma, diabetes, anaphylaxis, medium-chain acyl-CoA dehydrogenase deficiency (MCAD), and nutritional deficiencies. Of the 24 deaths, 4 met the Commission's criteria for fatal neglect. In 2 of these cases, criminal charges were laid against caregivers.

Additionally, 3 child deaths over the same period were attributed specifically to malnutrition, all of which led to criminal proceedings and were classified by the Commission as fatal neglect.

Safety on e-scooters and e-bikes

Since 2022 in Queensland, 5 fatalities involving children aged 12 to 15 were linked to e-scooter incidents. These deaths underscore the urgent need for targeted interventions. The most common contributing factors included unsupervised riding, absence of helmet use, reckless or dangerous driving, and excessive speed.

Improving safety when young people ride e-scooters and e-bikes, published by the Commission in June 2025, delivers a critical examination of the growing safety risks associated with e-scooter and e-bike use among children and young people in Queensland. Leveraging national and international evidence, the paper identifies key risk factors—including age, helmet non-use, excessive speed, and lack of adult supervision—and assesses Queensland's regulatory framework in comparison to other jurisdictions.

In the paper the Commission recommends several policy reforms to enhance safety outcomes. Chief among these is the introduction of a minimum legal riding age of 16 years for e-scooters and e-bikes in Queensland. Additional measures include strengthening public education campaigns, improving infrastructure, and aligning enforcement practices with best-practice models from other regions.

Reviewing child restraint road rules

The Commission's report on seatbelt and child restraint use, published in October 2024, reviewed 20 years of road crash fatality data for children aged 0–12 years. The report recommended revising the road rules to narrow the gap between legislation and best practice, by raising the ages at which infants and children can transition from rear-facing and forward-facing child restraints and booster seats. Following its release, the Commission joined the National Transport Commission's Child Restraint Review Expert Advisory Group, which continues to advise Ministers on updating the Australian Road Rules to reflect current safety research and best practice, ensuring stronger protection for children.

Trends in child mortality

Child mortality rates in Queensland have generally declined over the past 2 decades, with an average annual decrease of 2.2% from 2004–09 to 2020–25. This trend has been largely driven by reductions in deaths from natural causes, which make up the majority of child fatalities, and have also declined by 2.2% annually.

The mortality rate for external causes fell by 2.3% per year on average. The rate of transport deaths, which is a leading external cause of death, declined by an average of 3.7% annually. However, a spike in transport deaths between 2020 and 2023 caused the overall downward trend to plateau. Mortality rates for drowning, other non-intentional injury and fatal assault and neglect have decreased over the 21 years.

In contrast, the suicide rate showed a gradual increase over time, rising by 1.2% per year on average. Between 2014–19 and 2016–21, suicide rates surpassed transport deaths, driven by high numbers in 2018–19 and 2020–21. In the most recent 4 years, suicide deaths have been lower, leading to a slight reduction in the overall rate.

The mortality rate for deaths from unexplained causes decreased by 2.2% per year on average. Child deaths from unexplained causes have exceeded deaths from transport and suicide in almost all periods since 2008–13.

While Queensland's overall child mortality rate has declined steadily over the past 2 decades, this improvement has not been shared equally. Infant mortality among Aboriginal and Torres Strait Islander children has decreased faster than for non-Indigenous infants (2.5% compared to 1.6% annually since 2004), showing progress in early survival. However, when looking at children aged 0–17 years, there has been no clear downward trend. Instead, rates for Aboriginal and Torres Strait Islander children have plateaued and remain more than twice as high as for non-Indigenous children.

Leading cause by age

The leading causes of death vary with age, largely in line with the risks faced by children at each stage of development. Perinatal conditions and congenital anomalies were the leading causes of death for infants 0–27 days. 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. Suicide was the leading cause of death for children aged 10–14 years and 15–17 years.

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

** In the 5-year period 2020–21 to 2024–25.*

As shown in the table below, SIDS and undetermined causes is the leading non-natural cause of death in Queensland children aged 0–17 years, followed by transport, suicide and other non-intentional injury. These findings highlight urgent areas for targeted prevention and early intervention. Transport-related deaths emphasise the need to improve child restraint usage and enhance road safety education. The inclusion of suicide among leading causes of death signals an urgent demand for strengthened mental health support and early intervention strategies for children and young people. Continued fatalities from SIDS and causes classified as undetermined reinforce the continued importance of public health messaging promoting safe sleeping practices. The Commission will use these insights to guide ongoing efforts to strengthen protective systems and reduce preventable child deaths across the state.

Age category	Top 4 leading non-natural causes			
	1	2	3	4
0–17 years	SIDS and undetermined causes	Transport	Suicide	Other non-intentional injury

Vulnerable groups

Child mortality does not fall evenly across the population. Structural inequities mean that some groups of children experience greater exposure to harms that compromise their survival and development. Aboriginal and Torres Strait Islander children, and children who come into contact with the child protection system, are consistently and significantly over-represented in child mortality statistics.

Eighty-eight deaths in 2024–25 were of Aboriginal and Torres Strait Islander children. Of these, 66 died from natural causes (diseases and morbid conditions), 12 from external causes, 5 were unexplained deaths and 5 were pending a cause of death at the time of reporting.

Aboriginal and Torres Strait Islander children were over-represented in child deaths. The mortality rate for Aboriginal and Torres Strait Islander children was 2.4 times higher than for non-Indigenous children (respectively, 74.5 and 31.0 per 100,000). The Aboriginal and Torres Strait Islander mortality rate was 4 or more times the non-Indigenous rate for deaths from other non-intentional injuries and unexplained causes. The structural inequalities experienced by Aboriginal and Torres Strait Islander peoples are profound. A complex interplay of multiple factors can increase the risk of childhood injury and death.

Annual reports consistently show that children known to the child protection system experience higher mortality rates than the general child population, particularly in cases involving external causes of death. A 'child known to the child protection system' refers to any child who had contact with the child protection system in the 12 months prior to their death. This refers to the full breadth of services and interventions delivered by the Department of Families, Seniors, Disability Services and Child Safety (the department), including when a child is living with their family or when a child is subject to a Child Protection Order with their custody and/or guardianship granted by the Children's Court to the Chief Executive of the department. Service types may be intakes, assessments, Interventions with Parental Agreement and out-of-home care case management. Children living in out-of-home care may reside in foster or kinship care, or residential care.

Fifty-seven of the 427 children who died in 2024–25 were known to child protection, compared to 53 deaths in 2023–24. Ten of the 57 children were in out-of-home care at the time of their death.

Children known to the child protection system had a mortality rate almost twice the Queensland child mortality rate and were almost 4 times more likely to die of external causes than the total child population in Queensland. These elevated risks are closely linked to the intersecting and often compounding challenges faced by these children and their families, including intergenerational socio-economic disadvantage, mental illness, domestic and family violence, substance use, housing instability, and the children's own experiences of neglect and abuse causing long-term physical and psychological impacts. Such factors significantly increase the likelihood of child maltreatment and other adverse outcomes, including fatal incidents. The disproportionate number of children who had contact with the child protection system can, in large part, be attributed to the cumulative impact of these intersecting conditions in their lives. It is noted that of this cohort, 21 (37%) died because of disease or morbid conditions.

Child death prevention activities

During 2024–25, the Commission responded to 29 external requests for child death data, including the provision of data for or regarding:

- a coronial request for co-sleeping/unsafe sleeping risks for infants to inform discussions with Queensland Health
- playground-related fatalities to inform a coronial investigation and for a review of national playground standards
- feasibility study to develop a national child death data collection
- transport risks to inform development of an online road safety education program.

In May 2025, we hosted the Australian and New Zealand Child Death Review and Prevention 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.

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

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

The Commission continued to monitor and support the response to suicide deaths of young people including through a crucial information sharing process with the Department of Education. This process informs student wellbeing policy development and supports suicide postvention in affected schools.

Safer pathways through childhood framework 2022–2027

The ***Safer pathways through childhood framework*** sets the direction of the Commission's child death prevention functions. Reports under this function and the Action Plan for the coming year can be found on the Commission's website at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**.

Collaborative partnerships

This report includes chapters on categories of death, identifies trends and points to areas that would benefit from deeper investigation to better understand underlying causes and inform effective responses. The Commission recognises the value of diverse expertise and welcomes opportunities to collaborate with stakeholders engaged in related initiatives. By working together, we can strengthen protective systems and drive meaningful progress in reducing preventable child deaths across the state.

Data for prevention activities

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

The Commission can provide detailed child death data to genuine researchers and organisations at no cost.

Email **child_death_prevention@qfcc.qld.gov.au**

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

Annual report resources:

- 21-year summary tables
- fact sheets
- Appendices B to G

Australian child death statistics 2023

Safer Pathways Through Childhood Action Plan 2025–26

Seatbelt and child restraint use in children 0–12 years: Road crash child passenger deaths Queensland 2004–2023

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