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.

## Contact for enquiries

**Queensland Family and Child Commission**
Level 8, 63 George Street
PO Box 15217, Brisbane City East QLD 4002

Email: enquiries@qfcc.qld.gov.au
Website: www.qfcc.qld.gov.au

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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

Level 8, 63 George Street
Brisbane Qld 4000
PO Box 15217
Brisbane City East Qld 4002

Telephone: 07 3900 6000
Facsimile: 07 3900 6050
Website: qfcc.qld.gov.au
ABN: 91 102 013 458

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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*

# 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.

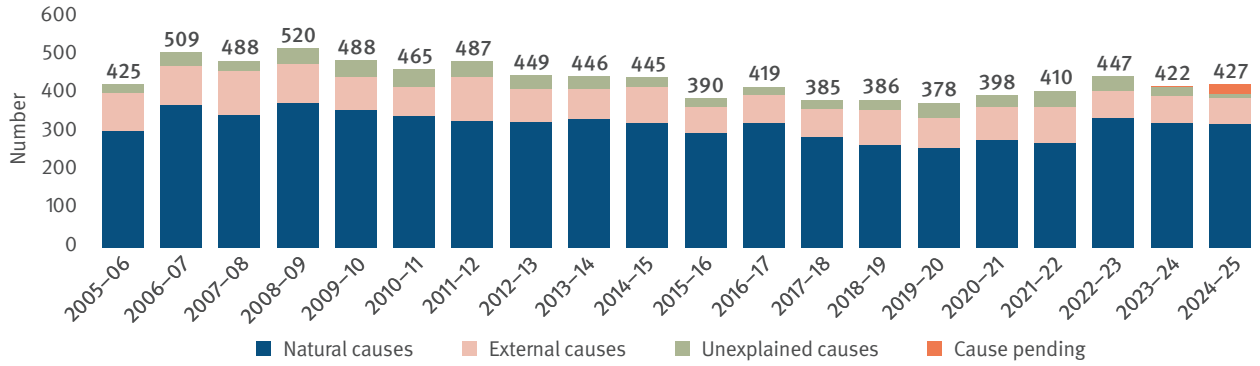
There is a long-recognised need for comparable and consistent national information on the causes and circumstances of child deaths and risk factors for these deaths. We are supporting work to achieve this and contributed data for a pilot by the Australian Institute of Health and Welfare (AIHW) of a national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

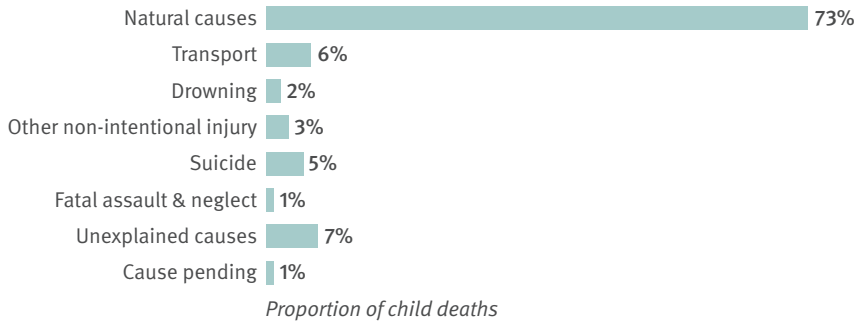
We continue to invite researchers to harness the rich and diverse data within the Child Death Register (the Register) to drive innovative, evidence-based research. By leveraging this resource, researchers can uncover new insights, inform policy, and contribute to meaningful advancements across systems. 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

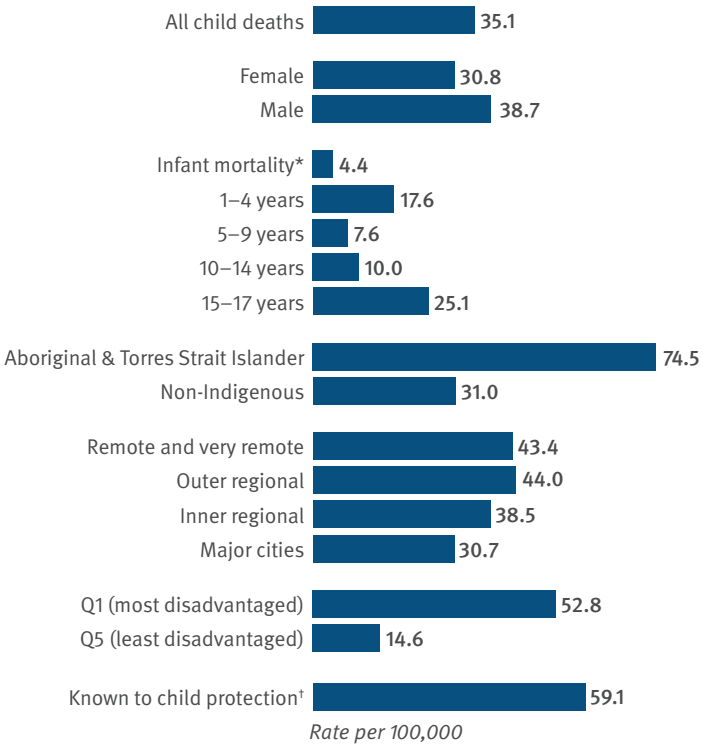
## 2005 to 2025




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




## Demographics




## Leading cause by age

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

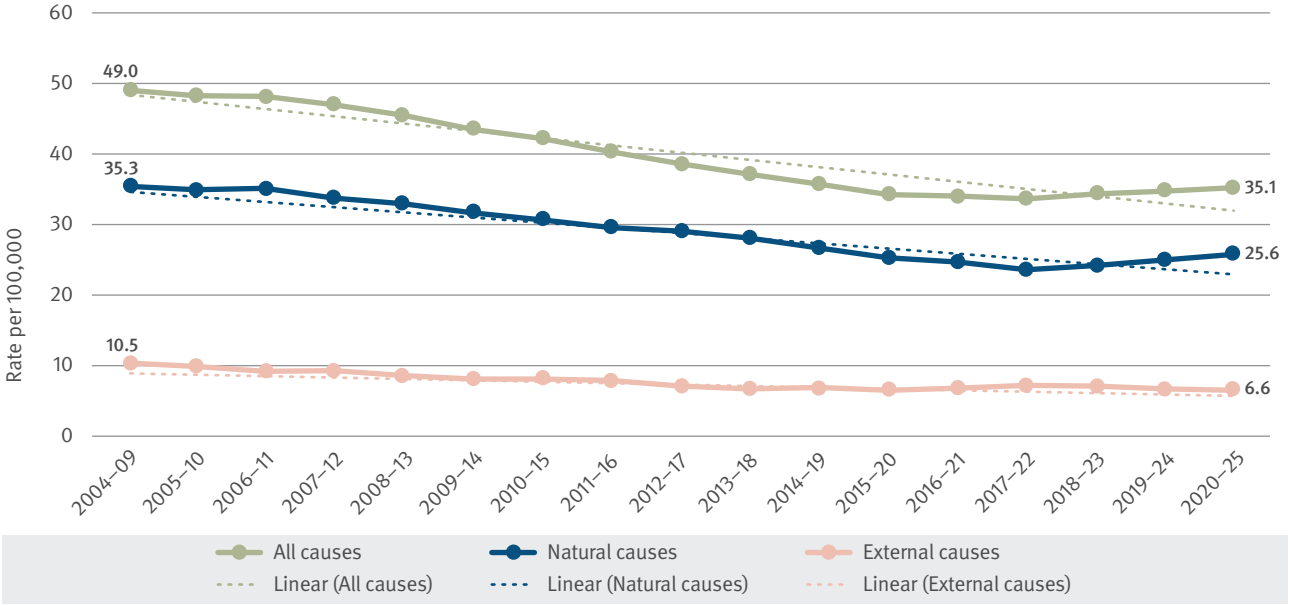
4 QFCC (Queensland Family and Child Commission) (2025) *Australian and New Zealand child death statistics 2022*, **www.qfcc.qld.gov.au/sector/child-death/child-death-statistics-anz**

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.

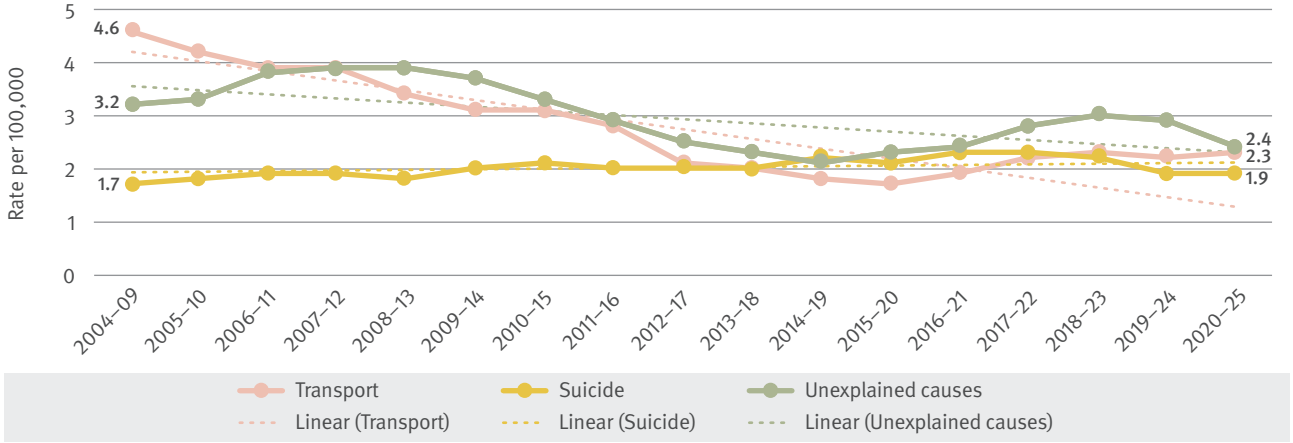
Mortality rates for drowning, other non-intentional injury and fatal assault and neglect, shown in Figure 1.3, decreased between 2004–09 and 2020–25, with the trend lines decreasing 3.0%, 1.9% and 1.7% respectively per year.[10]

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.

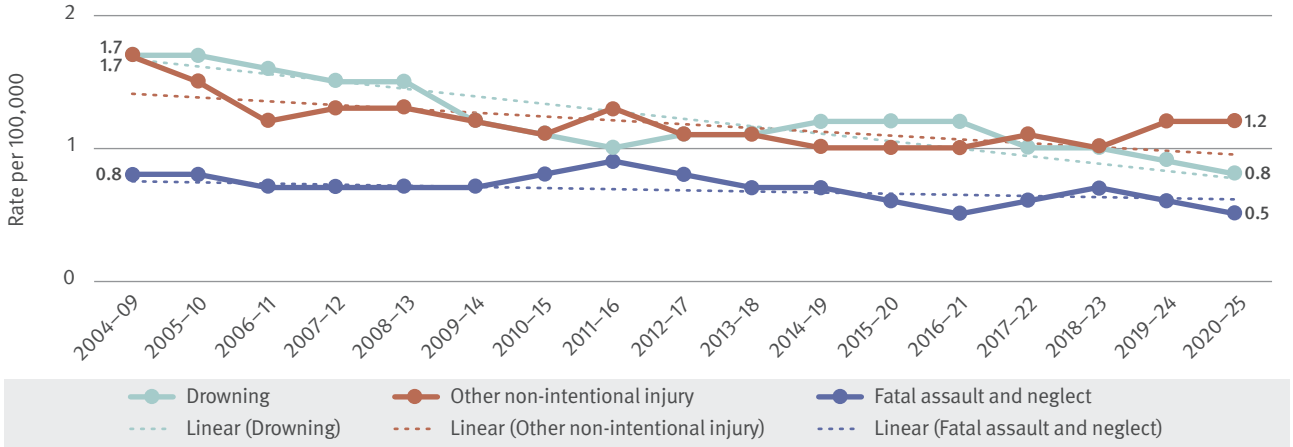
10 The decreases between 2004–09 and 2020–25 in other non-intentional injury and fatal assault and neglect did not reach statistical significance.

**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.*

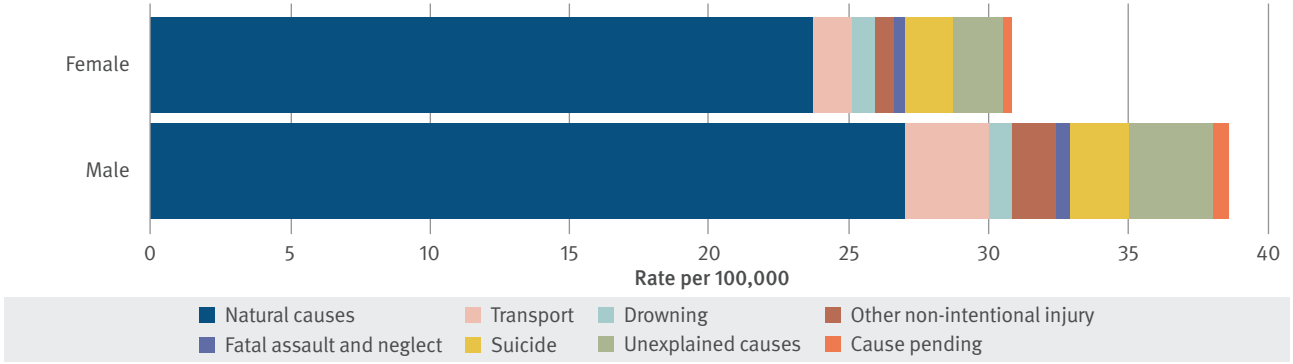
# Demographics

## 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.

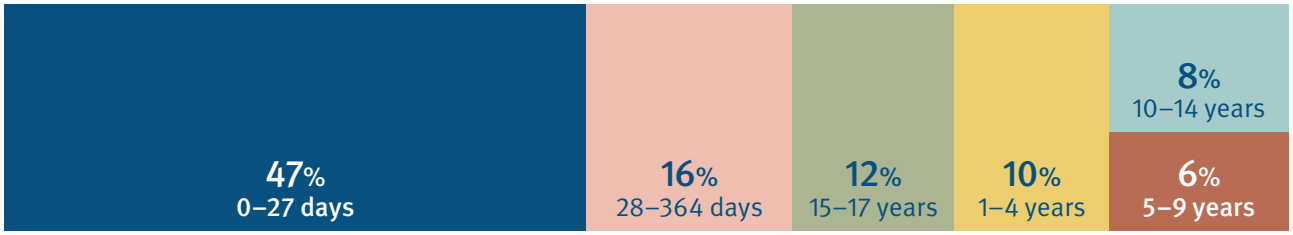
**Figure 1.4:** Deaths by sex and cause of death (rate), 2020–21 to 2024–25




## 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



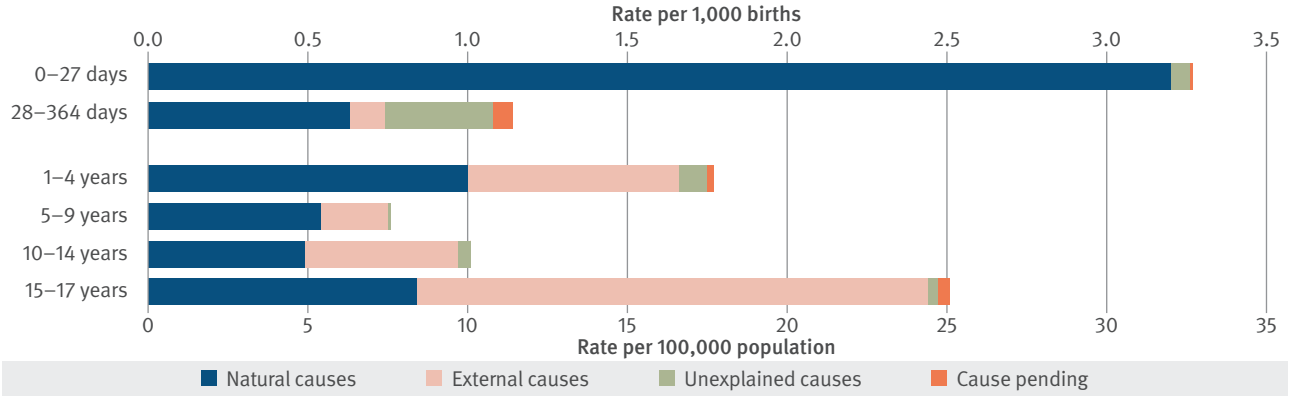

*Notes: Percentages may not add to 100 due to rounding.*

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.

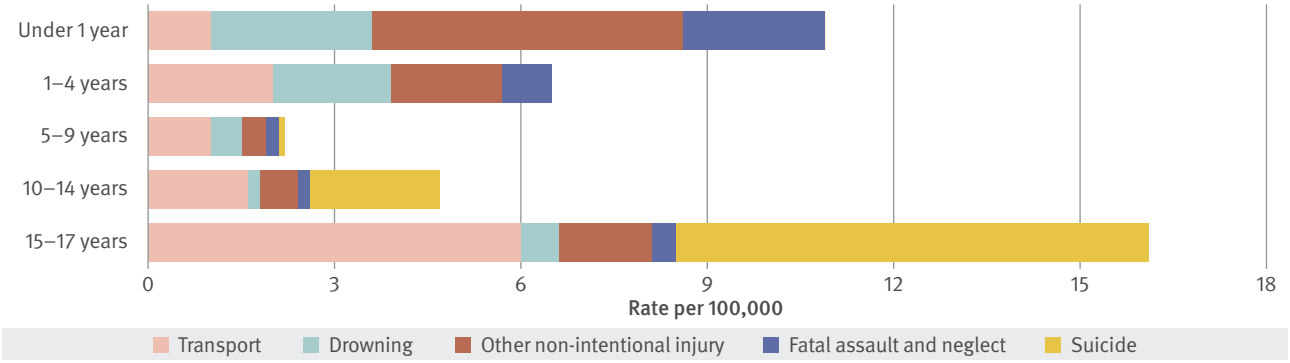
**Figure 1.6:** Deaths by age and major cause group (rate), 2020–21 to 2024–25




*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

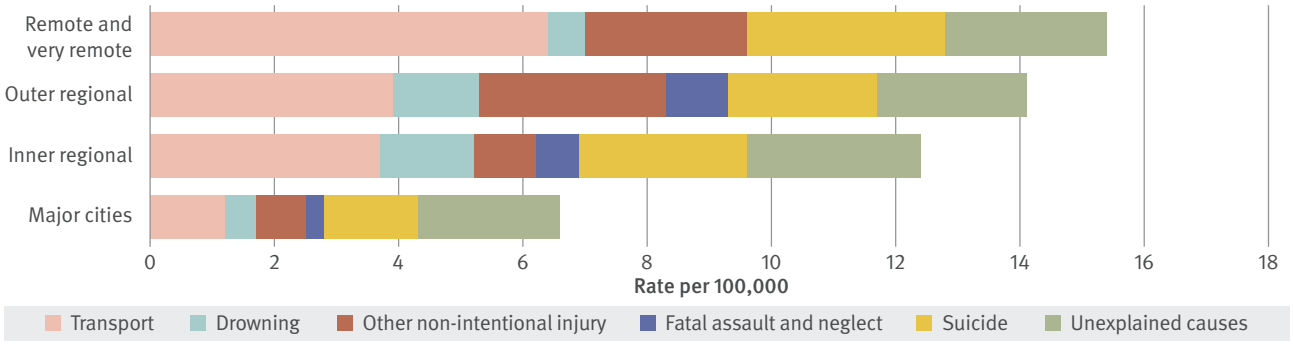
The child mortality rate from all causes was highest in outer regional areas and remote and very remote areas of Queensland, with rates of 44.0 and 43.4 per 100,000 respectively, compared with 38.5 in inner regional areas and 30.7 in major cities (5-year average).[12,13]

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



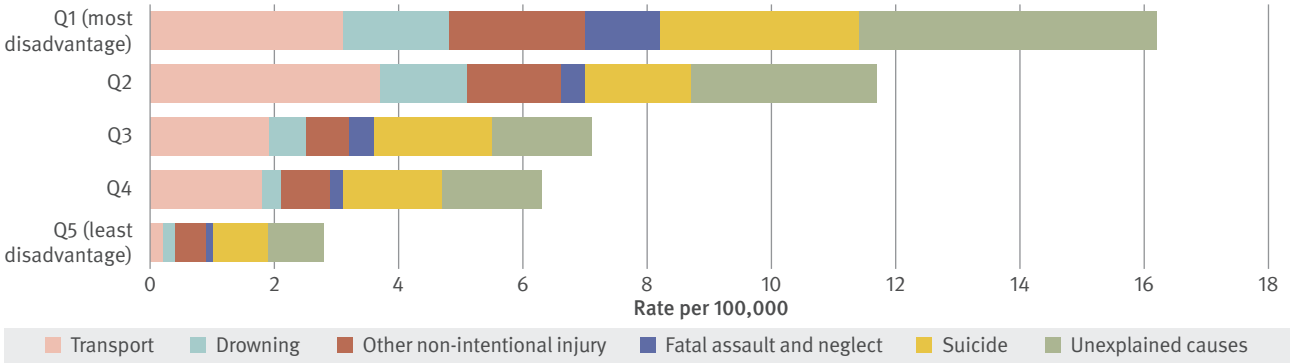

*Notes: Rates calculated per 100,000 population aged 0–17 years in each ARIA+ category, averaged over 5 years. Excludes the deaths of children whose usual place of residence was outside Queensland.*

## 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]

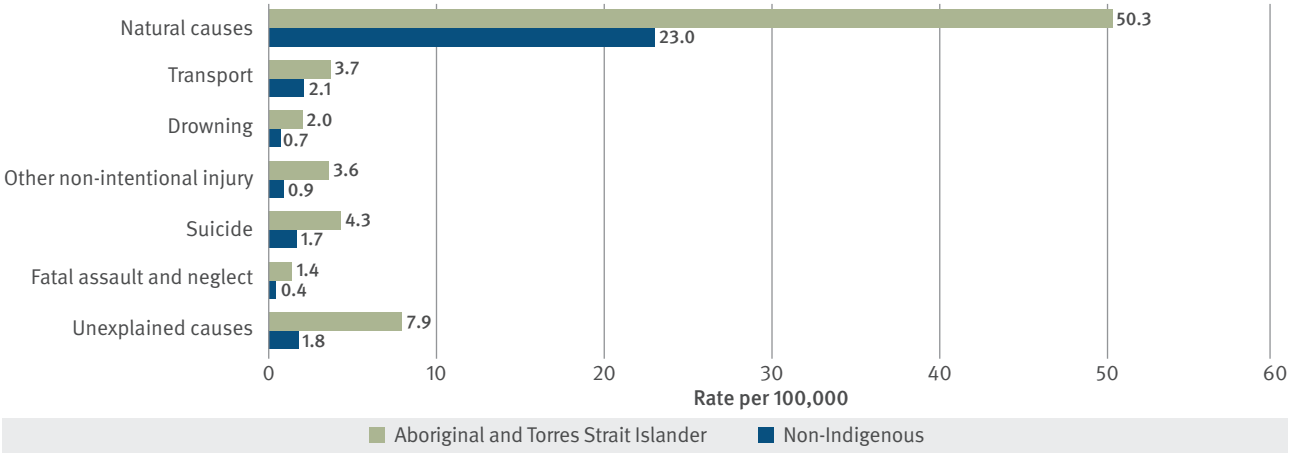
The Aboriginal and Torres Strait Islander infant mortality rate was 7.5 deaths per 1,000 Aboriginal and Torres Strait Islander births, compared with 4.0 deaths per 1,000 non-Indigenous births (5-year average).

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

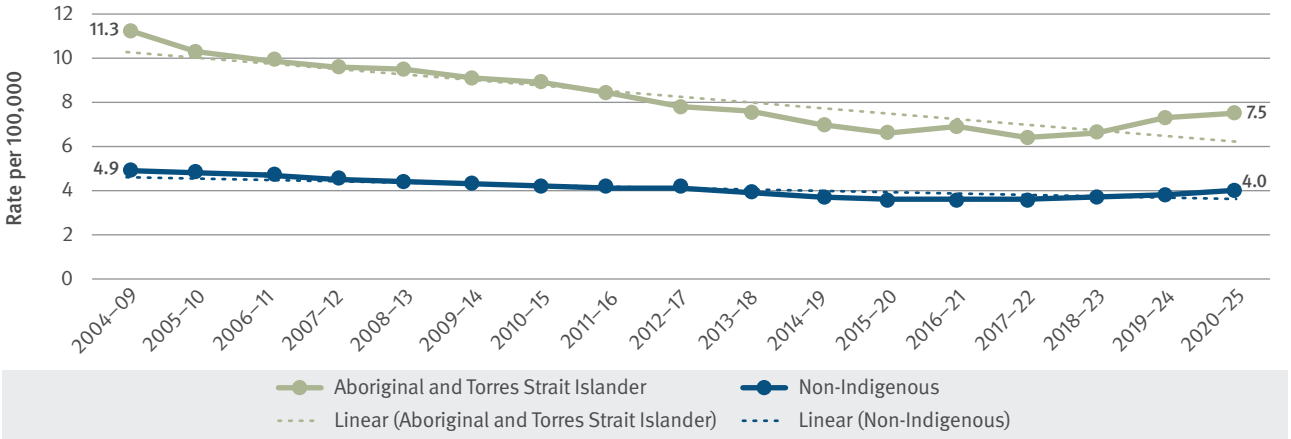
### Aboriginal and Torres Strait Islander population estimates

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.

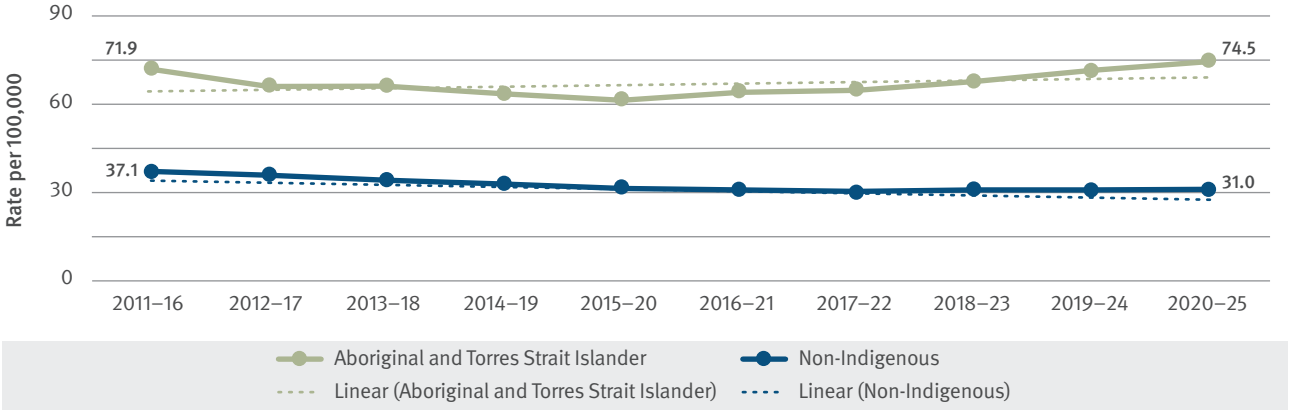
The trends in the child mortality rate (0–17 years) by Indigenous status between 2011–16 to 2020–25 are illustrated in Figure 1.12. No notable changes in mortality rates were apparent in either of the categories, with the slight increasing trend in the Aboriginal and Torres Strait Islander rate and the 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.

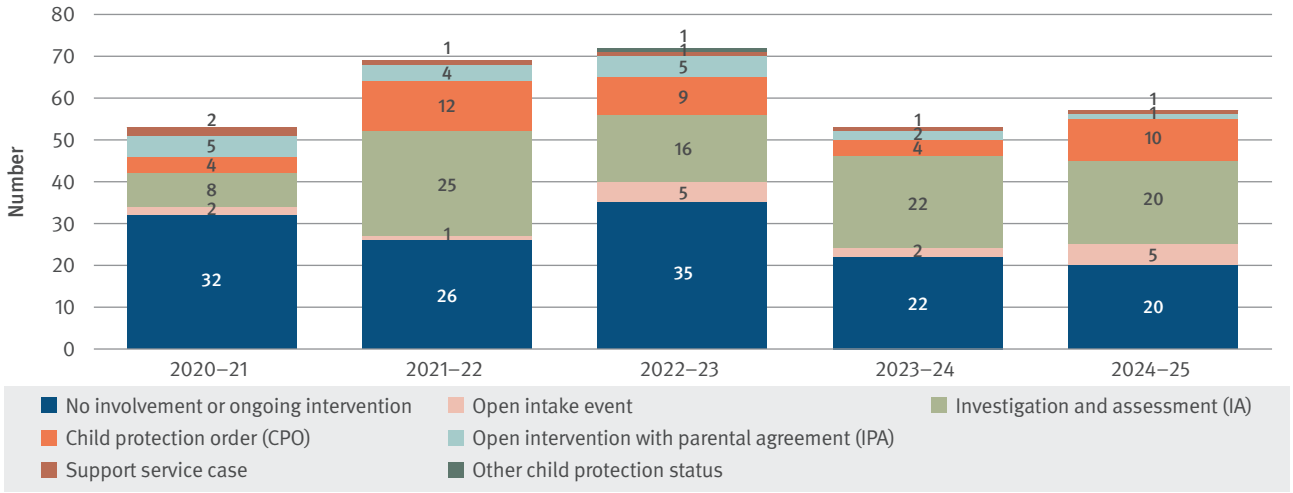
Fifty-seven children who died in 2024–25 were known to child protection in the 12 months prior to their deaths, an increase from 53 deaths in 2023–24. Twenty-one of these children died from natural causes, 16 from external causes, 10 from unexplained causes and 10 deaths were pending a cause at the time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

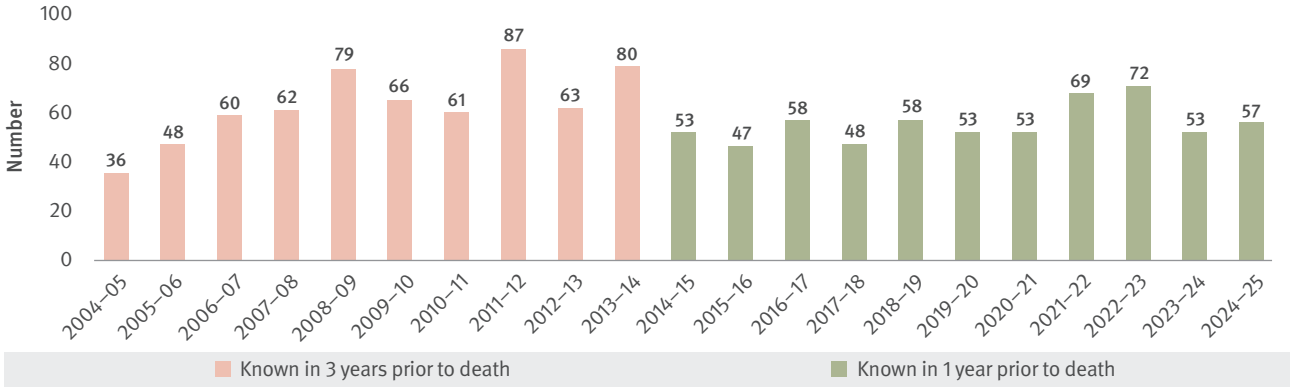
- 44% – no involvement or ongoing intervention
- 30% – investigation and assessment (IA)
- 13% – child protection order (CPO)
- 6% – intervention with parental agreement (IPA)
- 5% – open intake event.

**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).

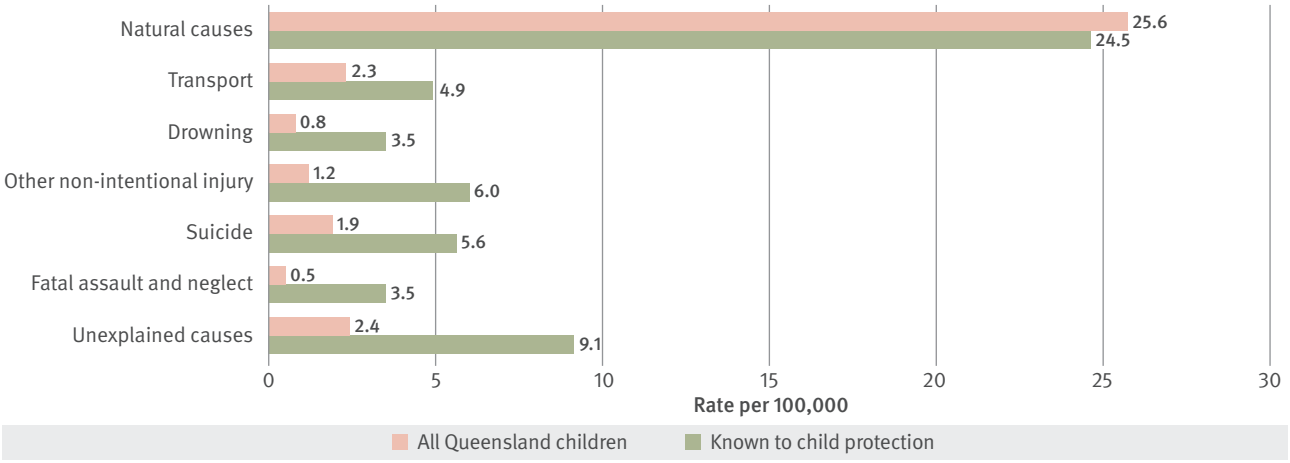
Children who are at increased risk of child maltreatment are often from families with high levels of socio-economic disadvantage, unmet parental needs including mental health, domestic and family violence, and problematic substance use and housing instability. All of which are risks for adverse childhood 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.

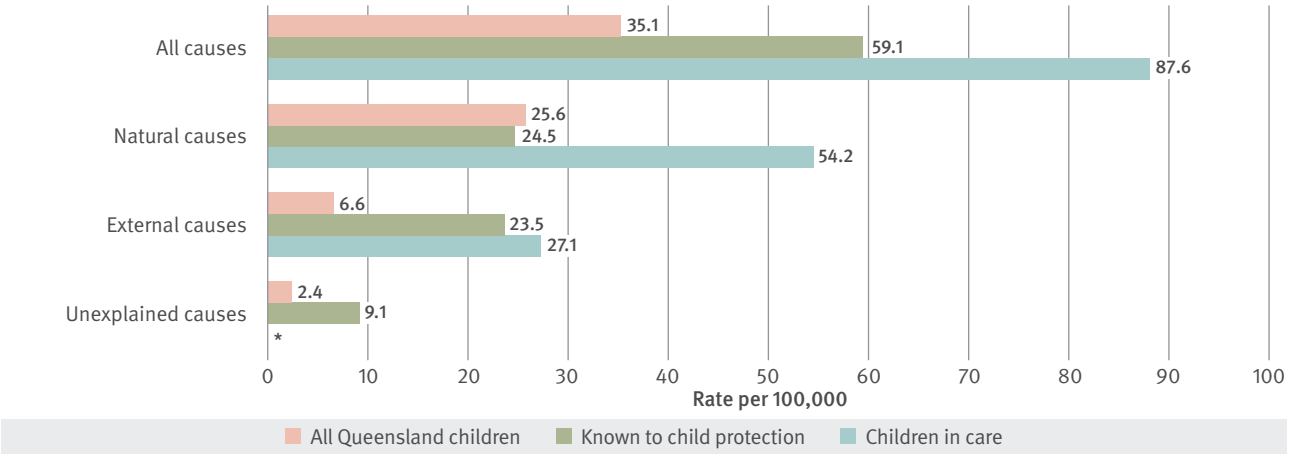
Ten children who died in 2024–25 were in care at the time of death. In the last 5 years, 42 children were in care at the time of their death, representing 14% of the 304 deaths of children known to the child protection system.

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

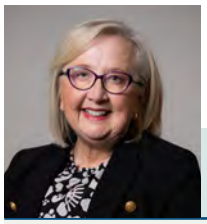
Reporting on deaths where the child or young person had been reported missing arose from the Commission review ***When a child is missing: Remembering Tiahleigh***—a report into Queensland's children missing from out-of-home care.[22]

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

## 2025 Australian and New Zealand Child Death Review and Prevention Conference



### 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

# Learnings

## 2025 Australian and New Zealand Child Death Review and Prevention Conference

### 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

# 2 Deaths from natural causes

**Deaths from natural causes (diseases and morbid conditions) accounted for three-quarters of child deaths, with these most likely to occur in the first days and weeks of life. Many of these early deaths were caused by perinatal conditions and congenital anomalies. Cancers and tumours were the leading natural cause of death, and among the top 3 causes of all deaths, for children aged 1–17 years.**

Our involvement in research has contributed to evidence-based practice improvements and the development of initiatives aimed at reducing preventable child deaths due to sepsis-related infections.

In partnership with the Queensland Paediatric Sepsis Program (QPSP) (Children's Health Queensland), we published the *Queensland paediatric sepsis mortality study* in 2024, Australia's first population-based study to better understand the true incidence of childhood deaths from sepsis.

Our study found sepsis is the biggest single cause of preventable death of children in Queensland. It suggests sepsis may be under-diagnosed in Queensland children, particularly in infection-related deaths that occur outside hospitals.

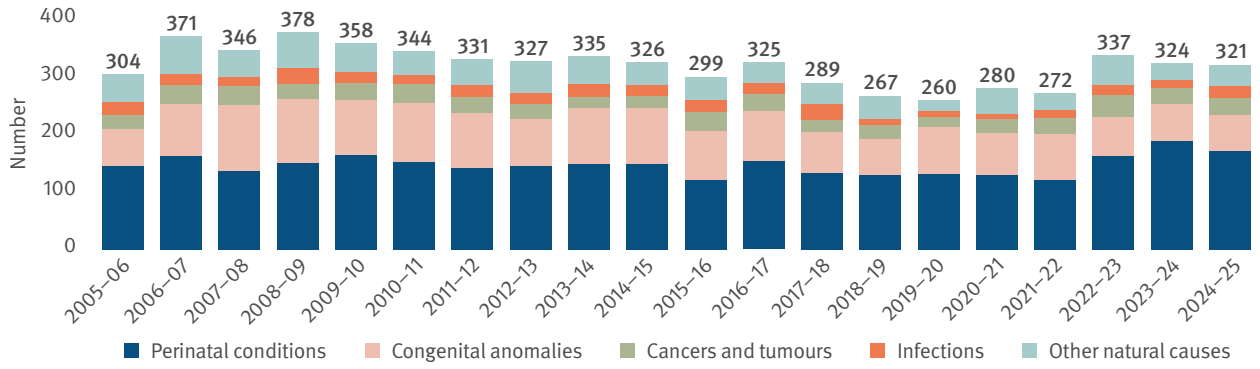
The study provides us with rich insights into the occurrence of sepsis and the opportunities for early detection and treatment. We continue to work with QPSP to improve our response to sepsis in 5 key areas – public awareness, clinical improvements, identifying sepsis on death certificates and in coronial investigations, and research. Child death review teams in New South Wales and South Australia have reached out to us to replicate the study in their jurisdictions.

Every child lost to sepsis is a reminder that we can do more. Sepsis can strike fast, but with knowledge, vigilance, and timely care, we can save lives. We commit to maintaining a spotlight on sepsis-related child deaths in future annual reports to help track progress on turning the trend in the numbers of deaths from sepsis among children in Queensland.

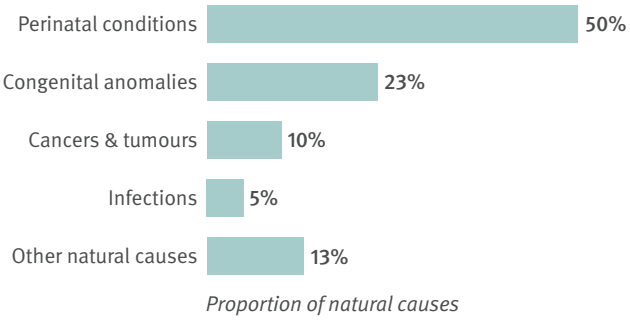
The Commission has also introduced a focus on deaths from potentially avoidable natural causes in our reporting. This includes deaths from conditions that can be mainly prevented through effective existing public health and primary prevention interventions and/or individualised care plans.

# Key facts on child deaths from natural causes

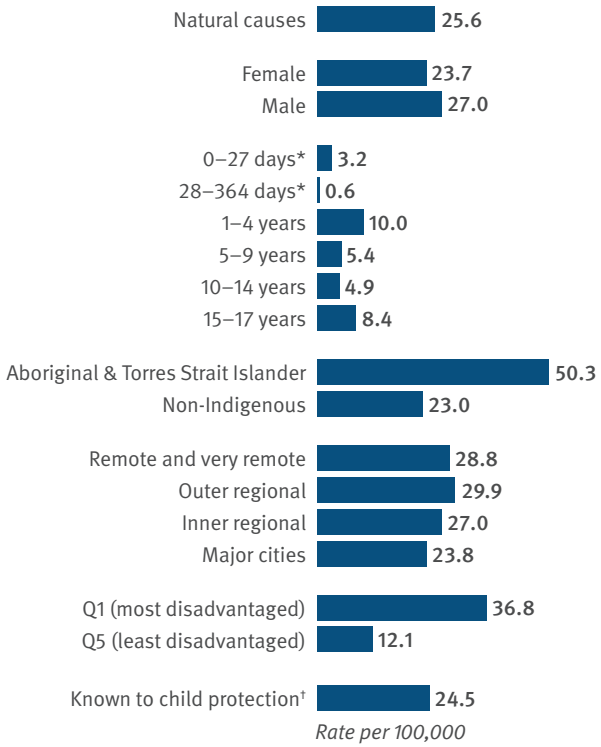
## 2005 to 2025




## 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 | **Congenital anomalies** 0.2 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 | **Cancers and tumours** 1.9 per 100,000 |
| 15–17 years | **Cancers and tumours** 2.5 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

### Classification of causes of death using ICD-10

The Commission uses the ***International statistical classification of diseases and related health problems***, tenth revision[23] (ICD-10) to classify causes of death. The ICD-10 chapters and codes form the major groups and sub-groups of diseases and conditions in reporting on deaths from natural causes.

Overall, there has been a downward trend in the mortality rate for natural causes (diseases and morbid conditions),[24] with the rate decreasing from 35.3 per 100,000 in 2004–09 to 25.6 per 100,000 in 2020–25 (a decrease of 2.0% per year on average).[25] The majority of child deaths each year are from natural causes. Natural causes have accounted for 73% of all child deaths over the past 5 years.

Perinatal conditions and congenital anomalies were the most common natural causes in 2024–25 (169 and 64 deaths respectively). Together, these causes accounted for 73% of all deaths from natural causes.

Appendix A, Table A.4 provides summary data and key characteristics for deaths from natural causes.

## Trends

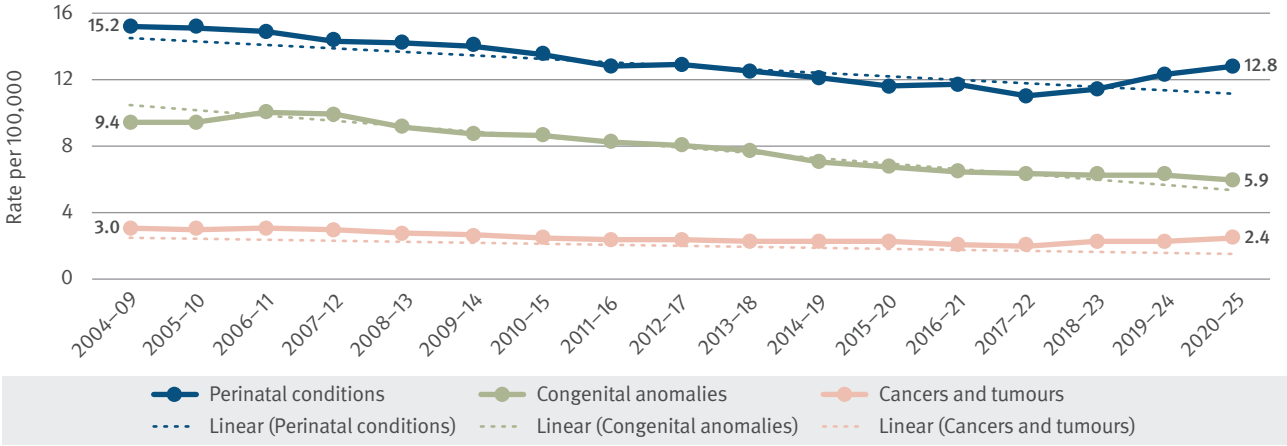
Although the broader trend in the natural cause mortality rate is decreasing, there have been higher natural cause deaths in the last 3 years with 337 in 2022–23, 324 in 2023–24 and 321 in 2024–25. In comparison, in the 5 years preceding the last 3, natural cause deaths were below 300 and ranged between 260 and 289.

The increased numbers are largely due to the increase in deaths from perinatal conditions, which increased from 121 in 2021–22 to 169 in 2024–25. Deaths from perinatal conditions, which predominantly occur in the neonatal period (0–27 days), are the largest contributor to child deaths.

The long-term trends in mortality rates from the leading natural causes are shown in Figure 2.1. The figure illustrates the recent increases in mortality from perinatal conditions.

Further analysis of the Child Death Register found the increase in perinatal conditions in 2024–25 has primarily occurred across one underlying cause of death block: Fetus and newborn affected by maternal factors and by complications of pregnancy, labour and delivery (P00–P04).

**Figure 2.1:** Perinatal conditions, congenital anomalies and cancers and tumours (5-year rolling rate), 2004–09 to 2020–25




23 https://icd.who.int/browse10/2019/en

24 Deaths are reported as explained diseases and morbid conditions only. Deaths from unexplained causes are included in Chapter 8.

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

## Sex

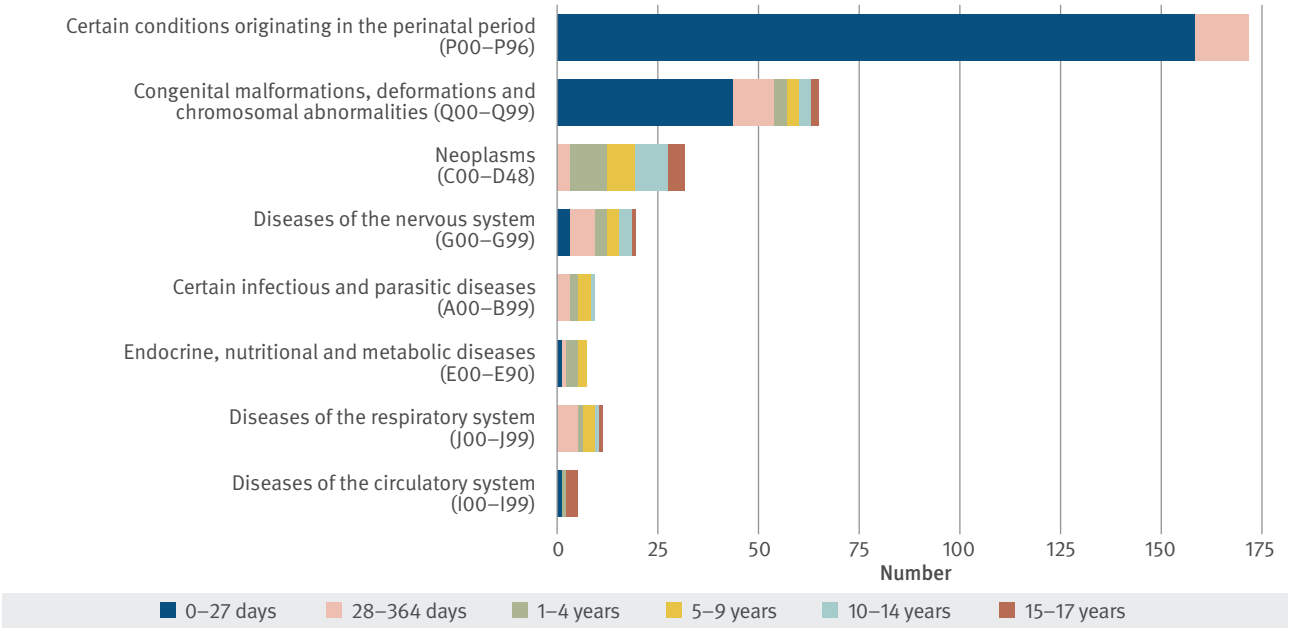
In 2024–25, of the 321 child deaths from natural causes 193 were male while 126 were female (in addition there were 2 infants of indeterminate sex). Child mortality from natural causes is marginally higher for males than females. Over the last 5 years, the male mortality rate was 27.0 deaths per 100,000 male children compared to 23.7 deaths per 100,000 female children.

## Age

Figure 2.2 illustrates the types of natural cause deaths for each age category in 2024–25. The following findings were evident:

- Almost all natural causes of death for infants (under 1 year) were from perinatal conditions and congenital anomalies (96% of all natural causes within this age group).
- Neoplasms (cancers and tumours) was the primary natural cause for children aged 1–17 years.

**Figure 2.2: Deaths from natural causes by ICD-10 chapter and age (number), 2024–25**



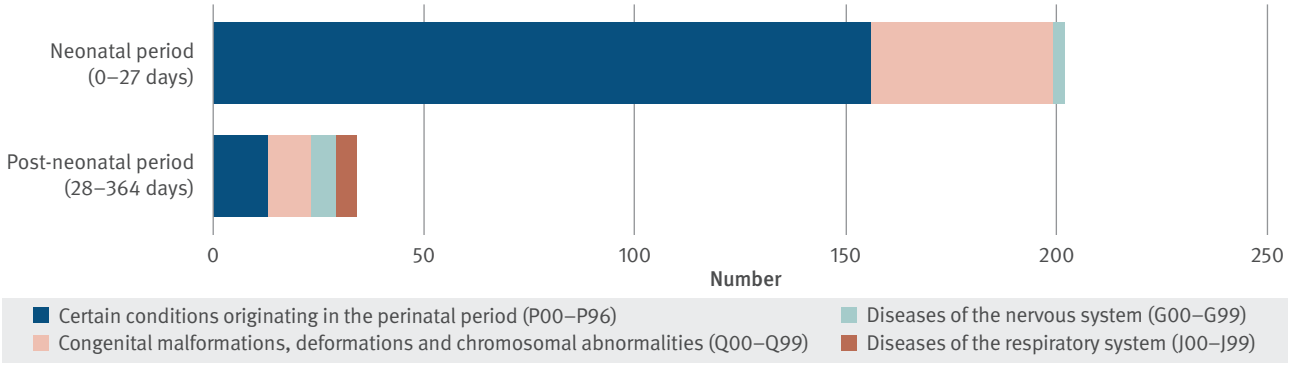

*Notes: Excludes causes where the total number of deaths was 4 or less.*

# Neonatal and post-neonatal infants

The neonatal period is defined as the first 28 days of life, beginning at birth and ending at 27 completed days. It is often subdivided into early neonatal (0–7 days) and late neonatal (8–27 days) stages. The post-neonatal period follows immediately after, spanning from 28 days to the end of the first year of life. These definitions are commonly used in public health and clinical settings to monitor infant development and mortality trends.

Figure 2.3 illustrates the types of natural cause deaths for infants in 2024–25. Natural causes of death for infants (under 1 year) were primarily from perinatal conditions and congenital anomalies, accounting for 169 and 53 out of 246 in single reporting year.

**Figure 2.3:** Deaths of infants from natural causes by ICD-10 chapter and age (number), 2024–25




*Notes: Excludes causes where the total number of deaths was 4 or less.*

Table 2.1 shows the age and causes of infant deaths in major groups in the last 5 years, across the neonatal and post-neonatal periods.

**Table 2.1:** Age and cause of infant deaths from natural causes (number), 2020–21 to 2024–25

| Age | | Cause of death | | | Total |
|---|---|---|---|---|---|
| | | Perinatal conditions (P00–P96) | Congenital anomalies (Q00–Q99) | Other diseases and morbid conditions[a] | |
| Neonatal (age in days) | <1 | 466 | 151 | 6 | 623 |
| | 1–6 | 126 | 39 | 3 | 168 |
| | 7–27 | 112 | 40 | 16 | 168 |
| Neonatal total | | 704 | 230 | 25 | 959 |
| Post-neonatal (age in months) | 1* | 34 | 22 | 13 | 69 |
| | 2 | 8 | 15 | 12 | 35 |
| | 3 | 5 | 5 | 8 | 18 |
| | 4 | 3 | 7 | 3 | 13 |
| | 5 | 2 | 5 | 4 | 11 |
| | 6 | 2 | 7 | 7 | 16 |
| | 7 | 0 | 5 | 3 | 8 |
| | 8 | 0 | 1 | 1 | 2 |
| | 9 | 2 | 1 | 6 | 9 |
| | 10 | 1 | 2 | 2 | 5 |
| | 11 | 1 | 1 | 2 | 4 |
| Post-neonatal total | | 58 | 71 | 61 | 190 |
| Total infants | | 762 | 301 | 86 | 1,149 |

* *28 days to <2 months.*

a *Includes certain infectious and parasitic diseases (A00–B99); neoplasms (C00–D48); diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50–D89); endocrine, nutritional and metabolic diseases (E00–E90); diseases of the nervous system (G00–G99); diseases of the circulatory system (I00–I99); diseases of the digestive system (K00–K93); diseases of the respiratory system (J00–J99); diseases of the musculoskeletal system and connective tissue (M00–M99); diseases of the genitourinary system (N00–N99); symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99); codes for special purposes (U00–U49).*

### Neonatal period (0–27 days)

Of the 1,149 infant deaths due to natural causes in the last 5 years, 83% occurred in the neonatal period. Of the 959 neonatal deaths, 65% (623) occurred on the day of birth and a further 18% (168) had occurred by the end of the first week.

The 2 leading causes—perinatal conditions (704 deaths) and congenital anomalies (230 deaths)—represent 97% of the neonatal deaths from natural causes.

### Post-neonatal period (28–364 days)

During the last 5 years, there were 190 deaths from natural causes during the post-neonatal period. The leading cause of death from natural causes in the post-neonatal period was congenital anomalies (71 deaths or 37%).[26]

## Major causes

### Perinatal conditions

Perinatal conditions are diseases and conditions which originate during pregnancy or the neonatal period (first 28 days of life), even though death or morbidity may occur later. Perinatal conditions include maternal conditions which affect the newborn, such as complications of labour and delivery, disorders relating to fetal growth, length of gestation and birth weight, as well as disorders specific to the perinatal period, such as respiratory and cardiovascular disorders, infections, and endocrine and metabolic disorders.

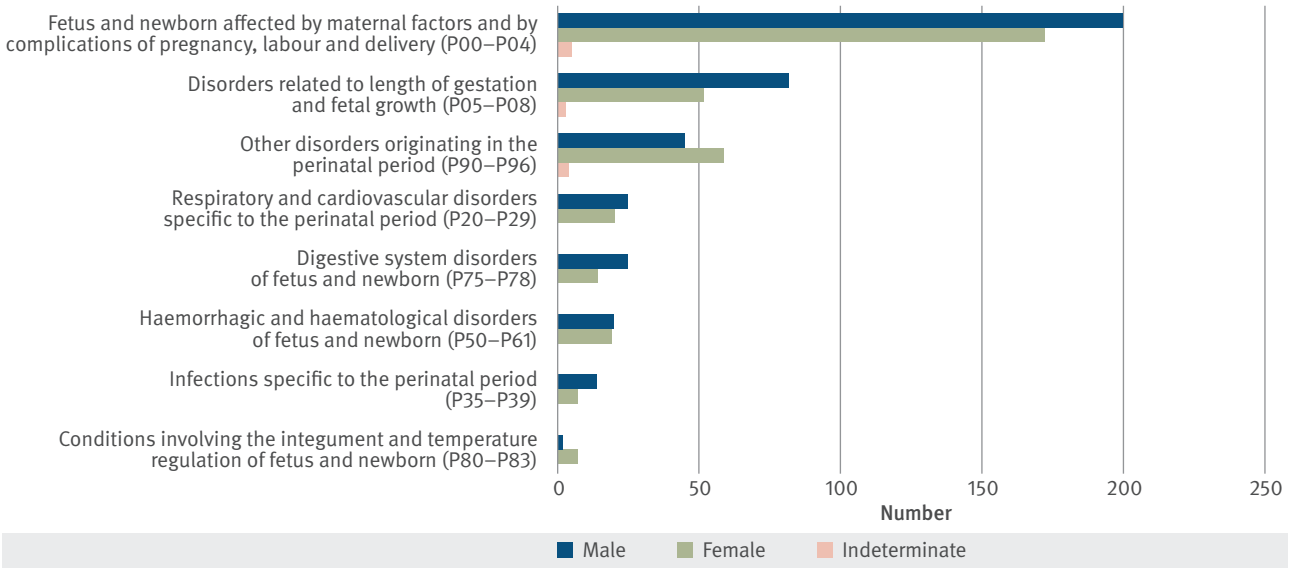
During 2024–25, there were 169 child deaths from perinatal conditions, at a mortality rate of 12.8 deaths per 100,000 children aged 0–17 years (5-year average). Perinatal conditions was the leading cause of death for infants (under 1 year).

As shown in Figure 2.4, over the past 5 years the majority of deaths due to perinatal conditions resulted from the fetus and/or newborn being affected by maternal factors or complications of pregnancy, labour and delivery (49%, 373 deaths), followed by disorders related to the length of gestation and fetal growth (18%, 136 deaths). Together, these causes accounted for 67% of all deaths due to perinatal conditions (511 of 776 deaths).[27]

26 The leading overall cause of death in the post-neonatal period was SIDS and undetermined causes, see **Table 1.1**.

27 Noting a small number of deaths from perinatal conditions occur in children aged 1 year and over.

**Figure 2.4:** Deaths due to perinatal conditions by sex (number), 2020–21 to 2024–25




*Notes: Excludes causes where the total number of deaths was less than 4.*

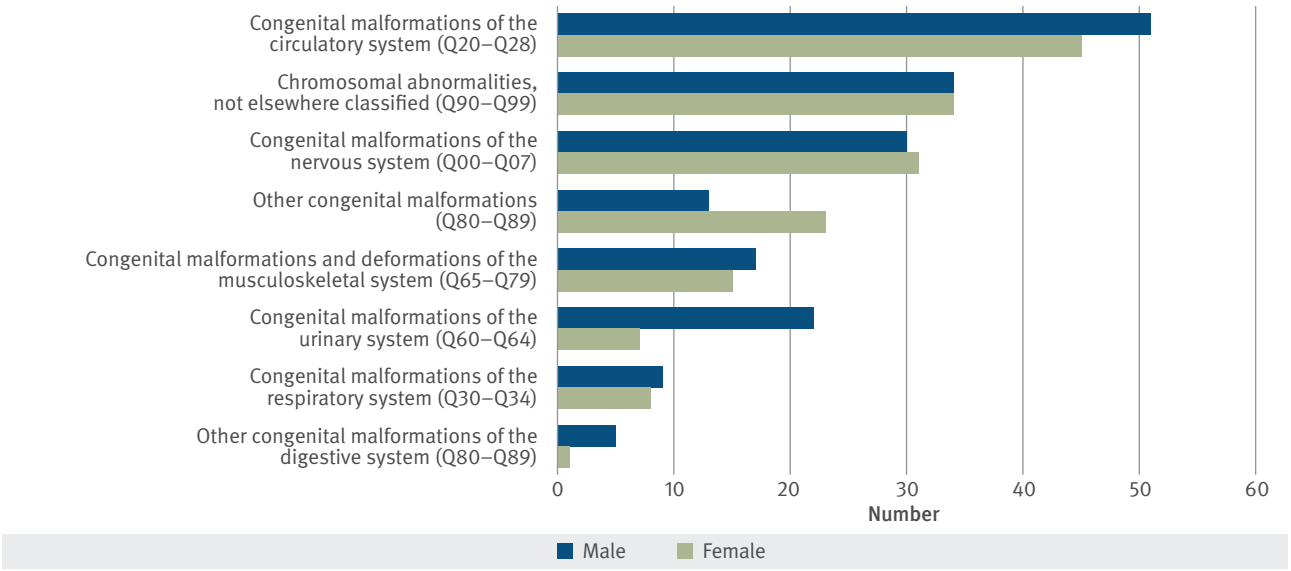
## Congenital anomalies

Congenital anomalies are mental and physical conditions present at birth which are either hereditary or caused by environmental factors.[28]

During 2024–25, there were 64 child deaths from congenital anomalies, at a 5-year average rate of 5.9 deaths per 100,000 children aged 0–17 years.

As shown in Figure 2.5, over the last 5 years the leading causes of death due to congenital anomalies were malformations of the circulatory system (27%, 96 deaths) and chromosomal abnormalities, not elsewhere classified (19%, 68 deaths).

**Figure 2.5:** Deaths due to congenital anomalies by sex (number), 2020–21 to 2024–25




*Notes: Excludes causes where the total number of deaths was less than 4. Excludes 1 child of indeterminate sex.*

28 ICD-10 Chapter XVII, Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99).

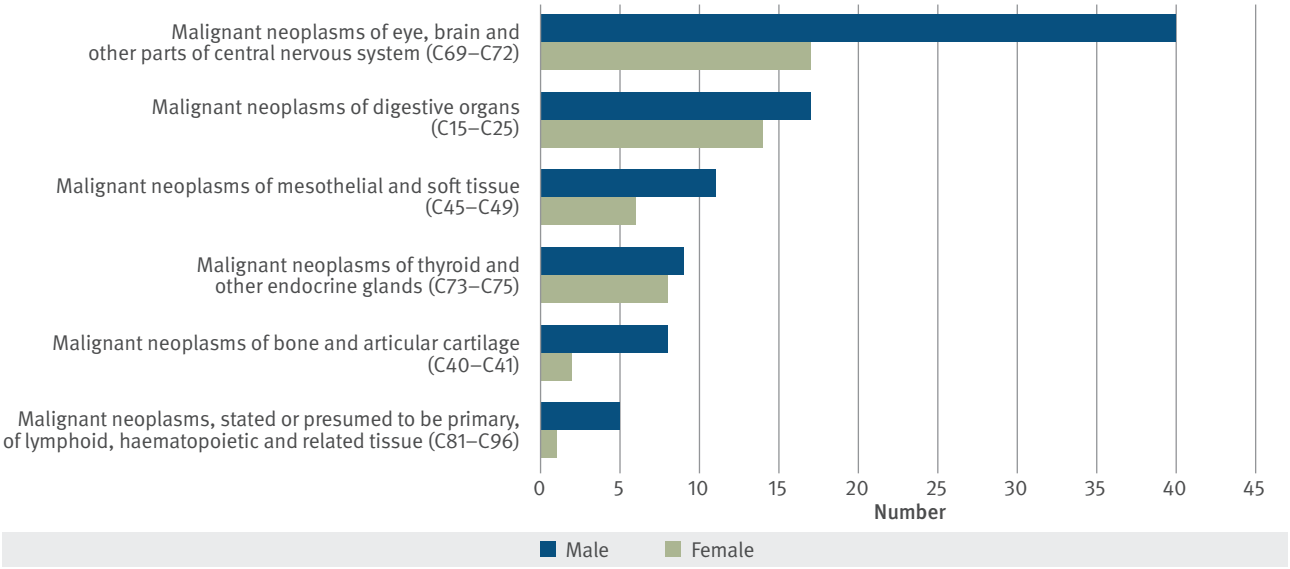
## Neoplasms (cancers and tumours)

The term 'neoplasm' is often used interchangeably with the words 'tumour' and 'cancer'.[29]

Thirty-one children and young people died from neoplasms in 2024–25, at a 5-year average rate of 2.4 deaths per 100,000 children aged 0–17 years. As noted in **Chapter 1**, neoplasms were the leading cause of death (all causes) for ages 1–9 years, and the leading natural cause of death for ages 10–17 years.

Over the last 5 years, 146 children lost their lives to cancers and tumours. As illustrated in Figure 2.6, the most common types were malignant neoplasms of eye, brain and other parts of central nervous system (57 deaths or 39%), followed by malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue (31 deaths or 21%).

**Figure 2.6:** Deaths due to neoplasms by sex (number), 2020–21 to 2024–25




*Notes: Excludes causes where the total number of deaths was 4 or less.*

## Infections

'Infections' is a hybrid category composed of certain infections and parasitic diseases, diseases of the nervous system and diseases of the respiratory system.[30]

Twenty children died from infections in 2024–25. Over the last 5 years, 74 children and young people died from infections, at a 5-year average rate of 1.2 deaths per 100,000 children aged 0–17 years. The most common types of infections were Influenza and pneumonia[31] (20 deaths or 27%), followed by other bacterial diseases (15 deaths or 20%)[32] and Inflammatory diseases of the central nervous system (14 deaths or 19%).[33]

29 ICD-10 Chapter II, Neoplasms.

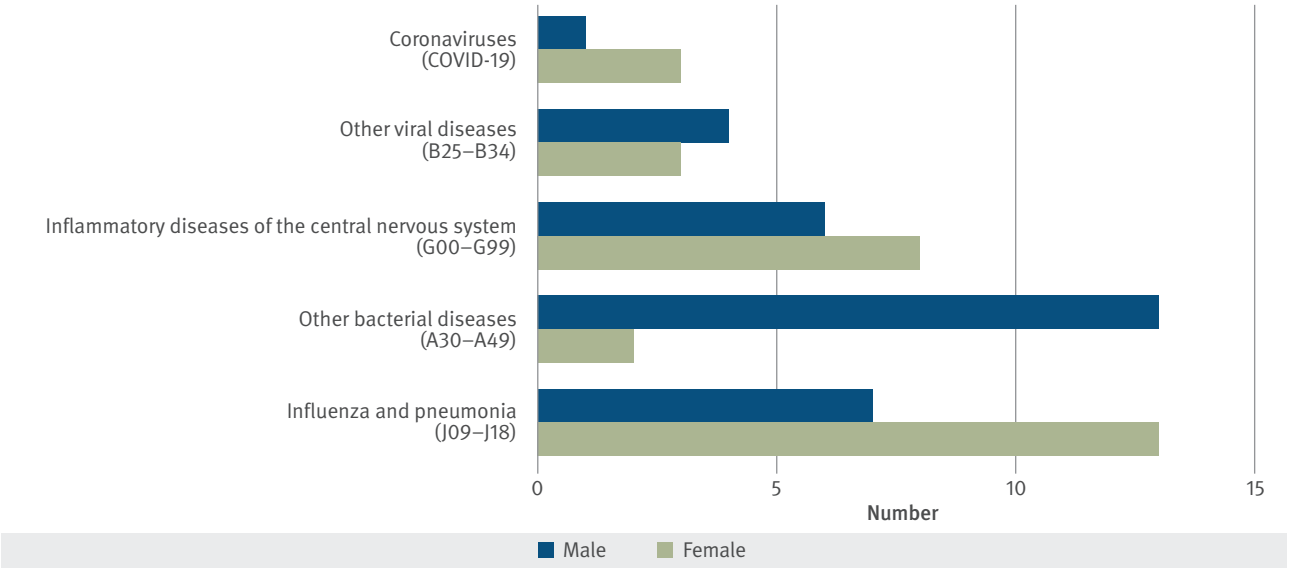
30 ICD-10 references: Chapter I, Certain infectious and parasitic diseases; Chapter VI, Diseases of the nervous system, codes G00–G09 only; Chapter X, Diseases of the respiratory system, codes J00–J22 only, Chapter XXII, Codes for special purposes, COVID 19 codes U07.1–U07.2 only.

31 ICD-10 Chapter X, Diseases of the respiratory system, Influenza and pneumonia (J09–J18).

32 ICD-10 Chapter I, Certain infectious and parasitic diseases, Other bacterial diseases (A30–A49).

33 ICD-10 Chapter VI, Diseases of the nervous system, Inflammatory disease of the central nervous system (G00–G09).

**Figure 2.7:** Deaths due to infections by sex (number), 2020–21 to 2024–25




*Notes: Excludes causes where the total number of deaths was less than 4.*

## Paediatric sepsis – research translation

Sepsis is a life-threatening condition triggered when the body's response to infection causes organ and tissue damage and remains a significant contributor to preventable childhood morbidity and mortality worldwide. In partnership with the Queensland Paediatric Sepsis Program (QPSP) (Children's Health Queensland) the Commission released the *Queensland Paediatric Sepsis Mortality Study* in 2024.[34]

The study identified several opportunities for practice improvement, particularly in the early identification of paediatric sepsis. One key recommendation was the enhancement of death records to better capture infection-related data. The QPSP, supported by the Commission, has been undertaking activities to translate the study recommendations into practice. Actions are intended 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.

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 (HHSs) and Public Health Networks (PHNs) 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 HHSs 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. Targeted improvements have also been made to the Child Death Register to better capture infection-related data, supporting more detailed and accurate reporting in the future.

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

## Deaths from notifiable conditions

There are national and local public health legislation requirements for health practitioners and laboratories to notify public health authorities of certain diseases in Australia.[35] Key factors considered when deciding if a condition should be notifiable include the overall impact of the disease on morbidity and mortality, potential for control, demonstrated public health concern and the availability of control measures. Notification allows authorities to detect outbreaks early and take rapid public health action, if necessary, and to plan and monitor these efforts. It also provides information on the occurrence of disease.

Thirty-seven children and young people died from a notifiable condition over the latest 5-year period as shown in Table 2.2. Twenty-five (68%) of the 37 deaths due to notifiable conditions were the result of potentially vaccine-preventable conditions, with the most common of these being invasive pneumococcal disease and influenza.[36,37]

COVID-19 was added to Queensland's Schedule of Notifiable Conditions in the *Public Health Regulation 2018* in January 2020. There were 5 child deaths due to coronavirus (COVID-19) during the 5-year reporting period.[38]

**Table 2.2: Deaths with notifiable conditions as underlying cause (number), 2020–21 to 2024–25**

| Notifiable condition | Total |
|---|---|
| Influenza^ | 9 |
| Pneumococcal disease (invasive)^ | 9 |
| Invasive group A streptococcal infection | 6 |
| Coronavirus (COVID-19)* | 5 |
| Respiratory syncytial virus | 3 |
| Meningococcal disease (invasive)^ | 2 |
| Rheumatic heart disease | 1 |
| Rotavirus | 1 |
| Syphilis (congenital) | 1 |
| **Total** | **37** |

^ *Potentially vaccine-preventable condition. Vaccines are available for selected strains of meningococcal, seasonal influenza and selected serotypes of pneumococcal disease. Serotyping information in relation to influenza, meningococcal and pneumococcal-related deaths is not available to the Commission, and so deaths are reported as being potentially vaccine-preventable only.*

* *Vaccines became available for coronavirus (COVID-19) for children during 2022.*

*Notes: The child deaths with notifiable conditions in this report may differ from communicable disease reports which use date of notification or date of onset of disease to define the reporting period. The deaths reported by Commission use date of death registration to define the reporting period, which may occur sometime after the notification of disease.*

35 The Queensland Health list of notifiable conditions can be found at **www.health.qld.gov.au/clinical-practice/guidelines-procedures/diseases-infection/notifiable-conditions/list**

36 In Australia, publicly funded immunisation programs are administered by state and territory governments. The current National Immunisation Program Schedule (valid from April 2019) includes vaccinations against the following diseases: hepatitis B, diphtheria, tetanus, pertussis (whooping cough), poliomyelitis, Haemophilus influenzae type b (Hib), pneumococcal disease, rotavirus, measles, mumps, rubella, meningococcal ACWY disease, varicella (chicken pox), influenza and human papillomavirus (HPV).

37 Vaccines are available for only selected strains of influenza, meningococcal disease and pneumococcal disease.

38 Information in this report on child deaths with notifiable diseases, including COVID-19, may differ from official reporting by Queensland Health due to different methodology. Further information about the Commission's methodology can be found in the Methodology in **Appendix B** available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

## Potentially avoidable natural cause deaths

Medical conditions such as asthma, diabetes, anaphylaxis, and nutritional deficiencies can result in fatal outcomes when left unmanaged. 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 these, 4 cases met the Commission's criteria for classification as fatal neglect. In 2 of those cases, criminal charges were laid against the child's caregiver(s), suggesting that inadequate medical oversight or neglect may have contributed to the deaths.

Additionally, 3 child deaths were attributed specifically to malnutrition during the same period. All 3 cases resulted in criminal proceedings against caregivers and were classified as fatal neglect.

In June 2025, the Chair of the Queensland Child Death Review Board (the Board) requested the Commission present a statistical analysis to the Board in relation to deaths due to natural causes. The Board is interested in the distinction between deaths that were due to expected, life-limiting conditions versus those where poor health management may have contributed to a premature death. The paper is to be presented at the Board meeting in September 2025.

# 3 Transport-related deaths

**Transport-related incidents were the leading external cause of death for children. Motor vehicle crashes accounted for over half of the deaths, followed by pedestrian-related incidents, then bicycle and quad bike incidents. Of all causes of death, transport incidents were among the top 3 leading causes for each age category from 1–17 years.**

In October 2024, we published *Seatbelt and child restraint use in children 0–12 years*, containing our analysis of road crash child passenger deaths. The data it contains highlights a critical gap between legal compliance and optimal safety, suggesting shifts in children's seat type, location and orientation may be taking place prematurely, before the child outgrows their existing restraint.

This research received extensive national media coverage and led to an invitation for the Commission to sit as a member of the Child Restraint Review Expert Advisory Group, National Transport Commission. We continue to provide information and advice to members to inform national safety improvements to child restraints.

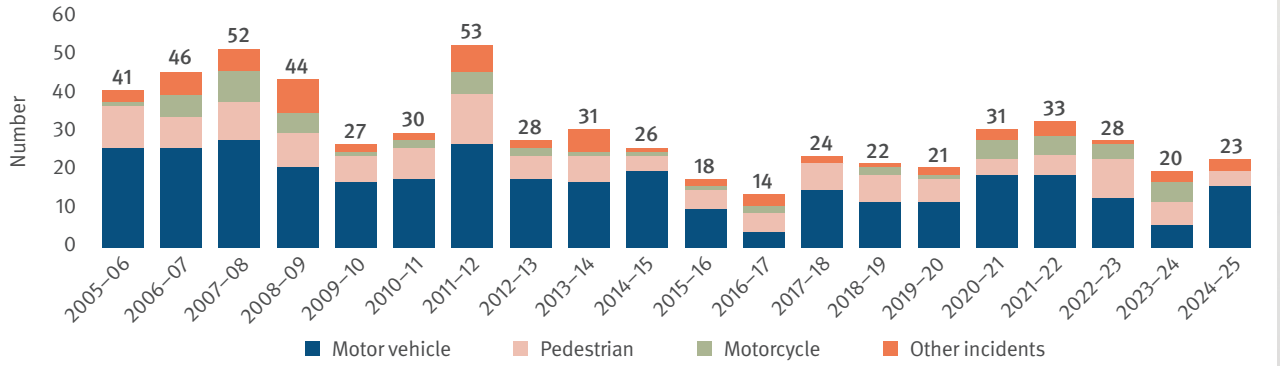
Concerned about observed rises in e-scooter and e-bike related fatalities, we investigated the safety issues and published *Improving safety when young people ride e-scooters and e-bikes Insights Paper*. This paper compiles the evidence around injuries and fatalities in e-scooter and e-bike incidents, risk factors, and how Queensland's road rules and laws surrounding their use compare to other jurisdictions. The Commission's paper makes a number of recommendations to improve safety outcomes, including the introduction of a minimum age of 16 years to lawfully ride these devices in Queensland.

We provided this paper alongside our submission to the state government's inquiry into e-mobility safety and use. Information from this paper has been mentioned across several media platforms and continues to contribute to robust policy discussions to ensure the safety of young e-mobility users and reduce preventable injuries and deaths.

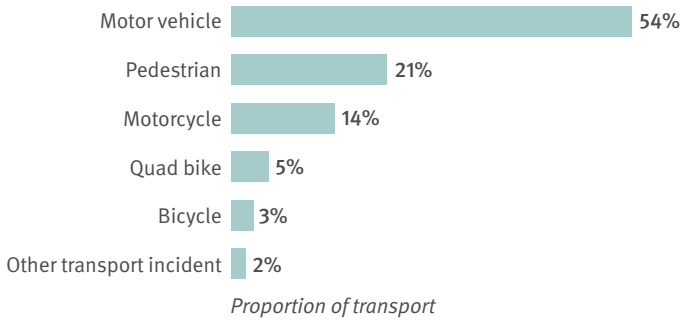
This year, data from the Register on rail crossings and e-scooter use was used to inform and strengthen the online road safety education program, *Journi*. Designed for children in Years 5 and 6 with the help of education experts and students, *Journi* is hosted by the Department of Transport and Main Roads. Data was used to provide insights on emerging road safety issues and update concepts in the online learning activity.

# Key facts on child deaths from transport

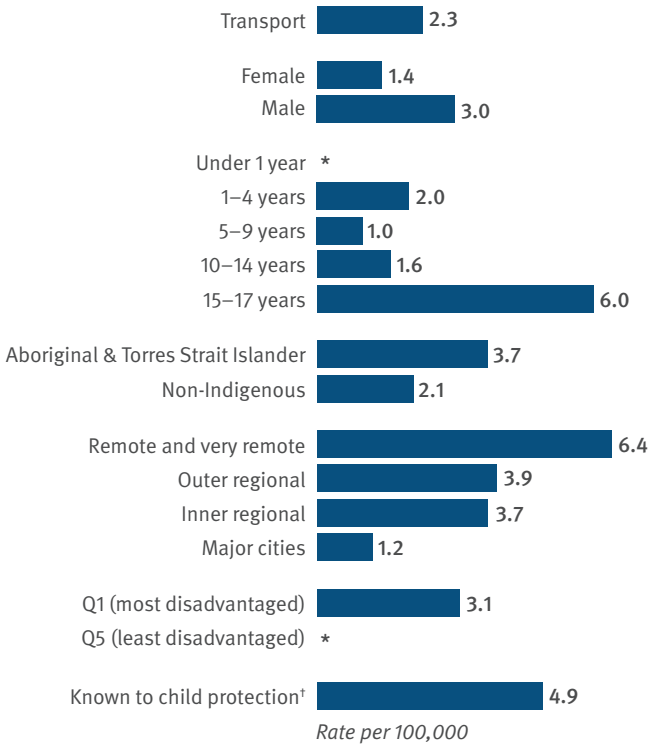
## 2005 to 2025




## 5-year summary (2020–2025) | Incident type




## Demographics




## Risk factors in fatal motor vehicle crashes

**53%** excessive speed

**34%** no or inappropriate restraint

**31%** failure to follow road rules

**29%** alcohol and/or substance use

**29%** inexperienced driver

**28%** reckless driving

*Notes: Counting is by date of death registration. Percentages may not add to 100 due to rounding.*
** rate not calculated for numbers less than 4.*
*† in the 12 months prior to death*

## Key findings

During 2024–25, 23 children and young people died from transport-related incidents in Queensland. This represents a 5-year average rate of 2.3 deaths per 100,000 children aged 0–17 years. **Table A.5** in **Appendix A** provides summary data and key characteristics for transport-related deaths in the last 5 years.[39]

Although there has been an overall decrease in the transport mortality rate since 2004, dropping by 3.7% per year on average (see Figure 1.2), transport remained the leading external causes of death for children and young people in Queensland in the last 5 years.

### Nature of transport incidents

In 2024–25, 16 children and young people died from motor vehicle crashes, 4 from pedestrian-related incidents, 2 from bicycle and one from quad bike incidents.

Over the last 5 years, the majority of the 135 transport-related fatalities were motor vehicle deaths (73 or 54%), followed by pedestrian deaths (29 or 21%) and motorcycle incidents (19 or 14%).

### Sex

Fourteen male children died from transport-related incidents in 2024–25, compared with 9 female children.

Over the last 5 years, the average annual transport-related mortality rate for males was twice the rate for females (3.0 per 100,000 males and 1.4 per 100,000 females). The pattern of male over-representation in transport mortality has been attributed to, in part, greater risk-taking behaviours displayed by young males, including young male drivers.[40]

### Age

Of the 23 transport-related fatalities during 2024–25, 11 were aged 15–17 years, 5 were aged 5–9 years, 3 each were aged 1–4 years and 10–14 years, and one was under 1 year.

The highest rate of transport deaths was among young people aged 15–17 years (6.0 per 100,000) which was 3 times the rate for the 1–4-year age group, which had the next highest rate (2.0 per 100,000) (5-year averages).

While risk taking in adolescent drivers may contribute to the higher rates of death in the 15–17 age group, driver inexperience, without an intention to drive recklessly, may also contribute. Relatively new drivers may lack critical driving skills such as hazard perception, attentional control, and the ability to manage multiple driving tasks.[41]

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

40 AIHW (Australian Institute of Health and Welfare) (2011) *Young Australians: Their health and wellbeing*, cat. no: PHE 140, Australian Government, **www.aihw.gov.au/reports/children-youth/young-australians-their-health-and-wellbeing-2011/report-editions**

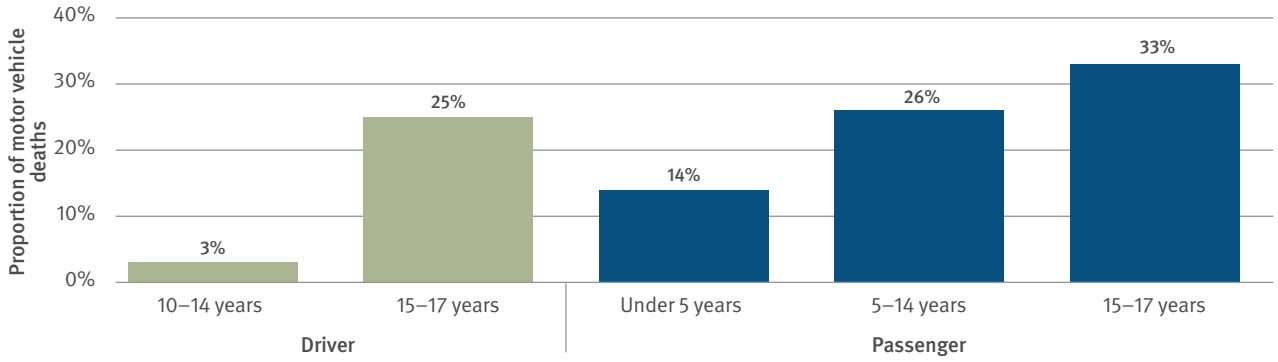
41 Centre for Accident Research and Road Safety Queensland (2019) *Adolescent risk-taking*, **https://research.qut.edu.au/carrs-q/wp-content/uploads/sites/296/2020/06/Adolescent-risk-taking.pdf**

# Transport-related characteristics

## Motor vehicle incidents

Figure 3.1 illustrates the role of the child or young person in motor vehicle fatalities over the last 5 years. Of the 73 children and young people who died in motor vehicle incidents between 2020–21 and 2024–25, 27% (20) were driving at the time of the incident while 73% (53) were passengers.

**Figure 3.1:** Motor vehicle fatalities by role and age category (proportion), 2020–21 to 2024–25




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

### Multiple fatalities

Multiple child, or child and adult, fatalities were recorded in 7 motor vehicle incidents in 2024–25. In the past 5 years, there was a total of 73 child deaths in 68 motor vehicle crashes. Five incidents involved multiple child fatalities, and 21 incidents involved adult fatalities.

### Roadway type

Of the 16 children and young people who died in motor vehicle incidents in 2024–25, 4 died in crashes on highways (roadways with a speed limit equal to or greater than 100km/hr), 6 on a major road (speed limit between 60 and 100km/hr), and 3 each on residential street (speed limit under 60km/hr) and rural roadway. Over the last 5 years, 36% (26 out of 73) of child deaths in motor vehicle crashes occurred on major roads, 33% were on highways, 16% on rural roadways and 11% on residential streets. Three deaths (4%) in the last 5 years occurred in off-road settings (i.e. not on public roadways).

### Risk factors associated with motor vehicle crashes

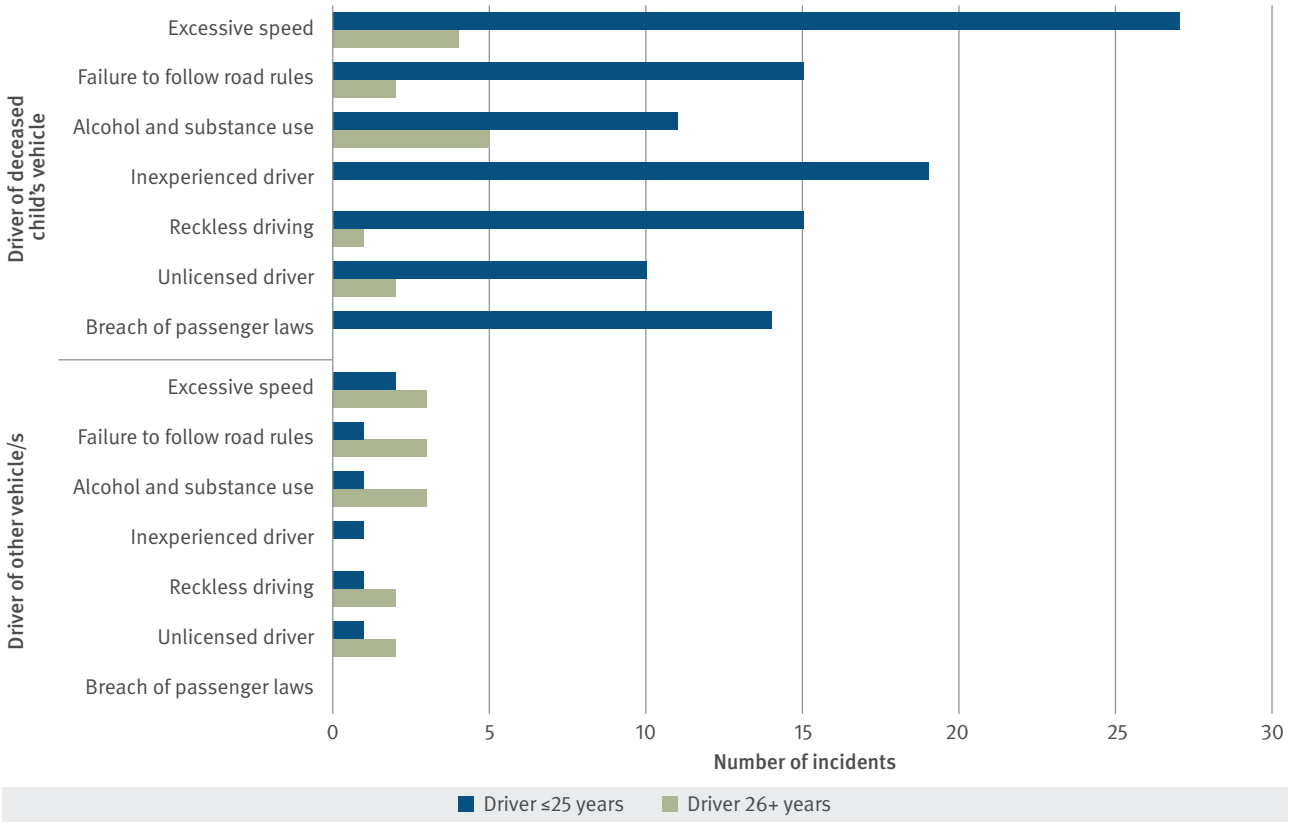
During 2024–25, 16 children and young person died in 15 motor vehicle incidents, an increase from the 6 deaths in 2023–24. Of the 16 deaths, 44% (7) were driving at the time of the incident while 56% (9) were passengers. Excessive speed was the most commonly identified risk factor (6 incidents), followed by unlicensed, suspended or disqualified driver (4 incidents) and driver inexperience, no or inappropriate restraint and alcohol or substance use (3 incidents each). Seven incidents had been identified to have 2 or more risk factors.

Over the last 5 years, 73 children died in 68 motor vehicle incidents. Single-vehicle accidents accounted for 60% (41) of those incidents. Forty-four incidents (65%) involved a young driver (up to 25 years of age) driving the vehicle in which the child/ren was/were travelling. Twenty-five children and young people (34%) were either not restrained or inappropriately restrained at the time of the crashes.

Risk factors identified in 68 incidents over the last 5 years are illustrated in Figure 3.2. The most common driver risk factors were:

- excessive speed (53%)
- failure to follow road rules (31%)
- alcohol and/or substance use (29%)
- inexperienced driver (29%)
- reckless/dangerous driving (28%).

**Figure 3.2: Most common driver risk factors in motor vehicle incidents, by role of vehicle and age of driver (number of incidents), 2020–21 to 2024–25**




*Notes: The role of the vehicle applies to the vehicle in which the deceased child was travelling and, where applicable, any further vehicles involved in the incident. Multiple risk factors may be present in each incident.*

## Seatbelt and child restraint use in children 0–12 years

In October 2024, the Commission published a report examining seatbelt and child restraint use among children aged 0 to 12 years. Analysis of data from the Child Death Register revealed that motor vehicle accidents continue to be a leading cause of death for children under 18 in Queensland. Between 2004 and 2023, 123 children in this age group lost their lives as passengers in road crashes. Encouragingly, the annual rate of child passenger fatalities declined by 3.7%, suggesting the strengthened seatbelt and child restraint laws along with other road safety measures have improved road safety. Despite this progress, there are still notable gaps in compliance with legal requirements and best practices, especially within priority populations.

One in 4 children who died were not using any form of restraint, including adult seatbelts. Since the introduction of strengthened child restraint laws in 2010, one-third of children who died were not secured in compliant restraints. Even among those who were restrained, approximately 75% were not restrained in accordance with best practice for their age, often transitioning prematurely to booster seats or adult seatbelts. This highlights a critical gap between legal compliance and optimal safety.

Best practice guidelines recommend that children under 13 should sit in the rear seat and use age-appropriate restraints based on size rather than age alone. While most younger children were rear seat passengers, one in 4 children aged 7–12 who died were seated in the front. The data also revealed early transitions from rear-facing to forward-facing restraints and from booster seats to adult seatbelts, which may reduce protection in crashes.

Children living in remote and disadvantaged areas were significantly over-represented in fatalities. The death rate in remote areas was more than 3 times higher than in major cities, and children in the most disadvantaged areas had death rates 3 times higher than those in the least disadvantaged areas. These disparities are compounded by limited access to appropriate restraints, lower health literacy, and longer emergency response times.

Aboriginal and Torres Strait Islander children were particularly vulnerable, with a mortality rate 3.8 times higher than non-Indigenous children. Nearly 60% of unrestrained children were First Nations children, and restraint compliance was extremely low in remote Indigenous communities. These findings suggest that systemic inequities, cultural factors, and access barriers play a significant role in restraint non-use.

Children known to the child protection system were also over-represented, accounting for nearly 30% of deaths. Less than half of these children were in legally compliant restraints, and over half of those not legally restrained were Aboriginal and Torres Strait Islander children. These children often face intergenerational adversity and are at higher risk of death from external causes, including transport injuries.

The report highlights the importance of accurate and complete data collection in crash investigations. Missing data on restraint type and seat position limits the ability to assess compliance and effectiveness. Improvements in data completeness have been noted in recent years, but further training and expertise in forensic crash investigation are needed to ensure high-quality data for research and policy development.

Key findings show that while restraint use has improved, many children are still not protected adequately. Legislation lags behind best practice, particularly regarding the age at which children transition between restraint types. Queensland allows rear-facing restraint only until 6 months of age, which is lower than many other developed countries. This early transition may contribute to higher mortality rates among infants.

Recommendations include strengthening child restraint laws to align with best practice, particularly extending rear-facing requirements and delaying transitions to adult seatbelts. Culturally responsive, community-based education and distribution programs should be prioritised for First Nations and remote communities. Improved data collection, targeted interventions, and public awareness campaigns are essential to reduce preventable deaths and improve road safety for children across Queensland.

The report is available at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

## Pedestrians

Four children and young people died in pedestrian incidents during 2024–25. Of these, 3 fatalities were linked to e-scooter incidents, while one was in the context of a low-speed vehicle run-over.

In the Child Death Register, incidents involving e-scooters and other personal mobility devices are classified as pedestrian deaths, consistent with ICD-10 coding guidelines (coded to V09). As of November 2022, Queensland's general road rules have formally included e-scooters under the regulations governing personal devices. Since 2022, 5 young people aged 12 to 15 have died in e-scooter related incidents. The most frequently identified contributing factor was riding without adult supervision (5), failure to follow road rules (5), riding without helmet (4), followed by reckless/dangerous driving (3) and excessive speed (2).

Over the last 5 years, there have been 29 pedestrian incidents, the majority of which were low-speed vehicle run-overs (19 out of 29 or 66%), followed by road and railway crossings (6 out of 29 or 21%). The risk of pedestrian injuries differed by age groups:

- Children under 5 years are most at risk from pedestrian incidents, accounting for 59% (17 of 29) of the pedestrian deaths over the 5-year period.
- Children aged 5–14 years accounted for 6 pedestrian deaths, 3 of which occurred while travelling on or crossing a roadway.
- Six young people aged 15–17 years died in pedestrian incidents. Of the 6 fatalities, 3 were related to e-scooter incidents. Two of the incidents have been identified to involve multiple risk factors such as riding without supervision, not wearing helmet, speeding, reckless/dangerous riding and alcohol or substance use.

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

In June 2025, the Commission released *Improving safety when young people ride e-scooters and e-bikes*, the first of a series of Insights Papers on the causes and factors that contribute to child fatalities in Queensland.

E-scooters and e-bikes are increasingly popular among young people in Queensland due to their affordability, ease of use, and recreational appeal. However, this surge in usage has led to a significant rise in injuries and fatalities, particularly among children under 15. Many incidents involve underage and unsupervised riding, lack of helmet use, speeding, and riding at night without lights. Emergency services have reported a 171% increase in scooter-related injuries over 5 years, with most incidents occurring during school commute hours and involving collisions with vehicles.

The physical environment and device design contribute to safety risks. Shared paths and roads expose young riders to potential collisions with pedestrians and vehicles. E-scooters are often unstable due to small wheels and top-heavy construction, making them difficult to control on uneven surfaces. Lithium-ion batteries used in these devices pose fire hazards, especially when poorly manufactured or handled. The absence of mandatory safety standards for these batteries and devices further increases the risk of serious accidents.

Regulatory inconsistencies across jurisdictions create confusion about where and how these devices can be safely used. Queensland has the youngest legal age for e-scooter use (12 years with supervision), while other states require riders to be at least 16 or 18. Enforcement is limited, and despite thousands of infringements issued, unsafe practices persist. The lack of compulsory third-party insurance for e-scooter riders in Queensland also leaves gaps in liability and protection, especially in the event of serious crashes.

Data and research limitations hinder effective safety planning. Injury and crash data often lack detail on device type, rider age, and incident circumstances, making it difficult to assess the full scope of the problem. Many incidents go unreported, and there is a lack of trip-level data to understand usage patterns and risk exposure. Improved data collection and analysis are essential for tailoring safety measures and monitoring progress toward injury reduction goals.

Education and awareness efforts are currently insufficient. Many young riders view e-scooters as toys, leading to casual and unsafe use. There are few training programs to teach safe riding skills, and public campaigns often fail to reach all communities due to cultural and communication barriers. Schools have an important role to play in promoting safe riding, but local management of safety processes leads to inconsistent practices across Queensland.

Key findings from the paper highlight that children under the legal riding age are frequently involved in incidents, often as unsupervised riders. Most injuries result from falls or collisions, and males aged 12–15 are disproportionately affected. The majority of incidents occur on roads or shared paths, and many involve non-compliant devices capable of exceeding legal speed limits. Helmet use remains low, and standard bicycle helmets may not provide adequate protection against facial injuries.

To address these challenges, the Commission recommends raising the minimum legal age for e-scooter use to 16 years, aligning Queensland with other jurisdictions. It also calls for improved data collection, including consistent device coding and trip-level data, to better understand usage and risk. Strengthening laws and enforcement, including penalties for unsafe behaviour and clearer rules at the point of sale, is essential to improve compliance and safety.

Additional recommendations include expanding public education and culturally informed awareness campaigns, promoting safe device design, and investing in infrastructure upgrades. Schools should adopt consistent safety protocols for managing e-mobility devices, and training programs should be developed to teach young riders practical skills and hazard awareness. A coordinated, multi-sector approach is needed to ensure the safety of young e-mobility users and reduce preventable injuries and deaths.

*Continued over page...*

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

More information about the safe use of personal mobility devices is available at **https://streetsmarts.initiatives.qld.gov.au/initiatives/pmd-rules/**

The Commission's report is available at **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

### Low-speed vehicle run-overs

The term 'Low-speed vehicle run-over' (LSVR) refers to incidents where a pedestrian, often a child, is struck by a slowly moving vehicle, typically in areas outside of regular traffic zones or while transitioning into or out of such areas. These events predominantly affect children under the age of 5.

Over the last 5 years, nineteen children and young people have lost their lives in LSVR incidents. Of these, 16 were children aged under the age of 5, and the majority incidents occurred at the child's home or the residence of someone familiar to the child (13 of 16 or 81%), with the driver most frequently identified as a parent or other close family member (14 of 16 or 88%).

## Motorcycles, bicycles and quad bikes

No motorcycle-related deaths among children and young people were recorded in 2024–25. However, in the last 5 years, there have been 19 fatalities involving children and young people riding motorcycles. In 18 of the 19 fatalities, the motorcycle was being operated by the child or young person themselves. Notably, helmet use was either absent or improper (e.g. not fastened correctly) in 10 of the 19 incidents, accounting for over half of the deaths. The most commonly identified risk factors across these incidents included speeding (37%), alcohol and/or substance use (26%) and reckless/dangerous riding (21%).

In the 2024–25 reporting period, 2 bicycle-related deaths were recorded. Over the past 5 years, 4 young people aged between 9 and 14 years have died in incidents involving bicycles.

One quad bike-related[42] death was recorded in 2024–25. Over the last 5 years, there have been 7 deaths of children and young people riding quad bikes. Five of the 7 deaths were children under the age of 16. The primary mechanisms of injury were: ejection from vehicle (3), vehicle rollover (2) and collision with a stationary object (2). Of the 7 deaths, 5 were not wearing helmets at the time of the incident. Lack of ability or driver inexperience have been identified as the most common contributing factor (5).

## Charges and criminal proceedings

Of the 22 transport-related incidents in 2024–25, 2 resulted in driving-related criminal charges (e.g. dangerous operation of a motor vehicle causing death). Over the last 5 years, there were criminal charges in relation to 28 of the 129 transport-related incidents.

Over the last 5 years, 8 young people have died in 7 separate incidents that involved allegedly stolen vehicles. Among these, 2 incidents involved motorcycles. One further fatality was identified as engaging in criminal activity at the time of the incident.

42 Also known as all-terrain vehicles or ATVs. Includes side-by-side vehicles (SSVs) and utility task vehicles (UTVs).

## Queensland Ambulance Service data

Injury data plays a crucial role in deepening our understanding of the risks that vehicles and machinery pose to children. The Queensland Ambulance Service (QAS) has contributed valuable data on ambulance responses to transport-related incidents involving children. This year, a new and improved methodology was introduced to identify and categorise these cases. The updated approach is more accurate, rigorous, and robust, resulting in a higher number of identified cases than reported in previous years across all incident types, particularly transport-related incidents.

Table 3.1 presents QAS responses to over 6,500 transport incidents involving children and young people during 2024–25, encompassing both fatal and non-fatal injuries. Half of these incidents involved motor vehicles (50%), followed by bicycles (20%) and scooters (15%). Transport incidents were most common among adolescents aged 15–17 years (35%) and 10–14 years (33%).

E-scooter-related incidents accounted for 64% of all scooter-related injuries. Of the 632 e-scooter injuries recorded, the majority occurred among older children, 47% in the 15–17 age group and 44% in the 10–14 age group.[43]

**Table 3.1:** Queensland Ambulance Service responses to transport incidents (number), 2024–25

| Type of incident | Under 1 year | 1–4 years | 5–9 years | 10–14 years | 15–17 years | Total |
|---|---|---|---|---|---|---|
| Motor vehicle | 191 | 540 | 659 | 677 | 1,233 | 3,300 |
| Bicycle | 5 | 97 | 198 | 669 | 368 | 1,337 |
| Scooter/e-scooter | 0 | 41 | 153 | 459 | 340 | 993 |
| *E-scooter* | *0* | *8* | *48* | *281* | *295* | *632* |
| *Other scooter* | *0* | *33* | *105* | *178* | *45* | *361* |
| Motorcycle | * | 5 | 57 | 221 | 249 | 532 |
| Pedestrian | * | 29 | 45 | 70 | 45 | 189 |
| Quad bike | 0 | 11 | 26 | 31 | 24 | 92 |
| Watercraft | 0 | * | * | 13 | 15 | 28 |
| Other (e.g. go kart, skateboard) | 0 | * | 15 | 40 | 40 | 95 |
| **Total** | **196** | **723** | **1,153** | **2,180** | **2,314** | **6,566** |

*Data source: Queensland Ambulance Service (Sep 2025)*

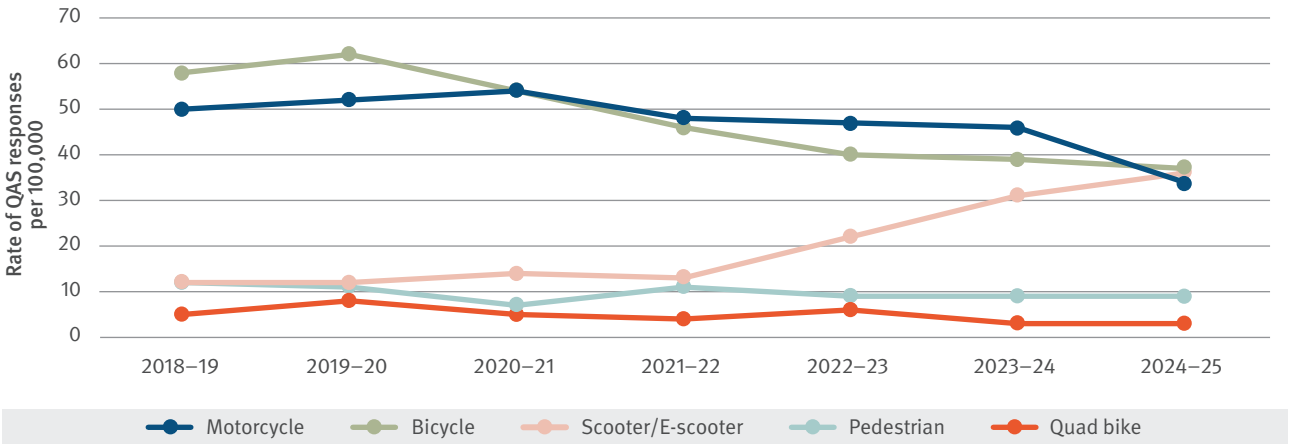
** Not reported for numbers less than 5 and excluded from totals.*

*Notes: Excludes data for children and young people whose gender was recorded as missing or indeterminate (n=33). Numbers in the table do not add to the total number of transport incidents attended by QAS (n=6,574) as cells with less than 5 are not shown, and are excluded from table totals.*

43 All scooter incidents were manually reviewed by QAS. Incidents were only identified as e-scooter incidents where the type of scooter (such as e-scooter, electronic scooter, motorised or powered scooters) was recorded somewhere in the record. QAS advise that there has been more frequent recording by paramedics of scooter type involved in scooter incidents in very recent years (particularly in 2024/25). Hence, there is less uncertainty about scooter type in the 24/25 reporting period than in previous years. The observed increase in e-scooter incidents may reflect a true increase in e-scooter incidents, but also improvements in scooter identification using QAS data.

Figure 3.3 presents the rate of QAS responses for selected transport-related incidents over the past 6 years.[44] To enable accurate trend analysis, the data shown is based on the previous methodology reported on in past annual child death reports. The most notable trend is a sharp increase in response rates for scooter/e-scooter incidents, particularly from 2020–21 onwards, reflecting their rising popularity and associated risks. In contrast, bicycle-related and motorcycle-related responses have declined in recent years, while responses to other transport incidents have remained relatively stable without clear trends.

**Figure 3.3:** Queensland Ambulance Services responses to selected transport incidents (rate per 100,000), 2018–19 to 2024–25




*Data source: Queensland Ambulance Service (Sep 2025)*

*Notes: Excludes cases where gender was recorded as indeterminate or missing. Rates are calculated for each financial year per 100,000 population aged 0–17 years.*

44 Data for the past years is published in previous editions of this report, from data originally provided by the QAS.

## Learnings

### 2025 Australian and New Zealand Child Death Review and Prevention Conference

#### Restraint practices among fatally injured child passengers and the general child passenger population

**Professor Julie Brown**
*Co-Director, Transurban Road Safety Centre at NeuRA*

At the 2025 Australian and New Zealand Child Death Review and Prevention Conference, hosted by the Commission, Professor Julie Brown, as Co-Director for Transurban Road Safety Centre at NeuRA, presented research on the critical differences in restraint practices between fatally injured child passengers and the broader population of child passengers in Australia. Drawing from detailed crash data and observational studies, the research investigated how misuse, non-use, or inappropriate restraint selection, contributed to child fatalities in motor vehicle incidents.

Key findings of the research suggest that a substantial number of children who died in crashes had been unrestrained, using their restraint incorrectly or were improperly restrained relative to their age, size, and legal requirements. Comparative data from the general population revealed widespread issues in the way restraints are being used, and a lack of awareness around best practice guidelines, particularly during transitions from booster seats to adult seatbelts.

The research also highlighted patterns of increased risk among specific cohorts, such as children in remote regions and socio-economically disadvantaged communities, where access to restraint fitting services had often been limited.

The presentation concluded with Professor Brown advocating for enhanced public education, improved accessibility to restraint fitting programs, and clearer messaging around best practice restraint use. Furthermore, Professor Brown called for evidence-informed policy reform to align legal requirements with current safety research, with the aim to reduce preventable injuries and fatalities among child passengers.

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

# 4 Drowning

**Ten children drowned across Queensland in 2024–25. Children under the age of 5 remain the most vulnerable, particularly in domestic settings such as backyard swimming pools and bathtubs. These environments, while familiar and seemingly safe, pose significant risks when supervision lapses or safety measures are inadequate.**

The Commission's data on child drownings is a vital resource for understanding the circumstances surrounding these deaths, informing prevention strategies and protecting young lives.

Pool fencing regulations have played a crucial role in reducing child drownings in Queensland, offering a considerable protective barrier between young children and water hazards. However, the effectiveness of these measures depends heavily on consistent compliance—particularly ensuring that gates are securely closed and never propped open.

The Commission's 2022 report on swimming pool immersions found pool fences were non-compliant in 90% of drowning cases, with pool gates deliberately propped open in many instances. Supervision was found to be inadequate in more than half of these cases.

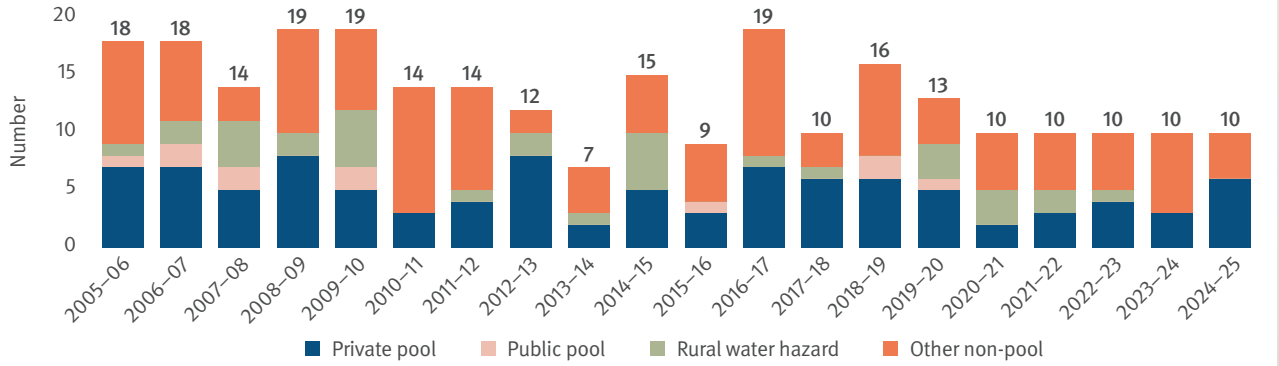
Even brief lapses in supervision or fencing integrity can have tragic consequences. Vigilant adult supervision remains essential at all times when children are near water, as no physical barrier can replace the attentiveness and responsiveness of a caregiver.

Water safety messaging informed by our work is helping to raise awareness, at a national level, about the risks from drowning and promote safer environments for children. We partner with Royal Life Saving Society Australia to ensure granular, age-specific insights from Queensland feed directly into the national analysis of drowning deaths in children aged 0–17 years. Information in the National Fatal Drowning Database is used to produce the annual National Drowning Report, and to inform research, policy, practice, and prevention programs.

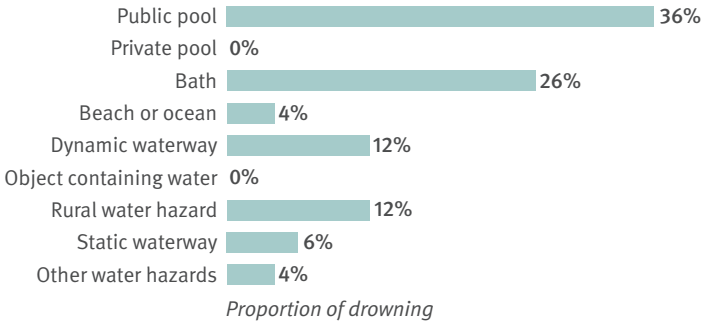
The Commission also promoted, via the 2025 Australian and New Zealand Child Death Review and Prevention Conference, the development of the Australian Water Safety Strategy 2030. The Strategy includes a systematic analysis of fatal drowning cases across a range of aquatic settings—pools, beaches, rivers, and remote waterbodies—to fill gaps in knowledge and target prevention efforts where they will have the greatest impact.

# Key facts on child deaths from drowning

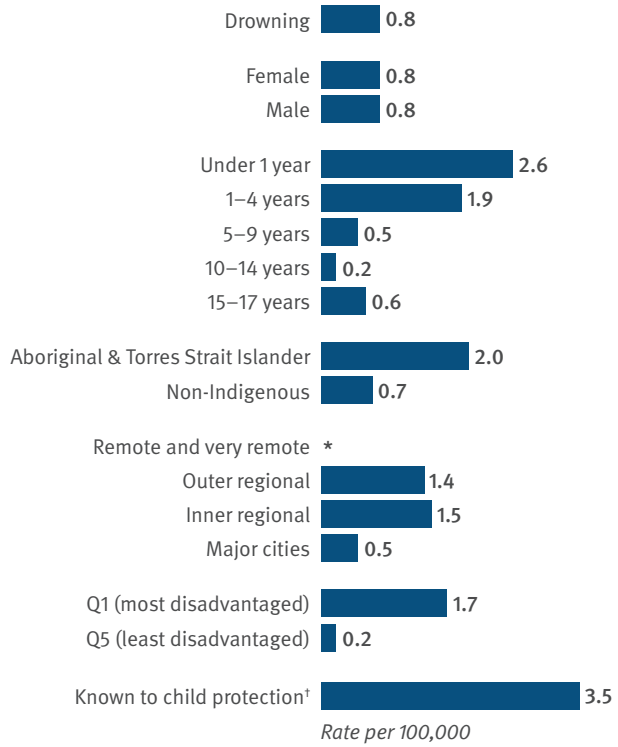
## 2005 to 2025




## 5-year summary (2020–2025) | Water hazard type




## Demographics




## Risk factors

**Under 5s**
are at greatest risk

**Under 1s**

In the last 5 years
7 out of 8 under 1 drownings
were **bathing incidents**

**1–4 years**

**48%** of all **drowning deaths**

**50%** were in **private pools**

**Medical conditions and autism**

**Heightened drowning risk**
for autistic children and children with medical conditions such as epilepsy

*Notes: Counting is by date of death registration. Percentages may not add to 100 due to rounding.*
** rate not calculated for numbers less than 4.*
*† in the 12 months prior to death.*

## Key findings

The deaths of 10 children and young people were attributed to drowning in Queensland in 2024–25. This is a rate of 0.8 deaths per 100,000 children aged 0–17 years over a 5-year period.

Table A.6 in Appendix A provides summary data and key characteristics for drowning deaths in the last 5 years.[45]

### Types of drowning-related deaths

Of the 10 child deaths in drowning incidents in 2024–25, 6 occurred in swimming pools and 4 were non-pool incidents.

Fifty children drowned in the last 5 years. Private pools were the most common incident locations for child drownings (36%), with all 18 of these incidents in residential locations (homes, townhouse or units).[46] Bath drownings were the second most common location (13 deaths or 26%).

Other child drownings over the last 5 years included rural water hazards (e.g. dams) (6 deaths or 12%), dynamic waterways (e.g. rivers, creeks) (6 deaths or 12%), and static waterways (e.g. lakes, reservoirs) (3 deaths or 6%).

### Sex

During 2024–25, 6 male children and 4 female children died in drowning incidents. The drowning rate over the last 5 years is 0.8 per 100,000 for both males and females.

### Age

Children aged under 5 years made up the largest group of drowning deaths in 2024–25 (50%), the 5-year average rate of drowning was highest in children aged under 1 year (2.6 per 100,000) followed by children aged 1–4 years (1.9 per 100,000).

## Risk factors and age

### Under 1 year

Eight children under the age of 1 year have drowned over the last 5 years, accounting for 16% of child drowning deaths. Seven deaths were bathing incidents, and in 5 of these incidents the infant was co-bathing with other children at the time. In all but one of the incidents the adult supervisors were aware of the infant's presence in the bath; however, they were not actively supervising at the time of the incident.

### 1–4 years

Over the last 5 years, 24 children aged 1–4 years have drowned, accounting for 48% of all drowning deaths over this period. Twelve of the 24 deaths (50%) occurred in private pools.

Pool fencing was non-compliant in 10 of the 12 incidents of private pool drownings. Non-compliant fencing includes the absence of fencing, fencing or gate defects, or propping pool gates open. The pool gate was propped open in 6 of the 12 incidents and there was no pool fence in one incident.

Seven of the 12 incidents occurred at the child's usual place of residence, while the remaining 5 occurred at the homes of extended family, family friends or neighbours.

Non-pool locations also present dangers to young children. Twelve children aged 1–4 years drowned in non-pool incidents over the last 5 years with the most common being rural water hazards (4) and bath drownings (4).

Thirteen of the 24 children were known to be in, on or around water hazards. None of those 13 children were within arm's reach, or being actively supervised by a capable supervisor, at the time of the incident.[47]

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

46 Non-residential private pools include, for example, those in motels and resorts.

47 Supervision recommendations for children aged 0–4 years by Royal Life Saving Australia, www.royallifesaving.com.au/about/campaigns-and-programs/keep-watch/keep-watch-actions. Active supervision means focusing all of your attention on your children all of the time, when they are in, on or around the water.

### 5–9 years

Eight children aged 5–9 years drowned over the last 5 years, accounting for 16% of all drowning deaths. The drownings involved a variety of water hazards.

In half of the cases, the child was known to be in, on or around water. All 4 children were either unsupervised or not actively supervised.[48] Three of the 4 children were identified by their families as weak swimmers and 2 of the 4 were identified to have a medical condition or impairment that would require a higher level of supervision.[49]

### 10–17 years

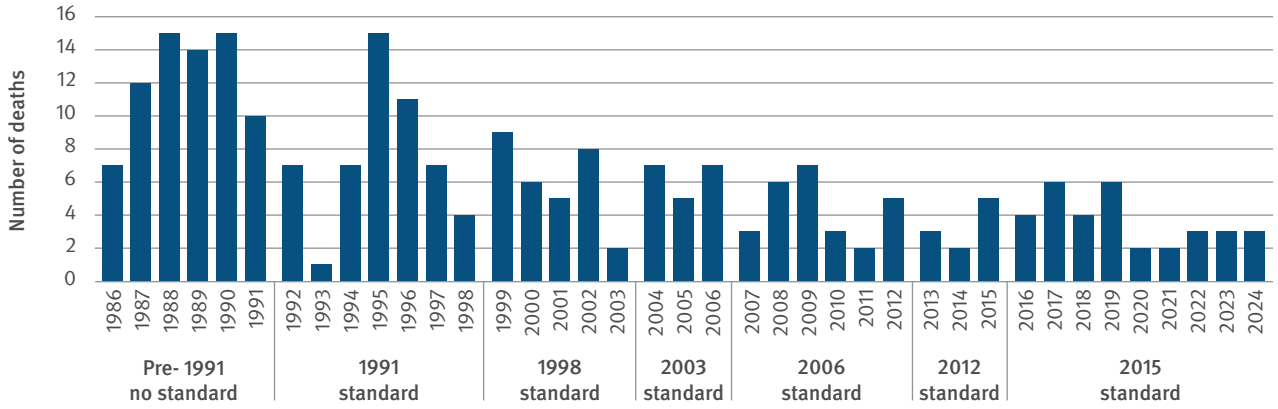
Ten young people aged 10–17 years drowned over the last 5 years (4 aged 10–14 years and 6 aged 15–17 years), accounting for 20% of all drowning deaths. The drownings occurred across a variety of water hazards.

## Preventative factors

Figure 4.1 tracks the number of drowning deaths of children aged 0–4 years in private pools in Queensland against changes to fencing requirements over time. A number of changes in pool fencing standards have occurred—from no standards in place prior to 1991, to requirements for new pools to have fencing, later extended to existing pools; followed by various changes in requirements such as fence height. Compliance requirements for pool registration and inspection were introduced in 2009.

Decreasing numbers of deaths are apparent over time, with average annual deaths of 12 deaths in 1986–89, 8.6 in the 1990s, 5.6 in the 2000s, 4 in the 2010s and 2.5 in the 2020s to date. As this would be set against an expected increase in pool ownership over time provides evidence that the introduction and strengthening of pool fencing regulations have improved safety for young children by limiting access to private pools. It is important to emphasis; however, that age-appropriate supervision must be used in conjunction with compliant physical barriers, both are critical to preventing pool drowning deaths in this age group.

**Figure 4.1:** Drowning deaths of children 0–4 years in Queensland private pools by applicable pool standard (number), 1986 to 2024




*Sources: Queensland Injury Surveillance Unit 2008, Injury Bulletin: Domestic pool immersion in Queensland children under 5 years of age. No.104; Queensland Child Death Register (2004–24).*

48 Supervision recommendations for children aged 5–14 years by Royal Life Saving Australia, www.royallifesaving.com.au/stay-safe-active/communities/how-to-keep-children-safe/children-aged-5-to-14-years

49 Supervision recommendations for children with epilepsy by Royal Life Saving Australia, www.royallifesaving.com.au/stay-safe-active/risk-factors/epilepsy-and-drowning

## Medical conditions or impairments

Medical conditions, such as cardiac-related conditions, epilepsy, diabetes, and autism, should be taken into consideration when children are in and around water, according to advice from Royal Life Saving Australia (RLS). Epilepsy has been found to be a risk factor for drowning, particularly in children. The increased risk is thought to be between 5 and 15 times greater than those without epilepsy. RLS advises that people with epilepsy consult with their doctor around water safety and the suitability of participating in water-related activities, regardless of the individual's swimming ability. It is also advisable that a child with epilepsy is actively supervised at all times when around water, including bath time regardless of their age. Of children and young people who have drowned in Queensland in the last 5 years, 11 (22%) had a known or suspected impairment or medical condition. Three of the children had epilepsy or a history of seizures.

Autistic children can be irresistibly drawn to water environments, finding the combination of buoyancy, temperature, and rhythmic movement deeply calming and engaging. Sensory input from water can help to regulate overstimulated nervous systems and reduce anxiety.[50] However, a water attraction can pose grave safety concerns—studies indicate that autistic children wander from home more frequently and are at a substantially higher risk of accidental drowning than their neurotypical peers. One large-scale analysis found that autistic children aged 2–14 years are over 160 times more likely to drown, often in familiar settings such as backyard pools and neighbourhood ponds.[51] Over the past 5 years, 9 children in Queensland aged 3–12 years, either diagnosed or suspected of being autistic, have died by drowning. These cases account for 18% of all drowning fatalities among individuals aged 0–17 years during this timeframe.

RLS prevention messaging for parents and carers of autistic children highlights the importance of:

- active adult supervision for all ages
- the erection of barriers to restrict access to water
- the creation of child safe play areas where there is a risk of drowning posed by natural waterways
- teaching water awareness, familiarising autistic children with water, setting rules, and discussing water safety. Autistic individuals may require one-on-one lessons with a specialised instructor.[52]

Of the 9 autistic children who drowned, 6 had wandered without their caregiver's knowledge immediately prior to the fatal incident. In addition to supervision and restricting access to water hazards, the risk of wandering also highlights the importance of water safety education/prevention programs.

A survey conducted by Autism Swim in 2021, revealed 91% of the families surveyed in the neurodiverse community had left previous aquatic services due to their autistic child's needs not being understood.[53] Specialised swimming lessons tailored for autistic learners address both the benefits and barriers inherent in aquatic programs. On the benefit side, structured swim instruction, integrating visual supports, predictable routines, and one-on-one coaching, has been shown to improve motor coordination, enhance water safety skills, foster social interaction, and further self-confidence in and out of the pool.[54] However, access remains limited: there are too few instructors certified in autism-specific aquatic techniques, one-to-one or small-group lessons carry prohibitive costs, and sensory sensitivities to chlorine odour, pool acoustics, or swim gear can trigger distress without careful environmental modifications and individualised supports.[55] Addressing these barriers requires expanded training for swim professionals, subsidised program funding, and ongoing collaboration among therapists, families, and community recreation centres.

50 Autism Society of Florida (n.d.) *Why water? The science behind our attraction to aquatic environment*, www.autismfl.org/post/why-water-the-science-behind-our-attraction-to-aquatic-environments accessed 25 September 2025.

51 Guan J and Li G (2017) 'Injury mortality in individuals with autism', *American Journal of Public Health*, May;107(5):791–793 doi.org/10.2105/AJPH.2017.303696

52 RLS drowning risk factors and preventions measures can be found at www.royallifesaving.com.au/stay-safe-active/risk-factors

53 https://autismswim.com.au/wp-content/uploads/2024/04/AS-Annual-report-Final-2024.pdf

54 SWIM Coaches and Teachers Australia (2025) *Autism and the aquatic environment: Challenges, strategies, and benefits*, https://swim.org.au/autism-and-the-aquatic-environment-challenges-strategies-and-benefits/ accessed 25 September 2025.

55 SWIM Coaches and Teachers Australia (2025) *Autism and the aquatic environment: Challenges, strategies, and benefits*, https://swim.org.au/autism-and-the-aquatic-environment-challenges-strategies-and-benefits/ accessed 25 September 2025.

## Queensland Ambulance Service data

Table 4.1 presents data on ambulance responses for fatal and non-fatal immersion injuries of children in the last year. There was a total of 288 immersion incidents. Of immersion incidents involving children, 45% occurred in swimming pools and 18% occurred at the beach or in the ocean. Immersion incidents were most common in children aged 1–4 years, and in this age group, the majority (71%) of incidents occurred in swimming pools.

**Table 4.1:** Queensland Ambulance Service responses to immersion incidents (number), 2024–25

| Type of incident | Under 1 year | 1–4 years | 5–9 years | 10–14 years | 15–17 years | Total |
|---|---|---|---|---|---|---|
| Pool | * | 75 | 30 | 15 | 7 | 127 |
| Bath | 18 | 15 | 0 | 0 | 0 | 33 |
| Beach/ocean | 0 | 5 | 5 | 18 | 24 | 52 |
| Other immersion | 11 | 12 | 8 | 20 | 21 | 72 |
| **Total** | **29** | **107** | **43** | **53** | **52** | **284** |

*Data source: Queensland Ambulance Service (Aug 2025)*

** Not reported for numbers less than 5 and excluded from totals.*

*Notes: Excludes data for children and young people whose gender was recorded as missing or indeterminate (n=2). Numbers in the table do not add to the total number of immersion incidents attended by Queensland Ambulance Service (n=288) as cells with less than 5 are not shown, and are excluded from table totals.*

## Learnings

### 2025 Australian and New Zealand Child Death Review and Prevention Conference

#### Using coronial data to inform the Australian Water Safety Strategy 2030: Reflections and lessons learnt

**Stacey Pidgeon**
*Royal Life Saving Society Australia*

At the 2025 Australian and New Zealand Child Death Review and Prevention Conference, hosted by the Commission in May, Stacey Pidgeon shared reflections from a research perspective on the development of the Australian Water Safety Strategy 2030 (the AWSS 2030). This presentation examined how coronial data had been instrumental in informing the development of the Strategy.

By analysing fatal drowning cases across diverse aquatic environments, the study uncovered key trends and risk factors, such as age, activity type, location, and supervision levels, that guided targeted prevention efforts. Coronial insights exposed gaps in existing safety frameworks and helped pinpoint at-risk communities and common contributing factors to drowning-related fatalities. This evidence base helped to strengthen policy development, support public education campaigns, and drive the design of tailored intervention programs aligning to key areas of the AWSS 2030.

The presentation concluded by highlighting the value of a data-driven lens and the importance of consistent surveillance, cross-agency collaboration, and culturally responsive messaging to reduce drowning rates. The AWSS 2030 reflects a national commitment to safer water practices and continuous improvement informed by real-world evidence.

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

**Read more:** www.royallifesaving.com.au/research-and-policy/australian-water-safety/australian-water-safety-strategy

# 5 Other non-intentional injury

**Seven children died in 2024–25 from other non-intentional injuries. These include non-intentional injury-related deaths outside of transport or drowning fatalities, for example, deaths from fire and smoke, poisoning, falls and threats to breathing.**

In some scenarios, improved safety may be regulated through legislation—such as mandating smoke alarms, and establishing product safety standards for cots, window coverings and blind cords, and button batteries.

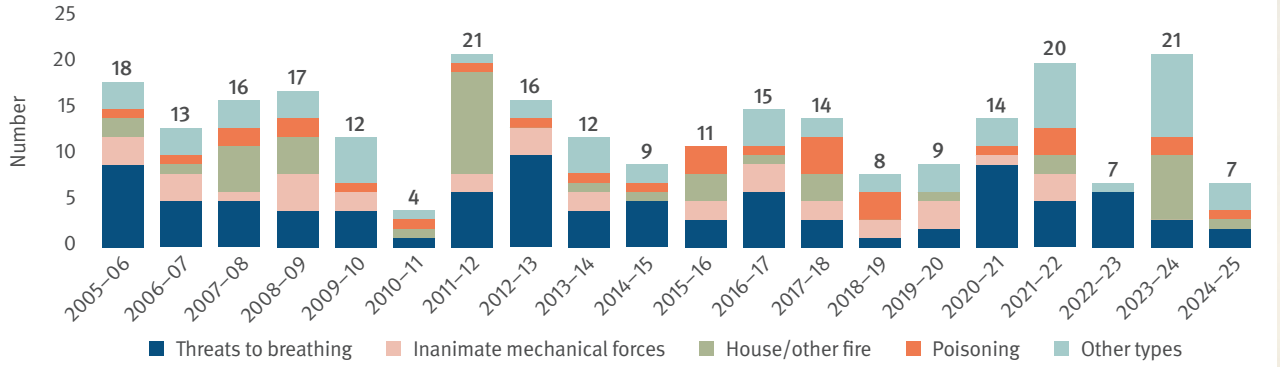
We share data with genuine researchers to enable more informed and coordinated responses across healthcare and public safety systems. This year, we provided data on child deaths involving:

- dog bite incidents, to identify patterns and high-risk areas
- toppling furniture, blind cords and windows, to inform changes to rental laws
- playground equipment, to inform a review of standards
- fencing design for use by Dr Ruth Barker, Director Queensland Injury Surveillance Unit, who was assisting a Northern Territory Coroner to investigate the death of a child
- risks in design and use of car restraints for children with disabilities, to inform discussions on national standards for child car restraints
- heat stress and vehicles, to identify the risks, trends, and to raise public awareness about prevention strategies.

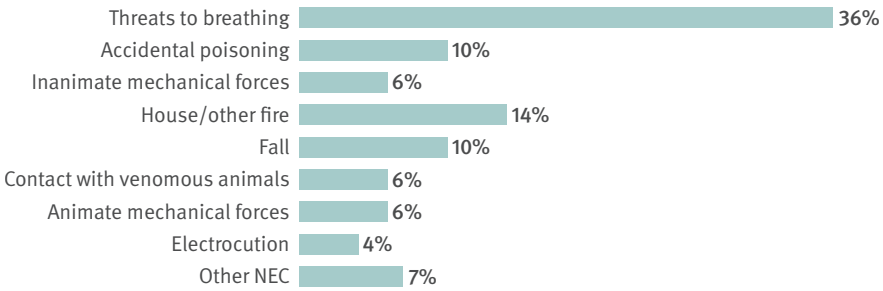
Data on incidents involving highly caustic hydroxide agents was used to inform a shared submission between the Commission, Dr Ruth Barker, Director Queensland Injury Surveillance Unit and the National Poisons Information Centres to the National Drugs and Poisons Scheduling Committee. The submission advocated for the reclassification of highly caustic hydroxide agents.

# Key facts on child deaths from other non-intentional injury

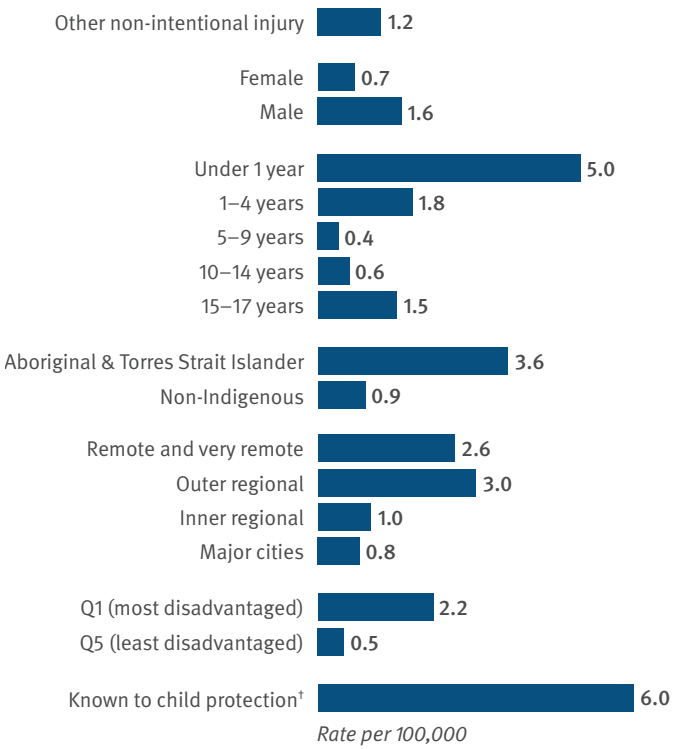
## 2005 to 2025




## 5-year summary (2020–2025) | Incident type




## Demographics




## High risk groups

### Under 5s

**54%** of deaths from non-intentional injury were aged **under 5 years**

**57%** of other non-intentional deaths in under 5s were from **threats to breathing**

### Young people

**22%** of deaths from non-intentional injury were **aged 15–17 years**

**57%** of **accidental poisoning** deaths were aged between 15–17 years

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

# Key findings

This chapter considers all non-intentional injury-related deaths outside of transport or drowning fatalities. A comprehensive outline of the types of incidents included in 'other non-intentional injury-related deaths' can be found in **Appendix E** (available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**).

## Injury type

In the 2024–25 reporting period, 7 children died from other non-intentional injuries. These included 2 from threats to breathing, one each from accidental poisoning, contact with venomous animals and plants, exposure to animate mechanical forces, heat stress, and house/other fire.

Over the past 5 years, 69 child deaths were attributed to other non-intentional injury. The most common types of injury were threats to breathing (25), house or other fire (10), accidental poisoning (7), and falls (7).[56]

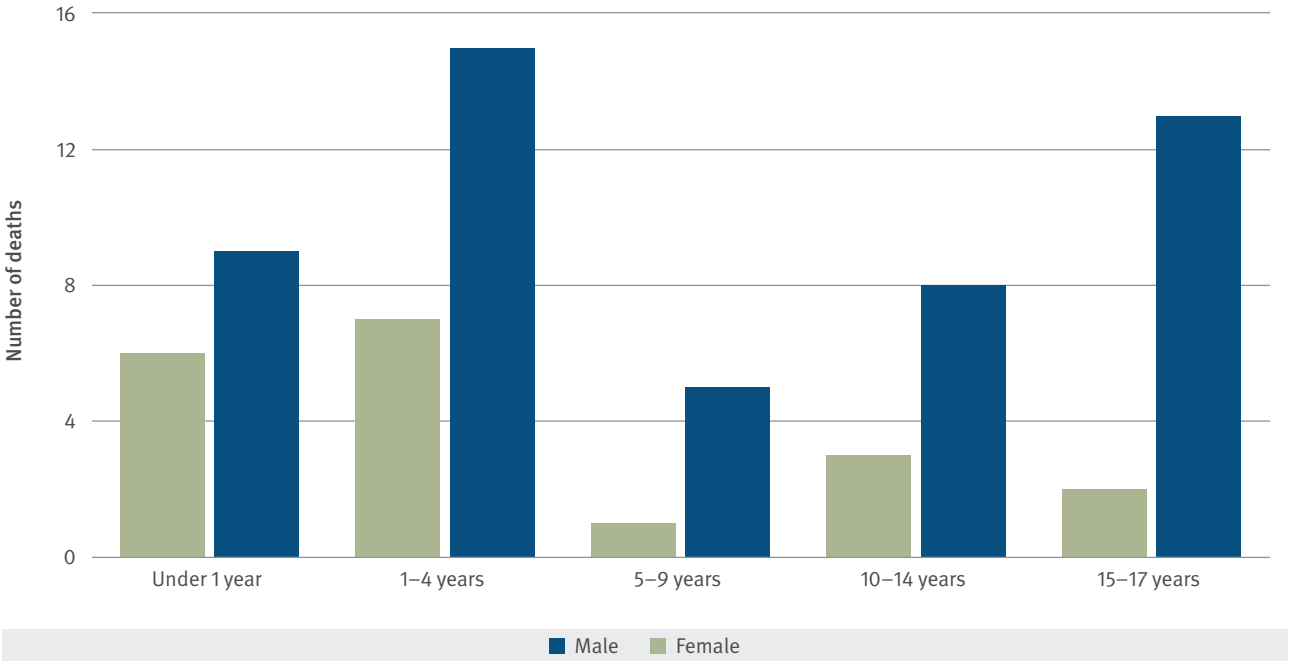
**Table A.7** in **Appendix A** provides summary data on other non-intentional injury deaths in the last 5 years.

## Age and sex

As illustrated in Figure 5.1, patterns in differential risk of death by age and sex emerge in deaths from non-intentional injuries. Over the last 5 years, males have made up 72% of deaths from non-intentional injuries. With the exception of infants under 1 year, the deaths of male children outnumbered the deaths of female children by more than a factor of 2 for all age groups 1–17 years.

The rate of death from non-intentional injuries was highest for infants aged under 1 year (5.0 per 100,000), followed by children aged 1–4 years (1.8 per 100,000) and young people aged 15–17 years (1.5 per 100,000) (5-year averages).

**Figure 5.1:** Other non-intentional injury deaths by age and sex (number), 2020–21 to 2024–25




56 Threats to breathing includes suffocation, strangulation and other threats to breathing.

# Risk factors

## Situational risks

Children, particularly young children, are at risk in certain settings and circumstances. Over the last 5 years:

- Seven children died in 3 residential house fires.
- Five children, all under the age of 4 years, died from heat stress when they were unintentionally left alone or became trapped in vehicles.
- Threats to breathing was the most common injury type for children aged 0–4 years (84% or 21 of 25 deaths).

## Sleep environment for infants

Infants are particularly vulnerable to sleep accidents due to their immature development and susceptibility to airway compromise from their environment. The ***Queensland Clinical Guideline: Safer infant sleep*** provides recommendations for infant caregivers around risk-reduction strategies, focusing primarily on a clear sleep space and airway.[57]

Of the 14 infant deaths due to other non-intentional injury over the last 5 years, all 14 occurred during a sleep event. The incidents included accidental overlay by a co-sleeping person (7 deaths), entrapment or entanglement in the sleep environment (5 deaths), and accidental suffocation by objects in the sleep environment (2 deaths).

These findings highlight the importance of safe sleep practices and environment for infants to reduce the risk of unintentional injury or death.

## Product safety

Various consumer products are subject to mandatory or voluntary safety standards, including products which present a higher risk of injury to children. During 2024–25, one child died after ingesting hazardous chemicals contained in a specialised industrial cleaning product.

Child fatalities involving consumer products in Queensland over the 5 years included:

- 2 from the use of an infant or child product where the products were either potentially maladapted or defective
- 2 from caustic injuries after ingesting caustic substances contained in domestic cleaning products (4 in total since 2006)
- one from strangulation after becoming entangled in a roller blind cord (4 in total since 2006)
- one from ingesting a button battery (2 in total since 2013)
- one from the use of household appliance where the product was maladapted
- one from toppling furniture (6 in total since 2004).

Unsafe petrol-handling practices were identified in 2 fire-related deaths. Further, there have been an additional 2 deaths of young children due to ingestion of petrol which had been decanted into bottles. These 2 deaths remain unregistered at the time of reporting and are not counted in the totals of this report. Queensland Poisons Information Centre provides guidance around the safe storage of petrol and other poisons in the home.[58]

Young children are particularly vulnerable to household hazards. Of note in the last 5 years is the storage practices of chemicals and poisons and the rapidity of fatal injury following ingestions. Kidsafe provides ***A parent's guide to kidsafe homes*** with a comprehensive list of common household risks and actions that caregivers can take to identify and reduce those risks within their homes.[59]

57 www.health.qld.gov.au/__data/assets/pdf_file/0025/1166353/g-safer-sleep.pdf

58 www.poisonsinfo.health.qld.gov.au/household-poisons

59 https://kidsafe.com.au/wp-content/uploads/2020/11/202010-A-Parents-Guide-to-Kidsafe-Homes-Web.pdf

## Campfire safety

Two deaths over the 5-year period involved injuries caused by campfires. Queensland Fire and Emergency Services provides guidance in their ***Campfire and camping safety*** information sheet around campfire safety practices, including safe ways to build and start a campfire, monitoring and extinguishing practices.[60]

## Risk-taking activities

Several fatalities over the last 5 years occurred in the context of risk-taking behaviours:

- Four deaths were attributed to drug overdose.
- Two deaths appeared to result from participation in choking games or pranks.
- Three deaths occurred during recreational activities at waterfalls or natural pools.
- One death resulted from contact with overhead power lines while climbing infrastructure.

In addition to the 3 other non-intentional injury deaths that occurred at waterfalls and natural pools, there were also 2 deaths that were the result of drowning in similar locations (covered in Chapter 3). Of the 5 deaths in these environments, 4 involved young people aged 15–17 years.

Waterfalls and natural pools present various safety hazards, including slips or falls, striking submerged objects, dynamic or fluctuating water levels, and submersion or entrapment under flowing water.

Royal Life Saving Australia's report ***Drowning in rivers, creeks, lakes and dams: A 10-year analysis*** highlights a growing concern around drowning incidents in national parks and waterfall areas.[61]

Notably, drug overdose or substance misuse was the leading causes of death among 15–17-year-olds in the other non-intentional injury category, accounting for 27% (4 out of 15 deaths).

### Lethal encounters with animals and marine creatures

Over the last 5 years, 8 children and young people lost their lives due to encounters with animals and marine creatures. Of these, 4 fatalities were caused by exposure to animate mechanical forces, such as attacks by sharks, crocodiles, and dogs, and 4 resulted from contact with venomous species, including snakes and box jellyfish.

### Charges and criminal proceedings

No deaths resulted in criminal charges in 2024–25. Over the last 5 years, there were criminal charges in relation to 4 deaths.

60 www.fire.qld.gov.au/sites/default/files/2021-12/CEU-CampfireSafety.pdf

61 www.royallifesaving.com.au/__data/assets/pdf_file/0006/72456/RLS_InlandWaterwaysReport2023_LR.pdf

## Protecting children from the dangers of heat in vehicles

In August 2025, the Queensland Family and Child Commission published an Insight Paper on children losing their lives due to vehicular hyperthermia.[62] The paper highlights a concerning trend in Queensland, where an average of 2 children are locked in vehicles daily. Between 2004 and 2024, 14 children under the age of 4 died from heat-related causes after being left in cars. These incidents often result from children accessing unlocked vehicles or caregivers unintentionally leaving them behind due to stress, distraction, or changes in routine.

Parked vehicles can become dangerously hot very quickly. Within just 5 minutes, 75% of the total temperature increase occurs. Even on mild days or in shaded areas, a car's interior can reach 40°C in 30 minutes, posing a serious risk to children left inside.

Children are especially susceptible to heat stress because their body temperature rises 3 to 5 times faster than that of adults. Once a child's body temperature exceeds 40°C, they are at risk of heatstroke, which can lead to organ failure, brain damage, or death.

Common myths about mitigating heat risks—such as leaving windows slightly open, parking in shade, or using sunshades—are largely ineffective. These measures may delay heat build-up slightly but do not prevent dangerous temperature levels. Vehicle size, colour, or type also have minimal impact on internal heat accumulation.

If a child is found in a hot vehicle, immediate action is critical. Call 000 for emergency services and RACQ on 13 1111, even if you're not a member. Remove the child safely, begin cooling measures such as removing clothing and applying damp cloths, and follow the DRSABCD first aid protocol. If necessary, break into the vehicle using a glass-breaking tool.

Caregivers should always check the back seat before leaving a vehicle and keep cars locked when not in use to prevent children from climbing inside. Childcare centres and transport providers should be equipped with emergency tools and trained in heat-related first aid procedures.

Following serious incidents, including the tragic deaths of children on buses, Queensland has implemented regulatory changes to improve safety. These include mandatory checks and procedures for transport providers to ensure no child is left behind.

The Commission recommends ongoing public education campaigns to dispel myths and raise awareness of the dangers of leaving children in vehicles. These campaigns should target caregivers, educators, and the general public to foster a culture of vigilance and proactive prevention.

62 www.qfcc.qld.gov.au/sites/default/files/2025-08/Paper-protecting-children-from-the-dangers-of-heat-in-vehicles.pdf

# 6 Suicide

**Youth suicide is a deeply tragic and complex issue that continues to affect families, schools, and communities across Australia. Twenty-four children and young people died from suicide in 2024–25 in Queensland. Addressing youth suicide requires compassion, awareness, and a commitment to creating safe, supportive environments where every young person feels seen, heard, and valued.**

The Commission is committed to supporting the Queensland Government's *Every life: The Queensland Suicide Prevention Plan 2019–2029*. This whole-of-government strategy aims to reduce suicide and its impact across the state by promoting early intervention, improving access to care, and fostering community-led solutions.

The Commission analyses data on childhood suicide to identify at-risk populations and improve mental health outcomes for all children. We also provide opportunities for others to share research insights to support responsive interventions and prevent suicide trajectories.

We engaged keynote speakers to present their research findings and insights on youth suicide at the 2025 Australian and New Zealand Child Death Review and Prevention Conference. Our discussions with the Australian Institute for Suicide Research and Prevention led to a partnership agreement to collaborate on a multi-year research project exploring help-seeking pathways by Aboriginal and Torres Strait Islander children who died by suicide in Queensland.

Our information sharing arrangement with the Department of Education helps them provide postvention supports in schools affected by suicide. We are in discussion with Be You, a national mental health in education service, to support their outreach to schools affected by suicide.

We continue to invite researchers to contact us to explore the data within the Register and discuss how it can be used to advance suicide prevention efforts. By collaborating with researchers, we aim to translate data-driven insights into meaningful strategies that reduce suicide risk and improve outcomes for individuals and communities.

When communicating about suicide, particularly involving children and young people, we are mindful of the importance of following evidence-informed guidelines to ensure safe and respectful language use. The Commission supports the use of the *Mindframe guidelines* on responsible, accurate and safe reporting on suicide, mental ill-health and alcohol and other drugs. We recommend referring to these guidelines when reporting on statistics in our reports and publications, available at www.mindframe.org.au.

## Reader advisory

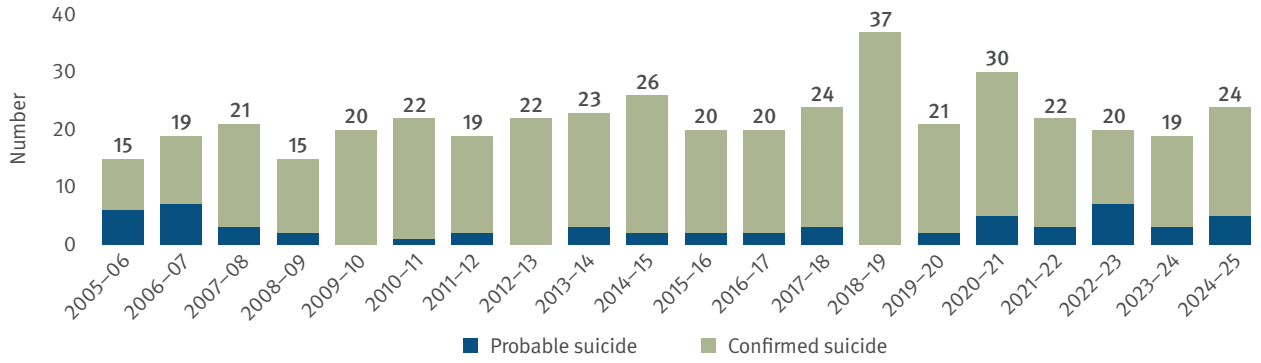
This chapter contains information about suicide among children and young people, which may be distressing. Readers are encouraged to seek support if affected by the content.

If you or someone you know is struggling, help is available:

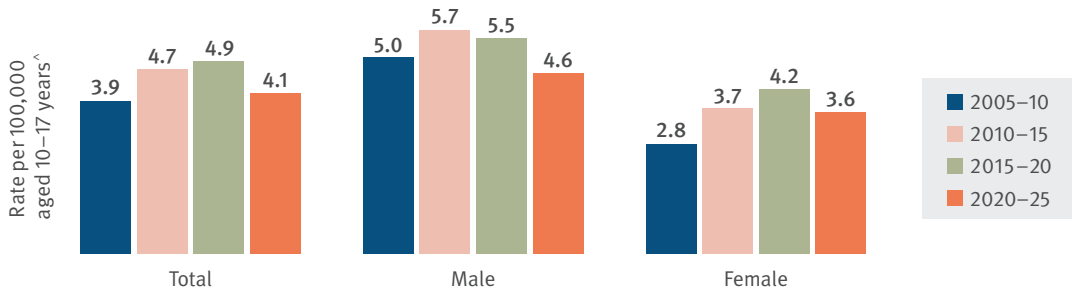
- **Lifeline:** 13 11 14 www.lifeline.org.au/gethelp
- **Kids Helpline (for young people aged 5 to 25 years):** 1800 551 800 www.kidshelpline.com.au
- **Suicide Call Back Service:** 1300 659 467 www.suicidecallbackservice.org.au
- **StandBy – Support After Suicide:** 1300 727 247 www.standbysupport.com.au

# Key facts on child deaths from suicide

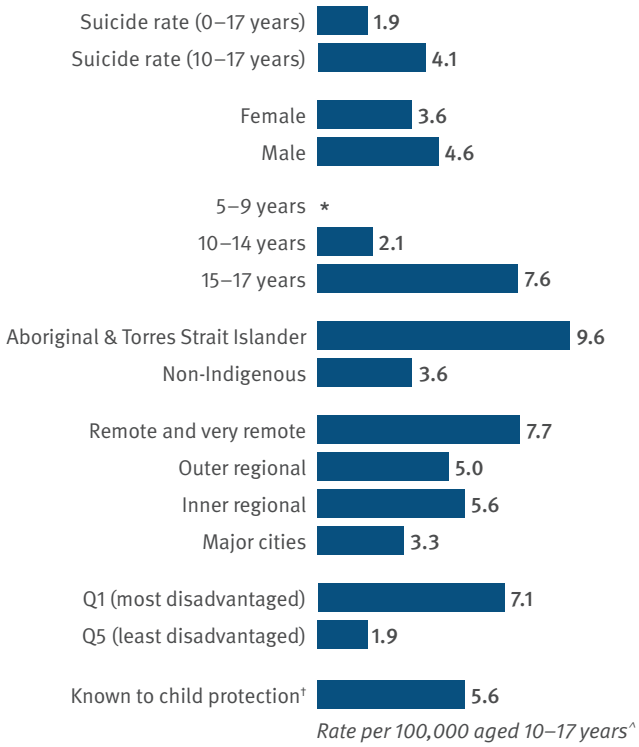
## 2005 to 2025




## 5-year summary (2020–2025) | Sex




## Demographics




## Risk factors

**46%** adverse childhood experiences

**41%** diagnosed mental health condition

**77%** self-harm and suicidal behaviours

**34%** history of alcohol and/or substance misuse

**45%** history of behaviour problems and/or offending

**17%** neurodivergent

*Notes: Counting is by date of death registration.*
** rate not calculated for numbers less than 4.*
*^ deaths in 5–9 age group are included in 10–17 year rates, with exception of age group rates.*
*† in the 12 months prior to death.*

# Key findings

### Defining and classifying suicide

Suspected suicide cases are assessed and categorised using a suicide classification model that considers factors such as: whether the incident was more consistent with death by suicide than any other cause; whether intent was communicated; any prior suicide attempts; and mental health history. Suicide classifications are made based on information held by the Commission at the time of reporting. Deaths are classified as possible suicides where there is insufficient information to determine fatal intent—these deaths will be reported under another applicable category. Where the fatal outcome was most likely not intended, such as the consequences of risk-taking behaviour, these deaths will be classified as 'other non-intentional injury'. Where the cause of the injury cannot be determined as either accidental or intentional the death will be classified as 'unexplained'.

Further information on the classification model can be found in **Appendix F** available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

Twenty-four children and young people died by suicide in 2024–25, an increase from 19 deaths in the previous reporting period.

Nineteen deaths in the 2024–25 period were classified as confirmed suicides and 5 deaths were probable suicides (i.e. more consistent with suicide than any other means).

A total of 115 young people died by suicide over the last 5 years, with an average of 23 deaths per year.[63] The suicide mortality rate has slowly increased across most of the periods (trend line up 1.2% per year on average). 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.[64]

Data from the Interim Queensland Suicide Register, published by the Australian Institute of Health and Welfare (AIHW), shows that in 2024, children and young people accounted for 2.7% of all suicide deaths in Queensland. While suicide among this age group is relatively uncommon compared to adults, it remains the leading cause of death for young people aged 10–14 years and 15–17 years.[65]

**Table A.8** in **Appendix A** provides summary data and key characteristics for suicide deaths in the last 5 years.

## Coronial findings

At the time of reporting, coronial findings had been finalised for 12 of the 24 suicides from 2024–25. Coroners made clear statements that suicide was the cause of death in all 12 cases.

## Intent stated or implied (orally or written)

There was evidence of suicidal intent in 15 of the 24 suicide deaths during 2024–25. Five young people stated or implied their intent to a friend or parent. Intent was stated or implied either by text or instant message or in person.[66] Suicide notes were left by 11 young people.

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

64 Suicide rates in this chapter are per 100,000 population aged 10–17 years and, with the exception of age specific rates, include the small number of suicides of children aged 5–9 years.

65 AIHW (2025) *Monthly suicide registers – Suicide & self-harm monitoring*, **www.aihw.gov.au/suicide-self-harm-monitoring/geography/states-territories/monthly-suicide-registers**

66 Each young person may have stated or implied their intent using more than one communication method.

## Age

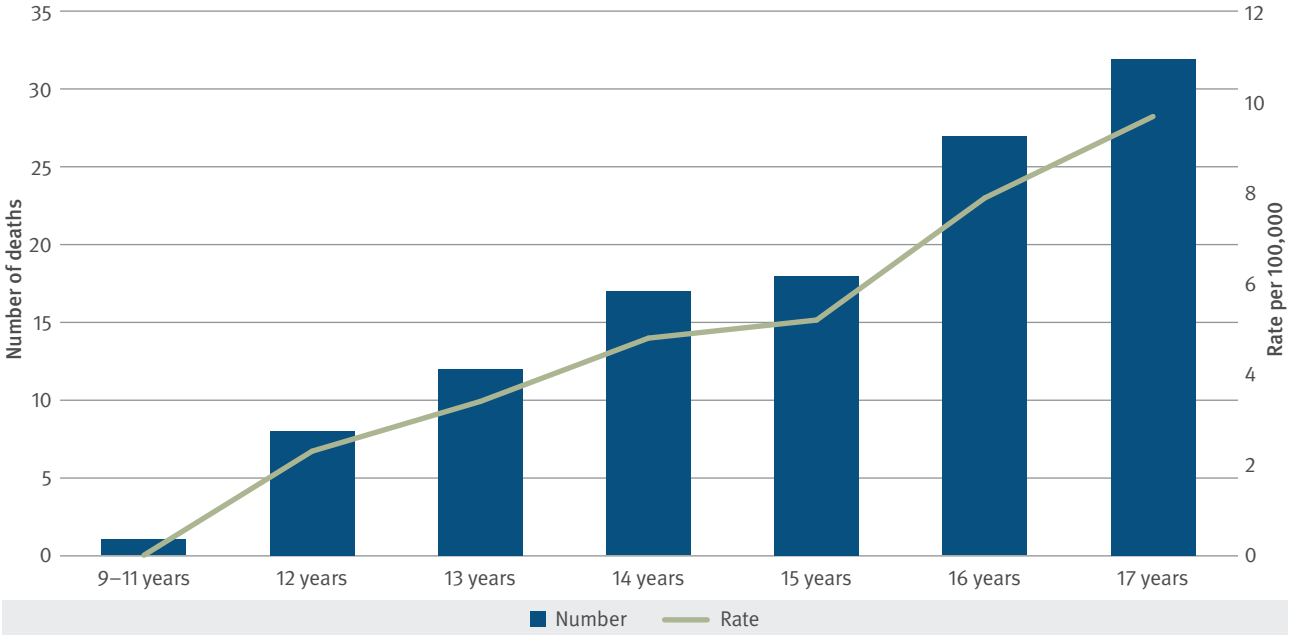
Of the 24 suicide deaths during 2024–25, 8 were aged 10–14 years and 16 were young people aged 15–17 years.

The 5-year suicide rate for young people aged 15–17 years was 3.5 times the rate for young people aged 10–14 years (7.6 deaths per 100,000 aged 15–17 years, compared with 2.1 deaths per 100,000 aged 10–14 years).

Recent research into suicidal behaviours among very young children remains minimal, reflecting longstanding assumptions about their cognitive capacity to understand and act on suicidal thoughts. However, emerging evidence reveals that children as young as 6 years old can and do engage in suicidal behaviour, underscoring the need for earlier recognition and targeted interventions. A national study in the United States identified 78 suicide deaths among children aged 6 to 9 years over a 15-year period, with most occurring at age 9.[67] The study highlights the need for early identification and intervention strategies, as well as further research into the developmental and environmental factors contributing to suicidality in this age group. Complementing these international findings, the Queensland child death register holds data dating back to 2004, including the suicide deaths of children as young as 9 years of age.

Numbers and rates of suicide deaths among young people generally increase with increasing age, as illustrated in Figure 6.1. For example, the rate of suicide for 12-year olds was 2.3 deaths per 100,000 while the rate for 17-year-olds was 9.7 deaths per 100,000 (5-year averages).

**Figure 6.1:** Numbers and rates of youth suicides in Queensland by single year of age, 2020–21 to 2024–25




## Sex

Of the 24 young people who died by suicide in 2024–25, 12 were female and 12 were male. Over the last 5 years, the average suicide rate for males was 1.3 times the rate for females (4.6 deaths per 100,000 males aged 10–17 years, compared with 3.6 deaths per 100,000 females aged 10–17 years). While male youth suicide numbers have historically been higher than those of females, there have been 2 previous reporting periods over the past 20 years in which the number of female suicides exceeded that of males.

67 Mintz S, Dykstra H, Cornette M, Wilson RF, Blair JM, Pilkey D, and Collier A (2024) 'Characteristics and Circumstances of Suicide Among Children Aged 6 to 9 Years — United States, 2006–2021', *Pediatrics*, 154 (Supplement 3) e2024067043L, doi.org/10.1542/peds.2024-067043L

Figure 6.2 illustrates the trends in the male and female suicide rates since 2004. It reflects a slow increasing trend in the suicide rate for females, however the change did not reach statistical significance.

**Figure 6.2:** Youth suicide by sex (5-year rolling rate), 2004–09 to 2020–25

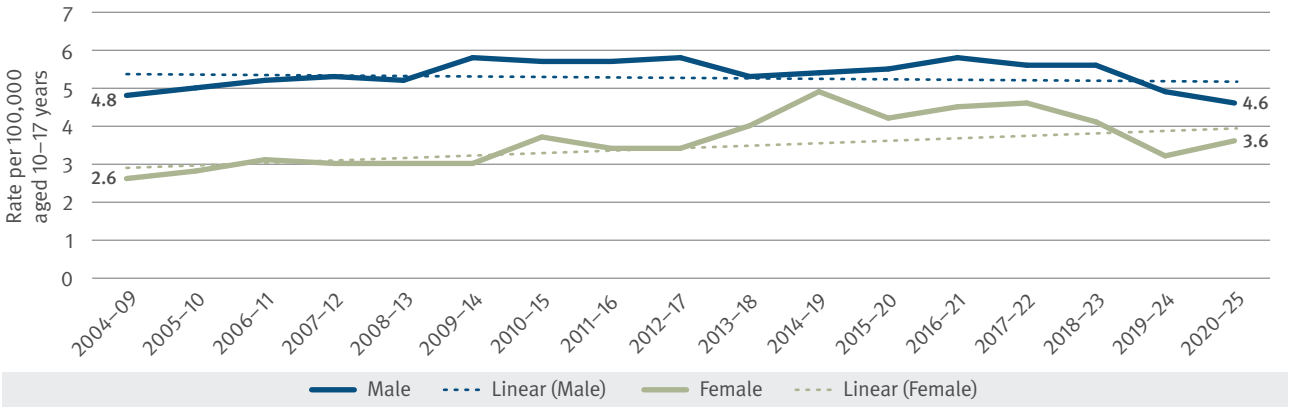
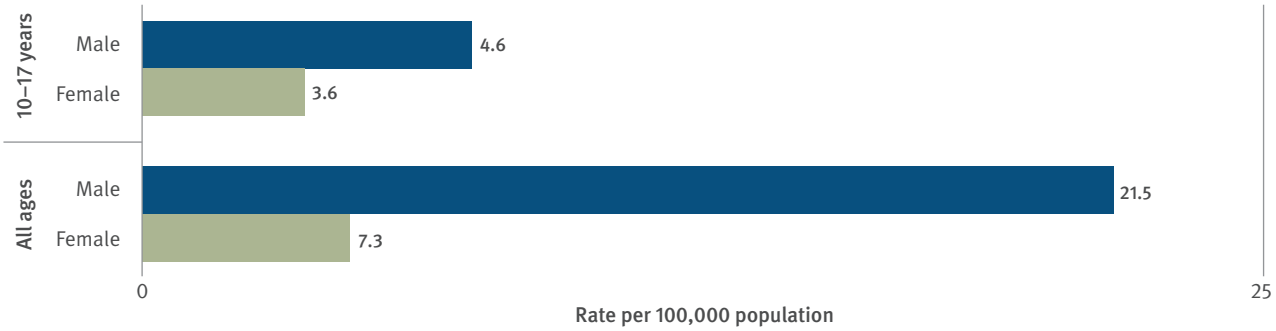



Figure 6.3 presents the male and female suicide rates in the youth population in contrast to the population level suicide rates by sex (age-standardised). It illustrates the much higher rate of male suicide in the 'all ages' data compared with the much closer male and female rates for 10–17-year-olds.

**Figure 6.3:** Male and female youth suicide rates (2020–25) and Queensland total suicide rates(2023, age-standardised)




*Sources: QFCC Queendland Child Death Register; ABS (2024) Causes of Death, Queensland, 2023, 'Table 4.1: Underlying cause of death, All causes, Queensland, 2023', www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#data-downloads*

# Risk factors

## Child maltreatment and adverse childhood experiences

Recent data from the AIHW indicates that one in 32 children in Australia came into contact with the child protection system in 2023–24. Of those, approximately one in 4 (7.3 per 1,000 children) resulted in findings of substantiated maltreatment. Emotional abuse was the most frequently substantiated type of abuse (57%), followed by neglect (21%), physical abuse (12%) and sexual abuse (9.1%).[68]

The National Health and Medical Research Council 2023 report, *The prevalence and impact of child maltreatment in Australia: Findings from the Australian child maltreatment study*, found that one in 4 16–24 year olds reported experiencing child maltreatment and that the abuse often occurred over a number of years. The report identified that young people aged 16–24 years who had experienced child maltreatment were at increased risk of developing cannabis dependence, attempting suicide, non-suicidal self-injury or developing a mental disorder.

68 AIHW (2024) *Family, domestic and sexual violence*, www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/child-protection

Other literature on suicide provides a relatively consistent account of the factors and life circumstances that are associated with youth suicide.[69] The *Adverse childhood experiences study* has led research showing strong relationships between adverse experiences in childhood (child maltreatment and household dysfunction, including substance abuse, parent mental illness, exposure to domestic violence and parent criminal behaviour) and health and social problems across the lifespan, with a link to depressive disorders.[70]

Information available indicated 11 of the 24 young people who suicided in 2024–25 had a history of alleged childhood abuse and neglect, with similar numbers of identification across the maltreatment types.

Household dysfunction was identified in 7 of the 24 suicide deaths of young people in 2024–25, with exposure to domestic violence identified as the most common.

## Complex behaviours

Young people can engage in complex behaviours that go beyond what is developmentally appropriate. These behaviours may interfere with development and daily functioning, pose serious risks to the young person's health and safety, and impair healthy functioning. The behaviours often include self-harm and suicidal behaviours, verbal and physical assaults on others, destruction of property, engaging with adults who are considered exploitative, criminal behaviour, high-risk sexual behaviour, engaging in dangerous physical activities and substance dependency.

## Self-harm and suicidal behaviour

Research into youth suicide shows that a history of self-harming behaviour, suicidal ideation and previous suicide attempts are associated with future suicidality. In relation to the 24 young people who died by suicide in 2024–25:

- At least one risk factor was present for 16 of the 24 young people who suicided.
- Eleven young people had previously engaged in self-harming behaviour, such as cutting.
- Fifteen had previously expressed suicidal thoughts (ideation).[71]
- Five had previously attempted suicide, with 2 young people attempting suicide on more than one occasion.
- There was no evidence of previous self-harm or suicidal behaviour for 8 young people.

Contact data from the 2024 Kids Helpline Impact Report indicated that one in 6 contacts made to the helpline were suicide-related and one in 13 involved concerns about self-injury and self-harm.[72]

## Behavioural problems and offending

Thirteen of the young people who suicided in 2024–25 were identified as having exhibited behavioural problems or alleged offending, with aggression identified the most frequently followed by rule breaking, disciplinary problems with teachers and/or school, and alleged offending behaviour.

69 McDermott B (2021) *Highly vulnerable infants, children and young people: A joint child protection mental health response to prevent suicide*, Queensland Child Death Review Board, https://www.qfcc.qld.gov.au/board/publications

70 Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, and Anda RF (2004) 'Adverse childhood experiences and the risk of depressive disorders in adulthood', *Journal of Affective Disorders*, 82(2):217–225, doi.org/10.1016/j.jad.2003.12.013

71 Each young person with identified self-harm or suicidal behaviour may have exhibited more than one type of behaviour.

72 Kids Helpline (2023) *Kids Helpline impact report 2023*, www.kidshelpline.com.au/about/impact-report-2023

## Alcohol and substance misuse

Eight of the 24 young people who suicided during 2024–25 was reported as having a history of alcohol, tobacco and/or substance use with the most commonly identified being with alcohol, cannabis and illicit stimulants.[73]

## Mental health

A high proportion of mental illness has been found among young people who die by suicide. While mental health issues are prevalent among young people who suicide, many young people are treated for these conditions and only a very small number may go on to suicide.

Seven of the 24 young people who suicided during 2024–25 had a diagnosed mental health condition before their death. All 7 young people were known to have engaged with a healthcare professional and 6 had been prescribed medication for their condition/s. In 4 instances, there was information indicating that the young person had ceased taking their prescribed medication.

The range of mental health diagnoses included depressive disorders, anxiety disorders (including obsessive compulsive disorder), post traumatic stress disorder, oppositional defiant disorder, adjustment disorders and eating disorders. The most common diagnosed conditions were depressive and anxiety disorders. Five of the 7 young people were identified to have multiple mental health conditions (co-occurring conditions).

A further 10 young people were suspected to have a mental health issue. Two of those young people had engaged with a healthcare professional.

## Neurodivergence

Neurodivergence refers to the natural variation in how people's brains function, particularly in areas such as thinking, learning, attention, and social interaction. The term is often used to describe individuals whose cognitive profiles differ from what is considered 'neurotypical', including autism, attention deficit hyperactivity disorder, Tourette's syndrome, dyspraxia, dyslexia, dyscalculia and other learning disabilities.

In 2022, an estimated 4.3% of Australian children aged 5–14 years were identified as autistic, reflecting a continued increase in prevalence from 3.2% in 2018, with rates notably higher among males (6.1%) than females (2.3%).[74]

Autistic children and adolescents face a significantly higher risk of suicidal thoughts and behaviours compared to their neurotypical peers. A recent review found that over a quarter of autistic youth report suicidal ideation, with a notable proportion also attempting suicide.[75] This heightened risk is linked to co-occurring mental health conditions, social isolation, and interpersonal challenges. The vulnerability is even greater among autistic youth who are also gender diverse.

Six of the 24 young people who suicided during 2024–25 were described as neurodivergent.

Over the 5-year period from 2020–25, 20 of the 115 children who died by suicide were neurodivergent, representing 17% of cases. Attention deficit hyperactivity disorder (ADHD) and autism were the most commonly identified neurotypes, and 6 of these children were reported to have co-occurring neurodevelopmental differences.

73 Previous or current use of alcohol or drugs identified by friends, family members or in toxicology findings.

74 ABS (Australian Bureau of Statistics) (2023) *Autism in Australia, 2022*, www.abs.gov.au/articles/autism-australia-2022

75 Brown CM, Newell V, Sahin E, and Hedley D (2024) 'Updated Systematic Review of Suicide in Autism: 2018–2024', *Current Developmental Disorders Reports*, 11, 225–256, doi.org/10.1007/s40474-024-00308-9

## Cohorts in youth suicide

The *Adverse childhood experiences study* and the *Australian child maltreatment study* both highlight the risks to future health outcomes for those who have a history of adverse childhood experiences, including the increased risk of suicidal behaviour. While the cohort of young people who experience these adversities accounts for a significant proportion (46%), it appears that there are a number of other distinct groups within youth suicides.

Figure 6.4 provides a summary of the adverse childhood experiences, mental health diagnoses and complex behaviours identified for the 115 young people who suicided in Queensland in the last 5 years. This overview is based on information available to the Commission and may therefore under-represent the actual circumstances for the children and young people.

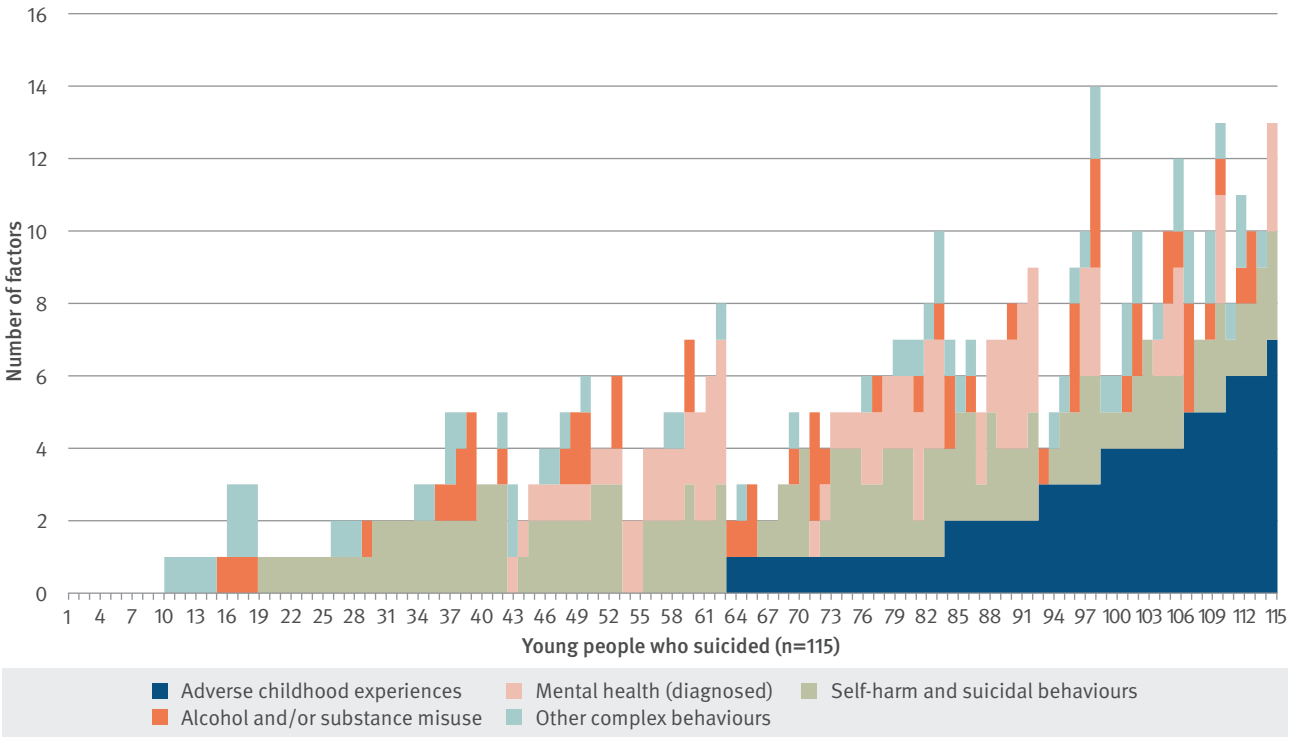
Across the cohort, 41% had a diagnosed mental health condition, 77% had a history of self-harm, suicidal ideation and/or prior suicide attempts, 34% had a history of alcohol and/or substance misuse, and 45% had other complex behaviours.

The data in Figure 6.4 shows a number of groups, based on the experiences of those young peoples' lives:

- Young people who have a history of adverse childhood experiences with, for most, co-occurring diagnosed mental health conditions and/or complex behaviours (46%).
- Young people with diagnosed mental health conditions with, for most, co-occurring complex behaviours (18%).
- Young people who demonstrate complex behaviours (29%) without other risk factors.
- Young people without any identified risk factors (7%).

The data highlights the importance of intervention and prevention strategies tailored to the life experiences of children and young people.

**Figure 6.4:** Adverse childhood experiences, diagnosed mental health conditions and complex behaviours in youth suicides (number), 2020–21 to 2024–25



## Stressful life events and precipitating incidents

Life stressors are events or experiences which produce significant strain on an individual; they can occur at any stage over the course of a person's lifetime and vary in severity and duration. Life stressors differ from precipitating incidents as they are more likely to occur in the background with strain accumulating over a period of time.

Precipitating incidents refer to events or stressors which occur prior to a suicide and which appear to have influenced the decision for a person to end their life. Most precipitating incidents will occur in the hours, days or weeks prior to death. Bereavement can be considered a precipitating incident, with an arbitrary timeframe of up to 6 months between the death of the family member or friend and the suicide of the young person.

### School-related stressors and signs of psychological distress

Fifteen of the 24 young people who suicided during 2024–25 had documented experiences of school-related stressors, including transitions in education, disciplinary action by teachers or schools and academic or achievement-related stress. Further, 6 of the 24 young people were noted to have been experiencing difficulties with school engagement; with chronic absenteeism, non-participation and truancy identified.

The Australian Institute of Family Studies' research snapshot on *Suicidal Thoughts and Behaviours in Adolescence* highlights several school-related stressors and indicators of disengagement that are associated with youth suicide risk.[76] Drawing on data from *Growing Up in Australia: The Longitudinal Study of Australian Children (LSAC)*, the report identifies that suicidal behaviours tend to increase during adolescence—a period marked by significant social, emotional, and educational transitions. Among young people who reported suicidal thoughts and behaviours, many also experienced complex life challenges, including academic pressure, school disengagement, and bullying. These findings suggest that difficulties within the school environment—such as feeling disconnected, struggling academically, or being targeted by peers—may co-occur with suicidal distress and should be considered in prevention and early intervention strategies.

### Digital psychosocial stressors

Understanding the influence of a digital world on children's relationships, connections, wellbeing and functioning is complex. Research suggests that underlying social and psychological challenges like low self-esteem, social isolation, or identity struggles can be worsened by harmful online experiences for children. When used positively, digital platforms can offer children connection, support, and resources. They can be used by children experiencing mental health concerns to seek help, support, understanding and information about their worries and symptoms.[77]

Increasingly more research is emerging on the study of children's social and mobile media use, in particular 'digital stress', and its association with adolescent socioemotional and psychosocial wellbeing and functioning. Digital stress includes, approval anxiety, availability stress, fear of missing out, connection overload and online vigilance.[78]

76 Australian Institute of Family Studies (2023) *Research snapshot: Suicidal thoughts and behaviours in adolescence*, https://aifs.gov.au/growing-australia/research/research-snapshots/suicidal-thoughts-and-behaviours-adolescence

77 Christensen H, Slade A, and Whitton AE (2024) 'Social media: the root cause of rising youth self-harm or a convenient scapegoat?', *Medical Journal of Australia*, Volume 221 (10), pp. 524-526, doi.org/10.5694/mja2.52503

78 Khetawat D and Steele RG (2024) 'Examining the association between digital stress components and psychological wellbeing: A meta-analysis', *Clinical child and family psychology review*, Volume 26, pp. 957-974, doi.org/10.5694/mja2.52503

Digital psychosocial stressors have been identified for 8 of the 24 young people who died by suicide, with documented experiences involving high levels of digital content consumption, use of digital platforms without parental consent, exposure to illicit content, involvement in sending or receiving sexually explicit material, experiences of cyberbullying, or being victims of sextortion.

According to the *Kids Helpline Impact Report 2024*, one in 7 contacts from children aged 10 to 14 seeking support for bullying (including cyber-bullying) also reported suicidal thoughts.[79]

Sextortion is an increasingly prevalent digital threat in Australia, with offenders primarily targeting teenage boys by coercing them into sending sexual images and threatening to share them unless payment is made. In 2024, Kids Helpline received 432 contacts related to sextortion—up from 367 in 2023—with young males aged 13 to 25 accounting for 85% of all sextortion-related counselling contacts.[80]

These findings highlight the importance of coordinated policy, education, and platform accountability to protect children from digital harms.[81]

In December 2025, Australia will implement a world-first social media age restriction law, *Online Safety (Age-Restricted Social Media Platforms) Rules 2025*, prohibiting children under 16 from holding accounts on platforms such as Facebook, Instagram, TikTok, Snapchat, X, and YouTube, in an effort to reduce exposure to harmful online content and improve youth wellbeing.

Clinicians working with children should be encouraged to assess digital media use in the context of a child's overall psychological and social functioning, and in consideration of a child's specific uses of digital media.[82]

## Contagion

Contagion refers to the process by which a prior suicide or attempted suicide of a family member or friend facilitates or influences suicidal behaviour in another person. Contagion was identified in 2 youth suicides during 2024–25.

## Other factors

Outside of adverse childhood experiences, the most common stressors and precipitating incidents evident for young people who suicided in 2024–25 included: parental separation (13); arguments with family members, intimate partners or friends (7); poor intra-familial relationships (7); relationship breakdowns (6); and social isolation (6).

79 Yourtown (2024) *Kids Helpline Impact Report 2024*, https://ytn-p-001.sitecorecontenthub.cloud/api/public/content/61b0c5d568434b1a9fa9881bc4a12884?v=b2a569f9

80 Yourtown (2024) *Kids Helpline Impact Report 2024*, https://ytn-p-001.sitecorecontenthub.cloud/api/public/content/61b0c5d568434b1a9fa9881bc4a12884?v=b2a569f9

81 Australian Policy Observatory (2025) *A precautionary approach to social media: protecting young minds in an evolving digital world*. https://apo.org.au/sites/default/files/resource-files/2025-08/apo-nid331769.pdf

82 Steele RG, Hall JA, and Christofferson JL (2020) 'Conceptualizing digital stress in adolescents and young adults: Toward the development of an empirically based model', *Clinical child and family psychology review*, Volume 23, pp. 15-26, doi.org/10.5694/mja2.52722

## Queensland Ambulance Service data

This year, a new and improved methodology was introduced by QAS to identify suicidal behaviour and self-harm related incidents. The updated approach is more accurate, rigorous, and robust, resulting in a higher number of identified cases than reported in previous years across. Queensland Ambulance Service (QAS) data indicates in the last year over 11,000 ambulance responses occurred for suicidal behaviour and self-harm-related incidents involving children, including both fatal and non-fatal injuries (see Table 6.1). Female patients accounted for 65% of responses.

**Table 6.1:** Queensland Ambulance Service responses to self-harm and suicidal behaviour incidents (number), 2024–25

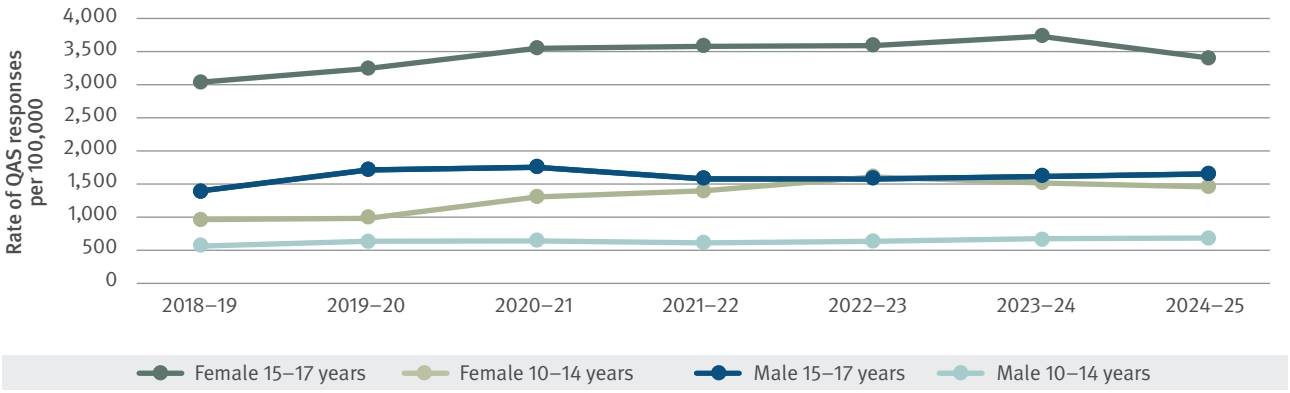
| Age | Female | Male | Not specified | Total |
|---|---|---|---|---|
| 5–9 years | 149 | 242 | 0 | 391 |
| 10–14 years | 2,891 | 1,359 | 46 | 4,296 |
| 15–17 years | 4,395 | 2,206 | 64 | 6,665 |
| **Total** | **7,435** | **3,807** | **64** | **11,352** |

*Data source: Queensland Ambulance Service (Aug 2025)*

*Notes: Not specified includes cases where gender was recorded as indeterminate or missing.*

Figure 6.5 presents the rate of Queensland Ambulance Service (QAS) responses for self-harm and suicidal behaviours over the past 7 years. To enable accurate trend analysis, the data shown is based on the previous methodology reported on in past annual child death reports. The rate for females aged 15–17 years has consistently remained substantially higher than all other demographic groups. While rates for males in both age groups have remained relatively stable over this time period, rates for females have shown more variability. In particular, rising rates were observed in females aged 15–17 years in earlier years, followed by a slight decline in the most recent reporting period.

**Figure 6.5:** Queensland Ambulance Services responses to self-harm and suicidal behaviour incidents (rate per 100,000), 2018–19 to 2024–25




*Data source: Queensland Ambulance Service (Aug 2025)*

*Notes: Excludes cases where gender was recorded as indeterminate or missing. Rates are calculated for each financial year per 100,000 children in each age/sex category.*

## Learnings

### 2025 Australian and New Zealand Child Death Review and Prevention Conference

#### Beyond Band-Aid Solutions: Multifactorial approaches to understanding and addressing youth suicidality

**Grace Sholl**
*Suicidologist and lived experience advocate*

Grace Sholl opened the 2025 Australian and New Zealand Child Death Review and Prevention Conference, hosted by the Commission in May, with *Beyond Band-Aid Solutions: Multifactorial approaches to understanding and addressing youth suicidality*. Grace proposed that suicide prevention must be designed by and for young people. She anchored her case in stark national figures—3.3 million Australians over 16 years of age will experience serious suicidal thoughts, 1.5 million will plan to suicide and 970,000 will attempt suicide. Grace noted that sexually diverse youth and those diagnosed with depression or attention deficit hyperactivity disorder (ADHD) face earlier onset and faster progression of suicidal behaviour.

The presentation highlighted how critical data gaps and inconsistent reporting across Australian jurisdictions mask the true numbers for repeated suicide attempts, non-fatal crises and probable suicides. Consequently, limitations in data can impede policy evaluation and targeted intervention. For Queensland, the Commission provides a robust breakdown by age, gender, intent and risk factors for children who have died by suicide, whereas, other jurisdictions tend to publish basic demographics.

Service delivery systemic shortcomings, where featured and included, pooled mental-health budgets that favour "marketable" programs over dedicated suicide support; almost non-existent crisis services for children under 16 years of age; and a lack of youth-specific training resulting in some clinicians who then tend to over-hospitalise young people often resulting in further traumatisation. In addition, ethical and funding barriers stifle life-saving research, sensationalist media deepens the stigma associated with mental health, and standard clinical tools fail to capture the complex, fluctuating nature of youth suicidality.

Grace proposed a multifactorial prevention model—combining universal upstream strategies, targeted interventions and ongoing lived-experience research, alongside an expansion of peer-led, community-based supports. She spotlighted the STARS framework (Systematic Tailored Assessment for Responding to Suicidality), a semi-structured, person-centred tool co-designed with young people to map psychosocial stressors, co-create safety plans and address long-term risk factors.

The presentation concluded with Grace recommending embedding youth co-design in all service development, a national standardisation of suicide reporting metrics, dedicated funding and specialist training for youth suicide prevention, and promotion of community-centred interventions alongside clinical care. By centring young people's expertise and autonomy, stakeholders can replace temporary fixes with sustainable, effective solutions.

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

## Learnings

### 2025 Australian and New Zealand Child Death Review and Prevention Conference

## Understanding the links between childhood domestic and family violence exposure and youth suicide risk

**Professor Silke Meyer**
*Leneen Forde Chair in Child and Family Research*

**Maria Atienzar**
*School of Health Sciences and Social Work, Griffith University*

Professor Silke Meyer and Maria Atienzar-Prieto presented at the 2025 Australian and New Zealand Child Death Review and Prevention Conference on a research study funded by the Queensland Mental Health Commission. The study delved into the lived experiences of young people who were exposed to domestic and family violence (DFV) during childhood and later died by suicide. Conducted by Griffith University, the study aimed to understand the long-term psychological consequences of early trauma, particularly how DFV impacts mental health, coping capacity, and overall life outcomes.

By analysing detailed case data, the study uncovered recurring patterns that revealed heightened vulnerability among children exposed to DFV—manifesting in emotional dysregulation, impaired stress response, and increased isolation. These factors, when left unaddressed, significantly elevated suicide risk. The research highlighted DFV as not merely a momentary disruption but a chronic condition with lasting developmental consequences.

The presentation concluded with a call for trauma-informed frameworks within healthcare, education and social services, in conjunction with proactive, integrated support systems that prioritise early intervention, mental health care, and community-based resources to help build resilience. In addition, policymakers were urged to adopt reforms that acknowledge the intersection of childhood trauma and suicide, with particular attention to improving data-sharing mechanisms and tailoring services to the needs of vulnerable youth populations.

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

Publication of the full report is still in progress and will be launched by the Queensland Mental Health Commission in the future. In the meantime, an earlier report which informed this study can be accessed at https://research-repository.griffith.edu.au/items/cb3d3321-519f-4449-bdb1-75440427adf5

# 7 Fatal assault and neglect

**Over the last 5 years, 28 children died due to fatal assault and neglect. Over half of these children were known to the child protection system within the 12 months prior to death.**

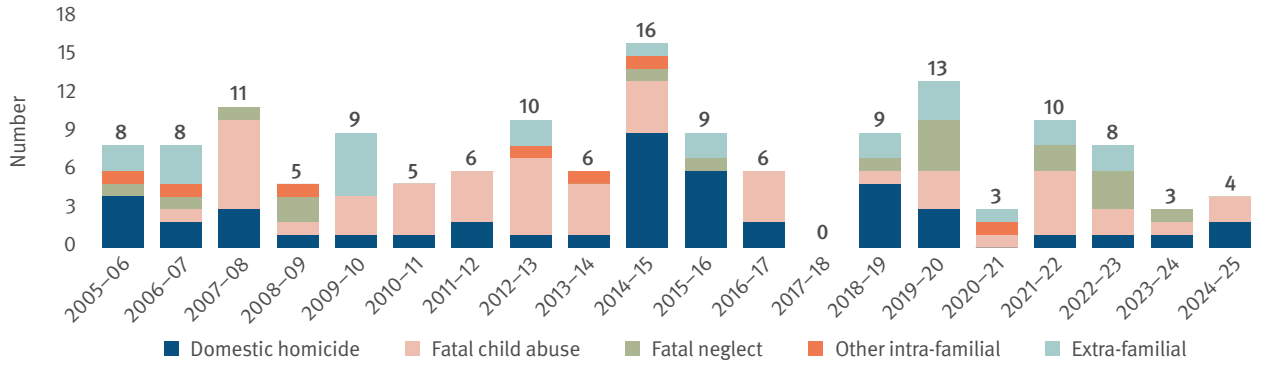
We remain committed to helping to prevent the occurrence of fatal assault and neglect incidents. This year we advanced a project aimed at strengthening the screening and classification of fatal assault and neglect cases within the Register. Through enriched classification we can deliver more robust and reliable identification of cases and better capture and report on the complex nature of risk factors contributing to these deaths. Through enhanced quality and depth of data, we can better support research, policy development and evidence-based action that strengthens early intervention and protection measures. This work is vital to safeguard at-risk children and helping to prevent future deaths.

We engaged Dr Holly Blackmore and Anna Butler to speak at the Australian and New Zealand Child Review and Death Prevention Conference about the Australian Domestic and Family Violence Death Review Network report, *Filicides in a domestic and family violence context 2010–2018*. The study examined cases of filicide that occurred within the context of domestic and family violence in Australia over a 9-year period. Prior domestic and family violence reports, missed intervention opportunities, and limited interagency coordination were identified as common characteristics across cases. The presentation emphasised the need for a unified, multi-agency response to prevent future filicide cases and ensure at-risk families receive the support they need before reaching crisis point.

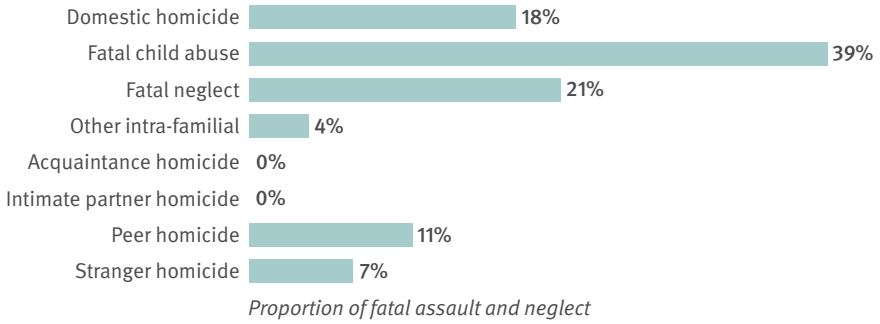
We were invited by Open Access Government, an international digital publication, to contribute an article on the findings of research we conducted with the University of Queensland. The study analysed filicide events between 2004 and 2020 to help identify critical indicators of elevated risk. By recognising and responding to red flags, professionals can play a vital role in preventing future tragedies. The article reinforces the importance of vigilance, cross-agency collaboration, and informed intervention strategies.

# Key facts on child deaths from fatal assault and neglect

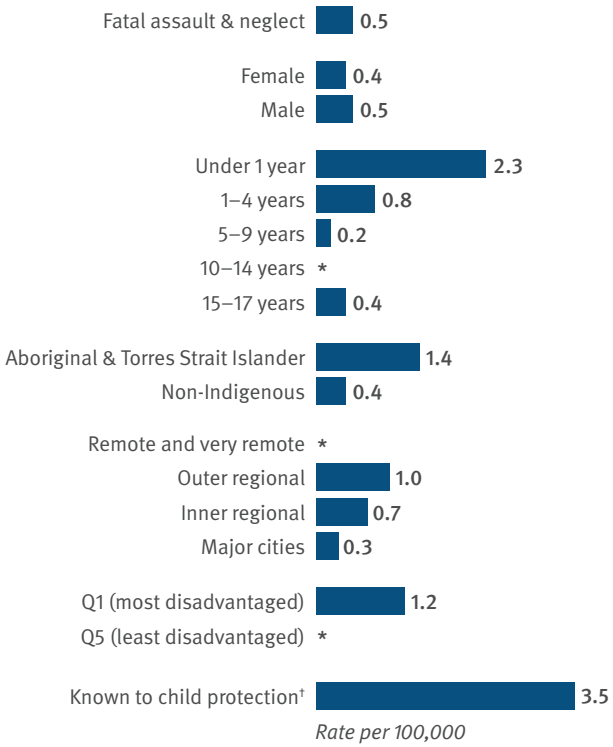
## 2005 to 2025




## 5-year summary (2020–2025) | Incident type




## Demographics




## Intra-familial fatal assault and neglect risk factors

**78%** **child experienced previous abuse**

**52%** **household domestic and family violence**

**39%** alleged perpetrator had **history of offending**

**43%** alleged perpetrator had **alcohol and/or substance misuse**

**57%** alleged perpetrator had **suspected or diagnosed mental health issues**

*Notes: Counting is by date of death registration. Percentages may not add to 100 due to rounding.*
** rate not calculated for numbers less than 4.*
*† in the 12 months prior to death.*

## Key findings

Deaths are classified as fatal assault and neglect where evidence available to the Commission indicates the child died as a result of inflicted injury or neglect, irrespective of whether a perpetrator has been identified and/or charged. Definitions for the types of fatal assault and neglect can be found in **Appendix C** and a description of the Commission's screening criteria can be found in **Appendix G** (both available at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**).

Based on information available to the Commission at the time of reporting, 4 deaths were identified as being the result of fatal assault and neglect in Queensland during 2024–25.

Over the last 5 years, 28 children died in fatal assault and neglect incidents. Twenty-three deaths were categorised as intra-familial, meaning that the alleged perpetrator was a parent, family member or person acting in a parental role. Five children died in domestic homicides. Eleven children were found to have died as a result of child abuse, 6 died from neglect and one was other intrafamilial.

Five deaths in the last 5 years were extra-familial homicides. Three deaths were peer homicides and 2 were stranger homicides.

Further summary information on deaths from fatal assault and neglect can be found in **Table A.9** in **Appendix A**.[83]

### Age and sex

Infants under 1 year had the highest rate of death from fatal assault and neglect over the last 5 years (2.3 per 100,000), followed by children 1–4 years (0.8 per 100,000) and 15–17 years (0.4 per 100,000). Twenty-one out of the 23 children who died in intrafamilial homicides were aged under 9 years, while all of the extra-familial homicide deaths were young people aged 15–17 years.

Of the 28 children who died from assault or neglect in 2020–25, 12 were female and 16 were male (a rate of 0.4 and 0.5 per 100,000, respectively). Males are more at risk of experiencing extra-familial homicide, 4 out of the 5 extra-familial homicide deaths over the last 5 years were male.

### Charges and criminal proceedings

Of the 28 fatal assault and neglect incidents during 2020–25, alleged perpetrators for 23 incidents have been charged, including one perpetrator who was subsequently deceased in a separate incident.

## Vulnerability characteristics

Of the 28 child deaths from assault and neglect during 2020–25, 18 (64%) children were known to the child protection system within the 12 months prior to death. It is noted that 2 of the 18 children were only known to child protection due to the incident leading to their death.

Available evidence indicated the following factors[84] were present for the 23 children who died from intra-familial homicide in 23 incidents over the last 5 years:

- 78% had experienced child abuse prior to the incident (18 of 23 children)
- 52% had evidence domestic and family violence was present in the child's household (12 of 23 children)
- 39% of the alleged perpetrators had a history of criminal offending (9 of the 23 incidents)
- 43% of the alleged perpetrators had a history of alcohol or substance use (10 of the 23 incidents)[85]
- 57% of the alleged perpetrators were identified as either having a diagnosed or suspected mental health issue (13 of the 23 incidents).

83 Tables with data for 2005–25 are available online at **www.qfcc.qld.gov.au/sector/child-death/child-death-reports-and-data**

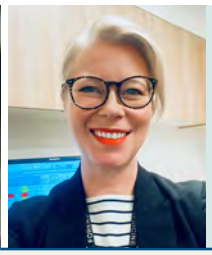
84 The Commission collects information on vulnerability characteristics relating to the child, family and, where relevant, the perpetrator. The information is based on statements of fact or clear statements of opinion by credible external sources, as recorded in source documents (primarily police and coronial reports). The information is subject to limitations, in that it is based on those factors which can be identified in the source information. Given the small numbers in this analysis and these limitations, the findings are considered indicative only.

85 Alcohol use – evidence the person exhibited problematic drinking behaviours such as binge drinking or the consumption of alcohol in settings or circumstances where it is not appropriate or safe to do so (e.g. while driving). Substance use – evidence of the use of illicit drugs, misuse of prescription medication or volatile substances.

## Learnings

### 2025 Australian and New Zealand Child Death Review and Prevention Conference

## Australian Domestic and Family Violence Death Review Network data report: Filicides in a domestic and family violence context 2010–2018



**Dr Holly Blackmore**
*Research Manager (Death Review)*
*Australia's National Research Organisation for Women's Safety*

**Anna Butler**
*Co-Chair, Australian Domestic and Family, Violence Death Review Network*
*Manager, NSW Domestic Violence Death Review Team*

Presenting at the 2025 Australian and New Zealand Child Death Review and Prevention Conference, Dr Holly Blackmore and Anna Butler spoke to the Australian Domestic and Family Violence Death Review Network data report, ***Filicides in a domestic and family violence context 2010–2018***. This report is a product from the ongoing partnership between the Network and ANROWS.

The study examined cases of filicide that occurred within the context of domestic and family violence (DFV) in Australia between 2010 and 2018. Drawing from detailed case analyses, the study revealed how filicide intersects with histories of DFV and examined a range of issues including parental separation, mental health and alcohol or substance issues, and interactions with services, with all cases ending in the tragic deaths of children at the hands of their caregivers. Furthermore, the study identified common characteristics across cases, including prior DFV reports, missed intervention opportunities, and limited interagency coordination.

The presentation drew attention to key characteristics found within a NSW case study, for example, perpetrator complex health issues, financial hardship, coercive control, and systemic failures to adequately assess threats to a child's safety in a DFV-affected household. The presentation also exposed the compounding effect of DFV with other vulnerabilities, such as health issues and substance use, on the decision-making and protective capacity of parents.

The presentation concluded by emphasising the importance of early identification, the need to strengthen intervention pathways and for professionals in child protection, police, health, and education to operate under a coordinated, trauma-informed framework. Ultimately, there is a need for a unified, multi-agency response to prevent future filicide cases and ensure families receive the support they need before reaching crisis point.

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

**Read more:**
www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-filicides/

https://www.anrows.org.au/resources/fact-sheet-what-we-know-about-parents-killing-their-children-in-the-context-of-domestic-and-family-violence/

# 8 Sudden unexpected deaths in infancy (SUDI)

**Twenty-nine infant deaths were classified as SUDI in 2024–25. Sudden infant death syndrome (SIDS) and undetermined causes, as a group, are the leading cause of death in infants aged 1 to 11 months and remain a key focus of our child death prevention efforts.**

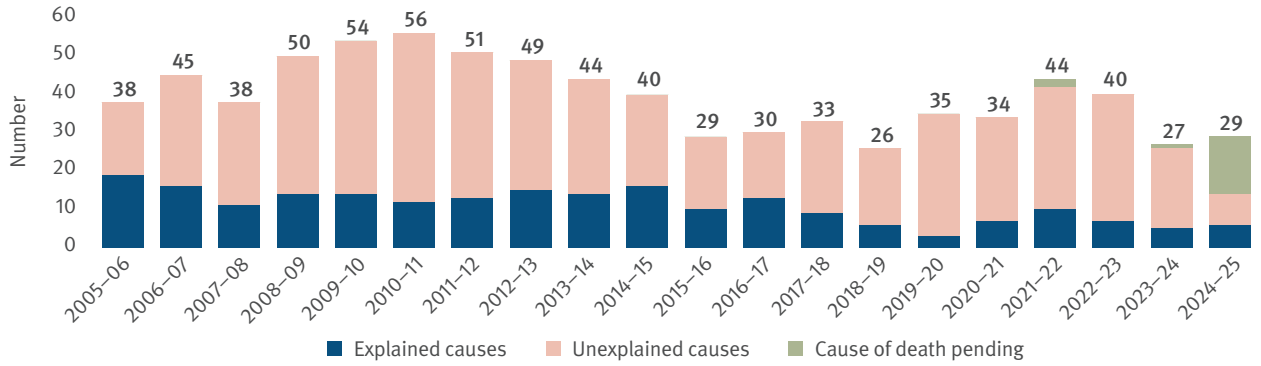
We continue to apply an evidence-based classification system to group cases of SUDI according to the likelihood of suffocation so we can better monitor the role of unsafe sleep environments and sleep-related accidents. We also continue to identify gaps in investigation and inform risk minimisation strategies as part of our normal operations. Through these ongoing efforts, we aim to reduce preventable infant deaths and support safer sleep practices across communities.

The Commission works in partnership with the Queensland Paediatric Quality Council (QPQC) on SUDI research and prevention. Data from the Register has been used to inform the following research, public education and policy/program developments:

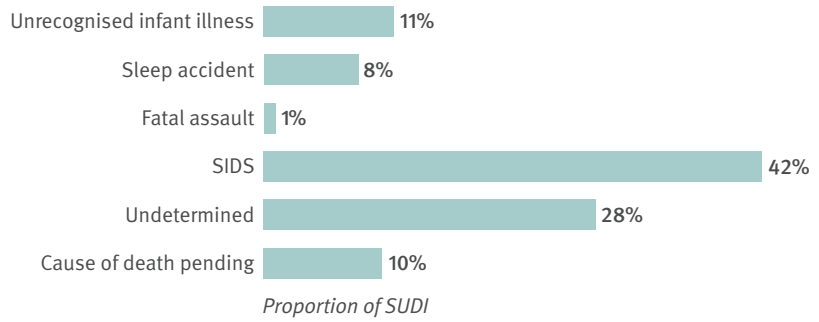
- Infant Mortality Subcommittee, QPQC, *Sudden and unexpected infant deaths during sleep in Queensland 2013–2016: Risk factors and opportunities for prevention* paper, released in April 2025.
- Institute for Urban Indigenous Health culturally responsive service planning.
- QPQC to support early intervention and regional planning.
- River's Gift to guide the development of an infant safe sleep education program in childcare centres across regional Queensland.
- First 2000 Days, Reform Office, Queensland Health to monitor SUDI trends for the Pepi-Pod® program as part of the Putting Queensland Kids First initiative addressing Queensland's higher SUDI rates.
- Coroners Court of Queensland to help investigate concerns around co-sleeping and unsafe infant sleeping practices, with analysis across Hospital and Health Service regions.

# Key facts on sudden unexpected deaths in infancy

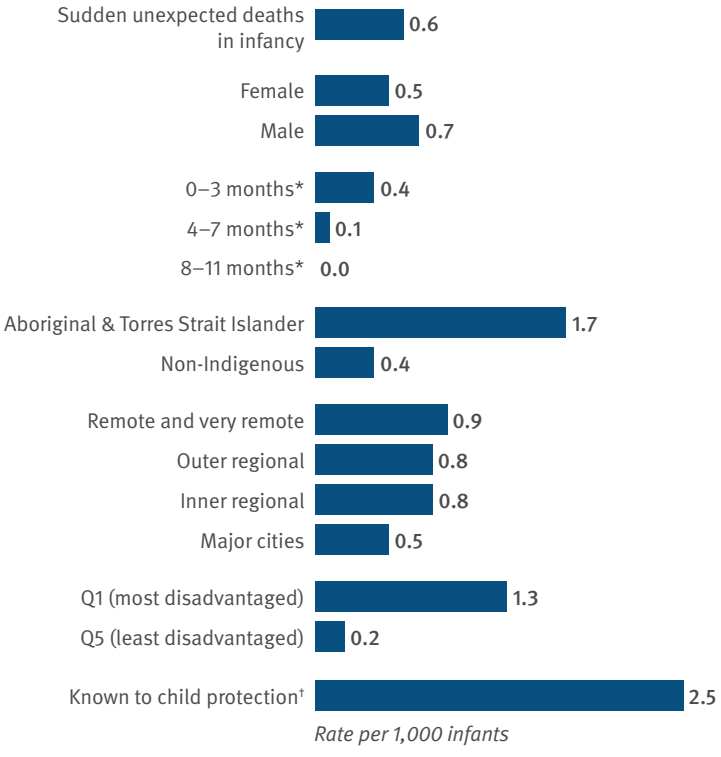
## 2005 to 2025




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




## Demographics




## Key points

### SUDI

Infants who die suddenly, usually during sleep, with no immediately obvious cause

### 35 SUDI per year

on average in last 5 years

### SIDS and undetermined causes

Cause remains unexplained after investigation

Leading cause of death for infants 1–11 months

### Unsafe sleep factors

present for many SUDI

*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

Sudden unexpected death in infancy (SUDI) is a research classification which groups together the deaths of apparently well infants who would be expected to thrive, yet, for reasons often unknown, die suddenly and unexpectedly. It does not correspond with any single medical definition or categorisation. Identifying deaths in this way assists in the identification of possible risk factors for, and associations with, sudden infant death and, most significantly, those factors which may be preventable or amenable to change.

SUDI is defined as the death of an infant aged less than 12 months, that is sudden and unexpected and where the cause was not immediately apparent at the time of death.

During 2024–25, there were 29 SUDI deaths in Queensland, with no significant change from the previous reporting period (27 deaths). Of the 29 SUDI, 15 were pending a cause at the time of reporting—this reflects the longer timeframes for SUDI deaths due to the complexity of the post-mortems and coronial investigation.

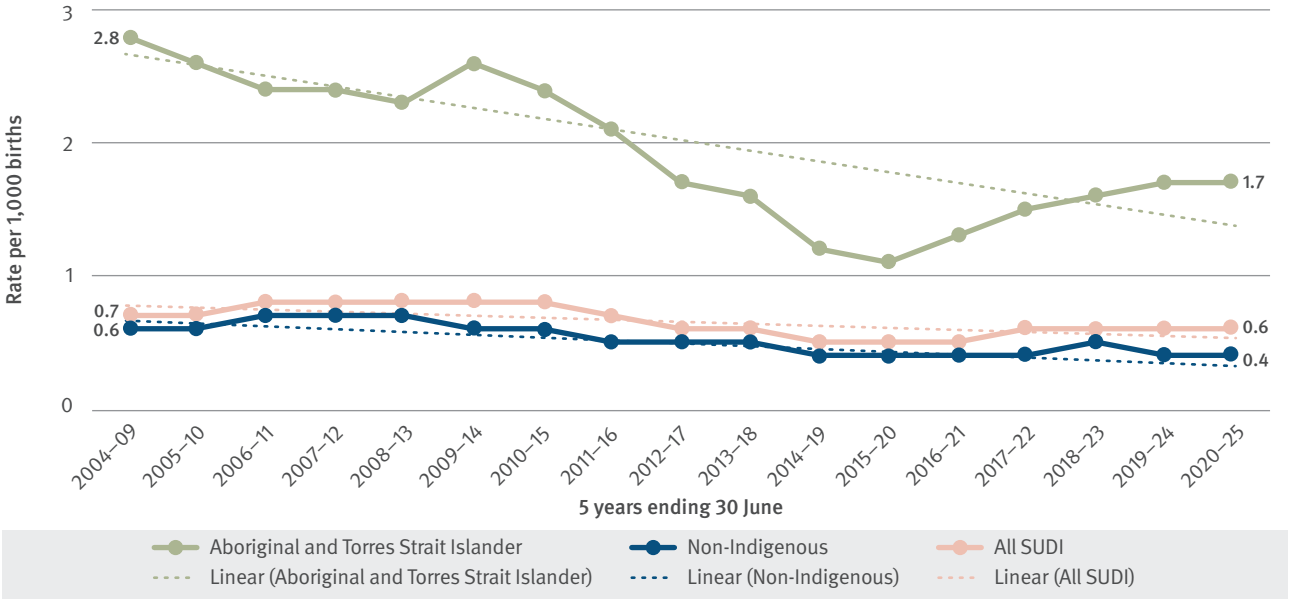
The SUDI mortality rate was 0.6 per 1,000 live births (5-year average).

Table A.11 in Appendix A provides summary data on SUDI in the last 5 years. Explained SUDIs are also included in the chapter relating to the specific causes of death.

### Aboriginal and Torres Strait Islander infants

Figure 8.1 shows the trends in the 5-year rolling rates of Aboriginal and Torres Strait Islander SUDI, non-Indigenous SUDI and all SUDI in Queensland. The SUDI rate for Aboriginal and Torres Strait Islander infants was around 4 times the non-Indigenous SUDI rate between 2004–09 and 2011–16. Rates of Aboriginal and Torres Strait Islander SUDI dropped considerably between 2014 and 2020, reducing to 2.5 times the non-Indigenous rate in 2015–20.[86] In more recent periods the rates of Aboriginal and Torres Strait Islander SUDI have been increasing, with Aboriginal and Torres Strait Islander SUDI rates 4 times the non-Indigenous SUDI rate in 2020–25.

**Figure 8.1:** SUDI by Aboriginal and Torres Strait Islander status (5-year rolling rate), 2004–09 to 2020–25




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

## Cause of death category

Cases of SUDI with an official cause of death are grouped into the following categories and sub-categories. Deaths with an explained cause will also be counted within the relevant chapter, namely Chapter 2 for illnesses, Chapter 5 for sleep accidents, and Chapter 7 for non-accidental injury.

**Explained SUDI**—infant deaths for which a cause was not immediately obvious; but for which post-mortem examinations were able to identify a specific reason:

- Infant illness or condition unrecognised at the time of death
- Sleep accidents (threats to breathing)
- Non-accidental injury (fatal assault).

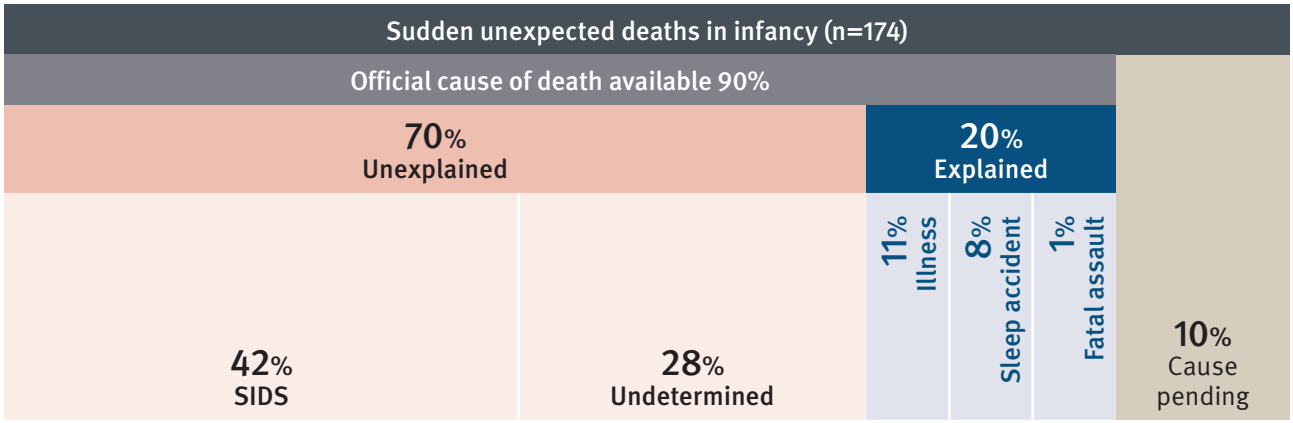
**Unexplained SUDI**—those infant deaths for which a cause could not be determined:

- Sudden infant death syndrome (SIDS)[87]
- Undetermined causes.[88]

It should be noted that postmortem examinations of SUDI cannot distinguish between undetermined causes and suffocation on the basis of the physiological findings.[89] This is known to contribute to an under classification of suffocation in official cause of death records.[90] Nonetheless, in many of the infant deaths considered sudden and unexpected, one or more aspects of the sleep environment were not consistent with a safe sleep environment.[91]

There were 174 SUDI in the last 5 years and, as indicated in Figure 8.2, 70% were found to be unexplained SUDI (SIDS and undetermined causes) while 20% were explained SUDI (illness, sleep accident and fatal assault). A further 10% were pending a cause at the time of reporting.

**Figure 8.2:** SUDI by cause of death (proportion), 2020–21 to 2024–25




*Notes: Percentages may not add to subtotals and totals due to rounding.*

87 Krous HF, Beckwith JB, Byard RW, Rognum TO, Bajanowski T, Corey T, Cutz E, Hanzlick R, Keens TG, and Mitchell EA (2004) 'Sudden infant death syndrome and unclassified sudden infant deaths: a definitional and diagnostic approach', *Pediatrics*, 114:234–8, doi:10.1542/peds.114.1.234

88 A finding where: natural disease processes are detected and are not considered sufficient to cause death but preclude a diagnosis of SIDS; there are signs of significant stress; non-accidental, but non-lethal, injuries are present; toxicology testing detects non-prescribed but non-lethal drugs; or a full autopsy has not been performed and a cause is not otherwise identified.

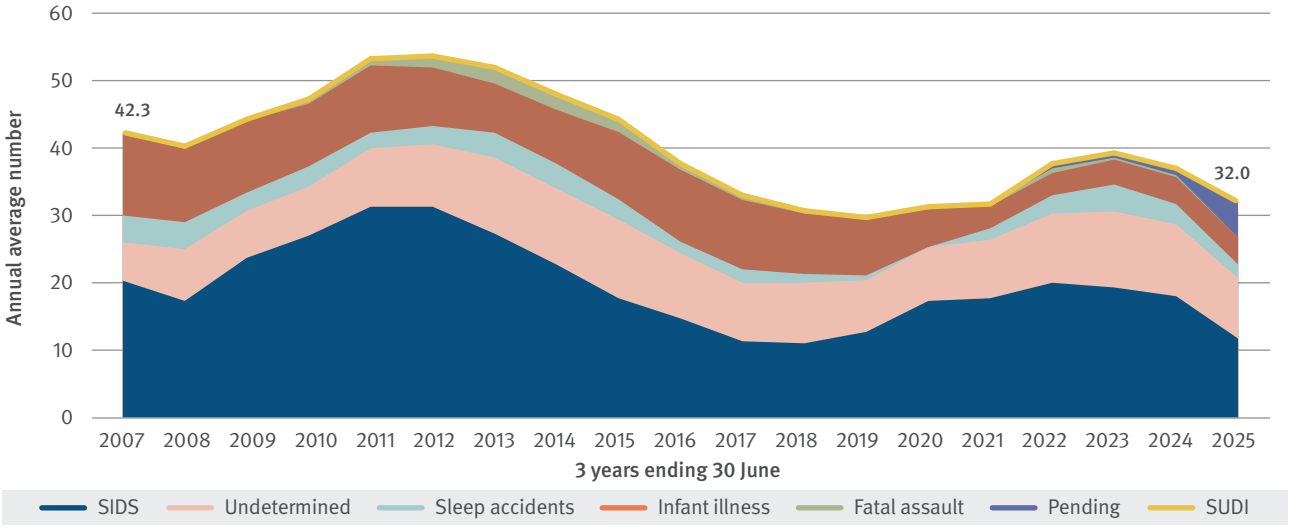
89 Byard RW and Jensen L (2007) 'Fatal asphyxia episodes in the very young – Classification and diagnostic issues.' *Forensic Science Medicine and Pathology* 3, 177-181; Byard RW (2018) 'The autopsy and pathology of Sudden Infant Death Syndrome' in Duncan, JR & Byard, RW (eds.) *SIDS, sudden infant and early childhood death: the past, the present and the future*, 497-538. Adelaide: University of Adelaide Press.

90 Shapiro-Mendoza CK, Camperlengo L, Ludvigsen R, Cottengim C, Anderson RN, Andrew T, Covington T, Hauck FR, Kemp J, and MacDorman M (2014) 'Classification system for the Sudden Unexpected Infant Death Case Registry and its application', *Pediatrics*, 134(1), e210–e219, doi.org/10.1542/peds.2014-0180; Shipstone RA et al (2020) 'An evaluation of pathologists' application of the diagnostic criteria from the San Diego definition of SIDS and unclassified sudden infant death', *International Journal of Legal Medicine*, 134(3), 1015–1021, doi.org/10.1007/s00414-019-02126-w

91 Factors in safe and unsafe sleep environments are described in the *Best practice guide for the design of safe infant sleeping environments*, available at www.productsafety.gov.au/about-us/publications/best-practice-guide-for-the-design-of-safe-infant-sleeping-environments

Fluctuations in the number and causes of SUDI are shown in Figure 8.3 as 3-year rolling averages. While the number of SUDI has decreased since 2011, average annual numbers increased again since 2019 before decreasing again after 2023.[92] Deaths from infant illness, undetermined causes and sleep accidents remained comparatively stable across the entire period; in contrast, SIDS deaths rose and fell. However, some caution is warranted as assigning definitive causes for SUDI remains complex and developments in cause of death classification are ongoing.[93]

**Figure 8.3:** SUDI by cause of death (3-year rolling average number), 2004–07 to 2022–25



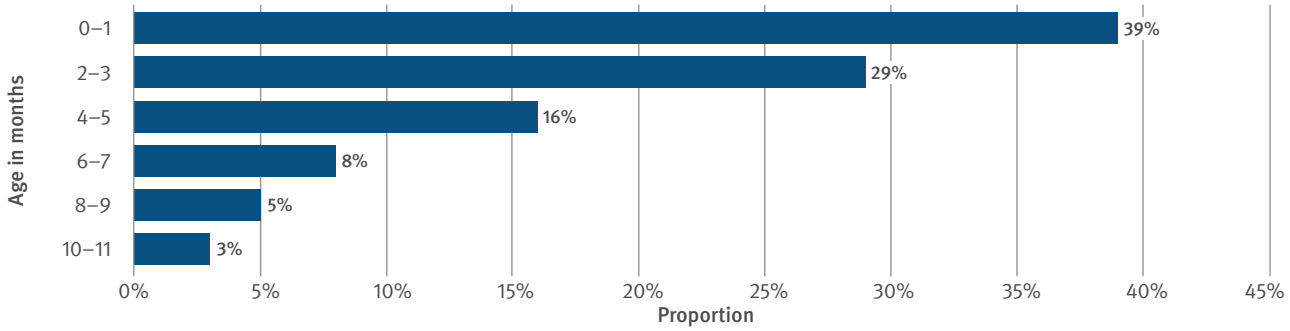

SUDI later found to be the result of fatal assault or neglect are excluded from the analyses presented throughout the remainder of this chapter.

## Sex and age

A slightly larger proportion of SUDI in the last 5 years were males (60% male compared with 40% female). The male SUDI rate was 0.7 per 1,000 male births compared to the female SUDI rate of 0.5 per 1,000 female births.

Figure 8.4 shows SUDI by age at death in the last 5 years. Approximately two-thirds of sudden unexpected deaths (68%) occurred among infants aged 0–3 months.

**Figure 8.4:** SUDI by age in months (proportion), 2020–21 to 2024–25




*Notes: Excludes SUDI from fatal assault and neglect. Percentages may not add to 100 due to rounding.*

92 An expanded table on SUDI from 2004 to 2025 is available on the report web page.

93 An expert panel review of Queensland post-neonatal SUDI deaths from 2013 recoded around half of the deaths to a different cause, with shifts occurring from explained to unexplained causes and vice versa. McEniery J, Cruice D (2018), **'The voice of the infant: Cause of death coding does not always reflect what really mattered in the life of the infant who died suddenly and unexpectedly'** [poster presentation], *Perinatal Society of Australia and New Zealand Conference*, Auckland, **www.childrens.health.qld.gov.au/chq/health-professionals/qpqc/**

## Risk factors for SUDI

A number of factors have been associated with an increased risk of SUDI.[94] These can be classified according to whether they are associated with the infant, the family or the sleep environment.

**Infant factors:** Prematurity and low birth weight, multiple gestation (twins, triplets), neonatal health problems, male sex, and recent history of minor viral respiratory infections and/or gastrointestinal illness.

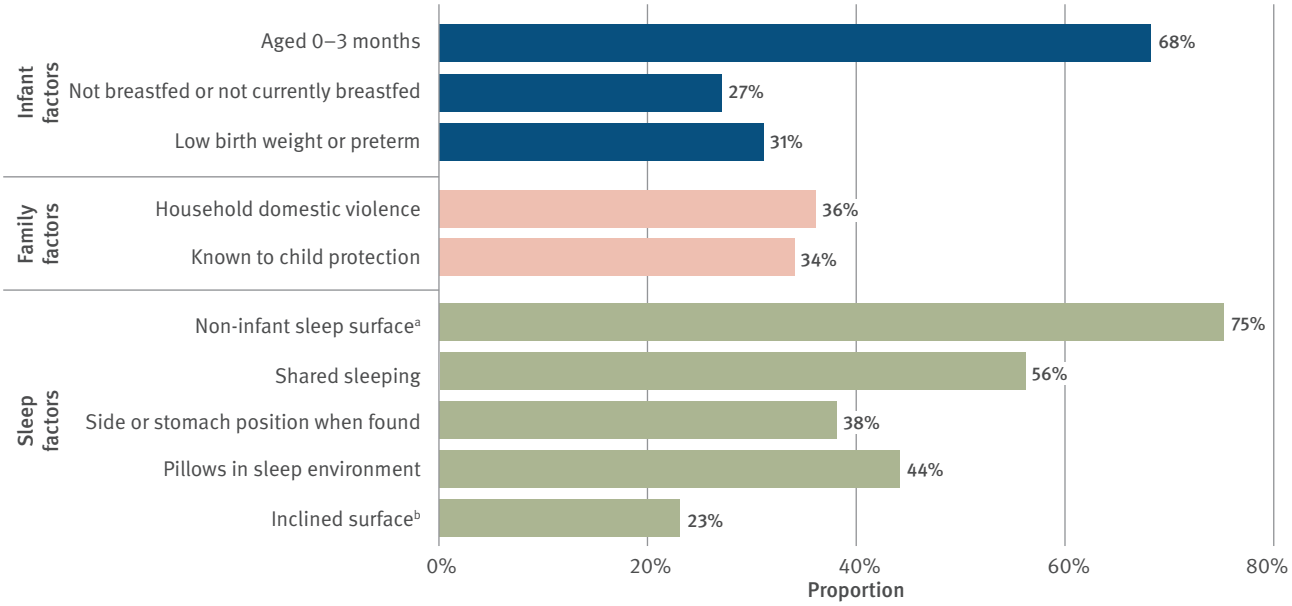
**Family factors:** Cigarette smoking during pregnancy and after birth, young maternal age (≤ 20 years), single marital status, high parity (number of births by mother) and short intervals between pregnancies, poor or delayed prenatal care, abuse or family violence, high-risk lifestyles including alcohol and illicit drug abuse, and social disadvantage and poverty.

**Sleep environment factors:** Sleeping on soft surfaces and loose bedding, prone (stomach) and side sleeping position, some forms of shared sleeping, and overwrapping or overheating.

Selected characteristics of the infant, family and unsafe sleep factors in SUDI deaths over the last 5 years are shown in Figure 8.5.[95] These indicate increased risk in the first months and for infants born with low birth weight.

Using non-infant sleep surfaces (75% of SUDI), sharing a sleep surface (56%) and sleep position on side or stomach (38%) are all reported to increase the risk of sudden unexpected infant deaths, as are pillows (44%) and excess bedding in the sleep space.

**Figure 8.5: SUDI by selected infant, family and sleep factors (proportion), 2020–21 to 2024–25**




*a Includes adult sleep surfaces and other surfaces such as a couch/chair or infant product not primarily for sleep (e.g. pram/stroller, baby capsule).*

*b Includes infants propped on pillows or other items, and products with an inclined surface: pram/stroller; infant swing/rocker; baby capsule/car seat.*

*Notes: Excludes SUDI from fatal assault and neglect.*

94 The Triple Risk Model proposes SUDI risk increases with combined factors of vulnerable infant; critical development period; and external stressors https://rednose.org.au/article/why-are-safe-sleeping-recommendations-so-important

95 Analysis based on the 174 SUDI deaths in the last 5 years, excluding one death found to be from fatal assault and neglect.

## Clinical guidelines: Safer infant sleep

The Queensland Health ***Safer infant sleep clinical guideline***, released in late 2022, highlights infant care practices that are associated with promoting airway protection for infants, which in turn reduces the risk of SUDI.[96]

Co-designed with key stakeholders including parent consumers, the guideline contains a clearly articulated risk minimisation approach to safer infant sleep. A risk minimisation approach ensures that caregivers receive information that includes benefits and risks, together with strategies to increase safety, in a range of diverse infant sleep environments, including shared sleeping. Evidence demonstrates risk minimisation approaches better equip families with the practical information they need to meet the needs of their infant within their family circumstances and the resources they have available.

Understanding infant vulnerabilities and removing as many factors as possible in the infant's environment which place them at increased risk for SUDI is a key message of the guideline. The new guideline also highlights the importance of communication between clinicians and families regarding implementation of these messages by families. Listening to and respecting family choices should shape how the information is shared so that families trust these messages and understand the relevance to their infant care decisions.[97]

Improving caregiver understanding of how infants breathe and the importance of protecting airways when sleeping helps families to understand why the safer sleep messages are relevant to their infant. It also creates the opportunity to assess risks in the infant sleep environment, consider infant vulnerabilities and make safer sleep plans which consider the family's unique circumstances.

The guideline also describes the importance of having conversations about safer infant sleep repeatedly over multiple time points and involving a wide range of potential carers (e.g. fathers, grandparents etc.).

Applying this simple message:

***Easier to breathe – Safer to sleep***, every time an infant sleeps is critical

96 Queensland Health (2022) *Queensland Clinical Guidelines, Safer infant sleeping*. Guideline No. MN22.71-V1-R27, www.health.qld.gov.au/__data/assets/pdf_file/0025/1166353/g-safer-sleep.pdf

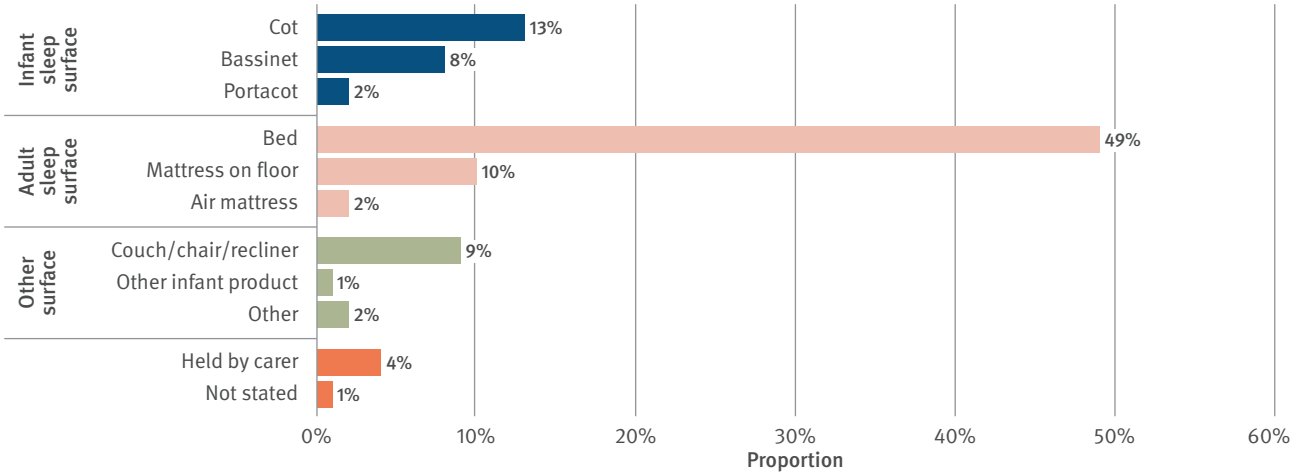
97 Pease A, Garstang JJ, Ellis C, Watson D, Ingram J, Cabral C, Blair PS, and Fleming PJ (2021) 'Decision-making for the infant sleep environment among families with children considered to be at risk of sudden unexpected death in infancy: a systematic review and qualitative metasynthesis', *BMJ Paediatrics Open*, https://bmjpaedsopen.bmj.com/content/5/1/e000983

# Sleep environment factors

## Sleep surface

As indicated in Figure 8.6, in over half the SUDI (61%) in the last 5 years the infant was on an adult sleep surface at the time of the incident and a further 9% were on a couch or recliner. Only 23% of SUDI occurred when an infant sleep product was being used.[98]

**Figure 8.6:** SUDI by sleep surface (proportion), 2020–21 to 2024–25




*Notes: Excludes SUDI from fatal assault and neglect. Percentages may not add to 100 due to rounding.*

# Infant sleep position

Safer infant sleep advice is to place infants on their backs to sleep (supine). Once infants can roll of their own accord it remains important that the sleep surface is firm and flat—the infant's face/nose may be obstructed if the surface is too soft.

Information from incident reports on infant sleep position is shown in Table 8.1. While 74 (43%) deceased infants in the last 5 years were placed and found on their back, a further 28 (16%) had moved from their back to stomach or side position when found. Of the 173 infants dying suddenly and unexpectedly, 65 were on their stomach or side when found (38% of SUDI excluding those from non-accidental injury).

**Table 8.1:** Infant sleep position when placed and found (number), 2020–21 to 2024–25

| Position when placed | Position when found | | | | | | Total |
|---|---|---|---|---|---|---|---|
| | Back | Stomach | Side | Other | Held by carer | Unknown | |
| Back (supine) | 74 | 21 | 7 | 1 | 0 | 4 | 107 |
| Stomach (prone) | 2 | 13 | 0 | 0 | 0 | 1 | 16 |
| Side | 2 | 7 | 8 | 0 | 0 | 1 | 18 |
| Other | 0 | 1 | 0 | 1 | 0 | 0 | 2 |
| Held by carer | 0 | 4 | 0 | 2 | 8 | 1 | 15 |
| Unknown | 5 | 4 | 0 | 2 | 0 | 4 | 15 |
| Total | 83 | 50 | 15 | 6 | 8 | 11 | 173 |

*Notes: Excludes SUDI from fatal assault and neglect.*

98 Percentages by surface types in Figure 8.6 may not add to subtotals presented in this paragraph due to rounding.

## Inclined surface

A firm, flat sleeping surface (not tilted or elevated) is recommended to reduce the risk of SUDI, including for babies with reflux.[99] Information in the Child Death Register indicates 23% of SUDI in the last 5 years were placed on an inclined surface. Most of these involved propping infants on pillows or other items. Some incidents involved an infant product with an inclined surface, including a hammock and infant car seat.

## Shared sleeping

Over half (97, 56%) of the infants whose deaths were sudden and unexpected were sharing a sleep surface with one or more people at the time of death. Not all shared sleeping was planned—in some incidents, the carer fell asleep while nursing the infant.

Sharing a sleep surface with a baby can increase the risk of SIDS and fatal sleep accidents in some circumstances.[100] Some studies have found there is an increased risk of SIDS only when mothers who smoke share a bed with their infant, although such findings are insufficient to enable complete reassurance that bed sharing is safe for non-smokers.

Risks are also associated with shared sleeping if infants are sharing a sleep surface with a caregiver who is under the influence of alcohol or drugs which cause sedation, if the caregiver is excessively tired or there are multiple people in the bed with the infant.

Of the 97 SUDI in a shared sleep environment over the last 5 years, the following additional risk factors were identified:

- tobacco (44%)
- position in sleep environment, such as placed between 2 people or on top of a co-sleeping person (31%)
- alcohol or substance use (27%)
- extreme fatigue (20%)
- obesity (6%).

## Unexplained deaths of children aged 1–17 years

While this chapter primarily examines sudden unexpected deaths of infants, a smaller proportion of unexplained-cause deaths were of children aged 1 year and over (see **Table A.10**, **Appendix A**). Over the last 5 years, while 85% of unexplained deaths were infants, 8% were aged 1–4 years and 8% were aged 5–17 years.

Some deaths in the younger age group show similarities to SUDI deaths in that they occurred during sleep with SUDI risk factors present. In some unexplained deaths, investigations have found the cause of death to be injury; however, it cannot be determined whether the cause of the injury was accidental or intentional.

99 Queensland Health (2022) *Queensland Clinical Guidelines. Safer infant sleep*, Guideline No. MN22.71V1-R27, www.health.qld.gov.au/__data/assets/pdf_file/0025/1166353/g-safer-sleep.pdf

100 Queensland Health (2022) *Queensland Clinical Guidelines. Safer infant sleep*, Guideline No. MN22.71V1-R27, www.health.qld.gov.au/__data/assets/pdf_file/0025/1166353/g-safer-sleep.pdf

## A systemic evaluation and comparison of the consistency of infant safer sleep messaging in Australia

This systematic review, published in Frontiers in Communication (2025), evaluates the consistency of publicly available infant safer sleep guidance documents in Australia, with a focus on messaging around shared sleep practices—a key factor in sudden unexpected death in infancy (SUDI) prevention.[101] The review analysed 32 documents from 26 organisations, including government bodies, professional associations, and educational groups, benchmarking them against the International Society for the Study and Prevention of Perinatal and Infant Death (ISPID) guidelines.

While all documents aligned with ISPID's core recommendations, only one—Queensland Health's Clinical Guidelines—included all 13 consensus recommendations. Most documents supported foundational safer sleep practices such as supine sleep positioning, avoiding soft bedding, and maintaining smoke-free environments. However, messaging around non-consensus topics like dummy use, swaddling, and in-bed sleep devices was inconsistent.

A major focus of the review was how organisations addressed shared sleep (bed-sharing/co-sleeping). Despite its prevalence—up to 76% of Australian families engage in shared sleep during the first 3 months—fewer than half of the documents acknowledged cultural or familial motivations for the practice. Only 35% recognised its bi-directional relationship with breastfeeding, despite evidence that shared sleep can support breastfeeding and maternal rest.

Documents were assessed using a seven-criteria framework to determine whether they adopted a Risk Elimination or Risk Minimisation approach. Risk Elimination messaging discourages shared sleep entirely, often using prescriptive or alarmist language. Risk Minimisation messaging, by contrast, provides balanced information, acknowledges real-world behaviours, and offers practical strategies for safer shared sleep. Queensland Health, the Australian College of Midwives, and the Australian Breastfeeding Association scored highest for Risk Minimisation alignment, while documents from Tasmania and the Northern Territory reflected strong Risk Elimination stances and limited guidance.

The review also identified accessibility issues, with some documents difficult to locate or requiring navigation across multiple webpages—posing a barrier for caregivers seeking timely and clear information.

Key policy implications include the urgent need for a nationally harmonised, evidence-based framework that integrates Risk Minimisation principles. Such a framework should:

- Respect parental autonomy and cultural practices.
- Provide clear, non-judgmental guidance on safer shared sleep.
- Align sleep safety messaging with national breastfeeding strategies.
- Address higher SUDI rates among Indigenous infants through culturally responsive communication.
- Ensure resources are easily accessible via centralised platforms.

The authors recommend incorporating shared sleep education into antenatal and postnatal care and training health professionals in culturally sensitive communication. Consistent, practical, and empathetic messaging is essential to empower families and reduce the risk of SUDI.

101 Kruse SP, D'Souza L, Young J, and Tuncer HGG (2025) 'A systematic evaluation and comparison of the consistency of infant safer sleep messaging in Australia', *Front. Commun.* 10:1527164, doi.org/10.3389/fcomm.2025.1527164

## Learnings

### 2025 Australian and New Zealand Child Death Review and Prevention Conference

#### Findings from the review of Queensland Sudden Unexpected Death in Infancy (SUDI) cases between 2013–2016

**Dr Julie McEniery**
*Queensland Paediatric Quality Council*

At the 2025 Australian and New Zealand Child Death Review and Prevention Conference, hosted by the Commission, Dr Julie McEniery spoke to the QPQC's report ***Findings from the review of Queensland Sudden Unexpected Death in Infancy (SUDI) cases between 2013–2016***.

This presentation outlined critical insights from the review of SUDI cases which occurred in the sleep setting in Queensland between 2013 and 2016, aiming to deepen understanding and inform preventive strategies. Drawing from comprehensive case data, the review examined the circumstances, patterns, and contributing risk factors surrounding these tragic and unexpected infant deaths.

The findings of the review led to the development of a model of contributory factors which integrates infant vulnerabilities (such as in-utero tobacco exposure), modifiable sleep environment risks, developmental ability, and family circumstances, highlighting their cumulative and dynamic effects.

Recommendations stemming from the review include:

- Promoting universal safe sleep messages with targeted, culturally responsive support for vulnerable families, that align with the Queensland Health ***Safer infant sleep clinical guideline***.
- Enhancing postnatal support services for at-risk families.
- Strengthening interagency coordination and data sharing to identify early warning signs.
- Supporting frontline health workers with targeted training in SUDI prevention.

The presentation concluded with Dr Julie McEniery reinforcing the importance of community engagement and sustained public health efforts to reduce the incidence of SUDI and protect Queensland's most vulnerable children.

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

**Read more:** www.childrens.health.qld.gov.au/__data/assets/pdf_file/0015/409110/sudden-and-unexpected-infant-deaths-during-sleep-in-Queensland-2013-2016.pdf

# 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.<br><br>*Related release: "Journi" online road safety education program*<br>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.

# Appendices



### *Appendices available online*

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

**Appendix B** — Methodology
**Appendix C** — Abbreviations and definitions
**Appendix D** — Cause of death by ICD-10 mortality coding classification
**Appendix E** — Inclusions within the other non-intentional injury category
**Appendix F** — Suicide classification model
**Appendix G** — Fatal assault and neglect definitions and screening criteria

# Appendix A
# Summary tables on child deaths in Queensland

## All child deaths

**Table A.1:** Summary of deaths of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All deaths** | | | | | | |
| Deaths of children 0–17 years | 398 | 410 | 447 | 422 | 427 | 35.1 |
| **Cause of death** | | | | | | |
| **Natural causes** | **280** | **272** | **337** | **324** | **321** | **25.6** |
| **External causes** | **88** | **95** | **73** | **73** | **68** | **6.6** |
| Transport | 31 | 33 | 28 | 20 | 23 | 2.3 |
| Drowning | 10 | 10 | 10 | 10 | 10 | 0.8 |
| Other non-intentional injury-related death | 14 | 20 | 7 | 21 | 7 | 1.2 |
| Suicide | 30 | 22 | 20 | 19 | 24 | 1.9 |
| Fatal assault and neglect | 3 | 10 | 8 | 3 | 4 | 0.5 |
| **Unexplained causes** | **30** | **41** | **37** | **23** | **13** | **2.4** |
| **Cause of death pending** | **0** | **2** | **0** | **2** | **25** | **0.5** |
| **Sudden unexpected death in infancy (SUDI)** | | | | | | |
| Sudden unexpected infant deaths | 34 | 44 | 40 | 27 | 29 | 0.6 |
| **Sex**[a] | | | | | | |
| Female | 185 | 175 | 193 | 173 | 171 | 30.8 |
| Male | 213 | 233 | 253 | 241 | 254 | 38.7 |
| **Age category** | | | | | | |
| Under 1 year | 239 | 250 | 280 | 280 | 278 | 4.4 |
| 1–4 years | 41 | 44 | 52 | 43 | 37 | 17.6 |
| 5–9 years | 19 | 24 | 37 | 18 | 29 | 7.6 |
| 10–14 years | 31 | 43 | 37 | 34 | 32 | 10.0 |
| 15–17 years | 68 | 49 | 41 | 47 | 51 | 25.1 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 73 | 71 | 94 | 91 | 88 | 74.5 |
| Non-Indigenous | 325 | 339 | 353 | 331 | 339 | 31.0 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 53 | 69 | 72 | 53 | 57 | 59.1 |

*Data source: Queensland Child Death Register (Aug 2025)*

*Rate per 1,000 live births.*

*a Excludes deaths of children whose sex was indeterminate.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting SUDI and age under 1 year which are per 1,000 births.*
3. *SUDI is a research category applying to infants only, where the death was sudden with no immediately obvious cause. The category is not a cause of death, which will be counted within the relevant cause, and will not add to the total.*
4. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

## Aboriginal and Torres Strait Islander children

**Table A.2:** Summary of deaths of Aboriginal and Torres Strait Islander children and young people in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **Aboriginal and Torres Strait Islander deaths** | | | | | | |
| Total | 73 | 71 | 94 | 91 | 88 | 74.5 |
| **Cause of death** | | | | | | |
| **Natural causes** | **48** | **33** | **63** | **72** | **66** | **50.3** |
| **External causes** | **17** | **23** | **20** | **12** | **12** | **15.0** |
| Transport | 3 | 4 | 7 | 4 | 3 | 3.7 |
| Drowning | 4 | 2 | 2 | 1 | 2 | 2.0 |
| Other non-intentional injury-related death | 5 | 6 | 3 | 5 | 1 | 3.6 |
| Suicide | 4 | 8 | 4 | 2 | 6 | 4.3 |
| Fatal assault and neglect | 1 | 3 | 4 | 0 | 0 | 1.4 |
| **Unexplained causes** | **8** | **13** | **11** | **7** | **5** | **7.9** |
| **Cause of death pending** | **0** | **2** | **0** | **0** | **5** | **1.2** |
| **Sudden unexpected deaths in infancy (SUDI)** | | | | | | |
| Sudden unexpected infant deaths | 12 | 15 | 14 | 9 | 12 | 1.7 |
| **Age category** | | | | | | |
| Under 1 year | 50 | 36 | 59 | 67 | 57 | 7.5 |
| 1–4 years | 8 | 12 | 11 | 12 | 8 | 41.2 |
| 5–9 years | 1 | 4 | 9 | 1 | 8 | 15.0 |
| 10–14 years | 4 | 7 | 4 | 7 | 5 | 16.9 |
| 15–17 years | 10 | 12 | 11 | 4 | 10 | 52.6 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 27 | 31 | 27 | 22 | 22 | 90.9 |

*Data source: Queensland Child Death Register (Aug 2025)*

*Rate per 1,000 live births.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting SUDI and age under 1 year which are per 1,000 births.*
3. *SUDI is a research category applying to infants only, where the death was sudden with no immediately obvious cause. The category is not a cause of death, which will be counted within the relevant cause, and will not add to the total.*

# Children known to child protection

**Table A.3:** Summary of deaths of children and young people known to child protection in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **Deaths of children known to child protection** | | | | | | |
| Total | 53 | 69 | 72 | 53 | 57 | 59.1 |
| **Cause of death** | | | | | | |
| **Natural causes** | **21** | **25** | **32** | **27** | **21** | **24.5** |
| **External causes** | **23** | **33** | **30** | **19** | **16** | **23.5** |
| Transport | 5 | 7 | 10 | 0 | 3 | 4.9 |
| Drowning | 5 | 5 | 4 | 3 | 1 | 3.5 |
| Other non-intentional injury-related death | 7 | 6 | 5 | 11 | 2 | 6.0 |
| Suicide | 4 | 8 | 6 | 4 | 7 | 5.6 |
| Fatal assault and neglect | 2 | 7 | 5 | 1 | 3 | 3.5 |
| **Unexplained causes** | **9** | **11** | **10** | **7** | **10** | **9.1** |
| **Cause of death pending** | **0** | **0** | **0** | **0** | **10** | **1.9** |
| **Sudden unexpected deaths in infancy (SUDI)** | | | | | | |
| Sudden unexpected infant deaths | 13 | 11 | 13 | 8 | 14 | 2.5 |
| **Age category** | | | | | | |
| Under 1 year | 24 | 22 | 27 | 21 | 28 | 5.1 |
| 1–4 years | 9 | 19 | 15 | 14 | 5 | 63.9 |
| 5–9 years | 5 | 4 | 11 | 3 | 5 | 19.0 |
| 10–14 years | 8 | 11 | 9 | 7 | 6 | 25.6 |
| 15–17 years | 7 | 13 | 10 | 8 | 13 | 59.2 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 27 | 31 | 27 | 22 | 22 | 90.9 |
| Non-Indigenous | 26 | 38 | 45 | 31 | 35 | 47.0 |
| **Child protection status** | | | | | | |
| No involvement or ongoing intervention | 32 | 26 | 35 | 22 | 20 | . . |
| Open intake event | 2 | 1 | 5 | 2 | 5 | . . |
| Investigation and assessment (IA) | 8 | 25 | 16 | 22 | 20 | . . |
| Child protection order (CPO) | 4 | 12 | 9 | 4 | 10 | . . |
| Open intervention with parental agreement (IPA) | 5 | 4 | 5 | 2 | 1 | . . |
| Support service case | 2 | 1 | 1 | 1 | 1 | . . |
| Other child protection status | 0 | 0 | 1 | 0 | 0 | . . |

*Data source: Queensland Child Death Register (Aug 2025)*

*Rate per 1,000 aged under 1 year.*

*. . Not calculated.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *The number of children known to child protection represents the number of children, whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death.*
3. *Five-year average rates of death for children known to child protection use as a denominator the 5-year average number of children aged 0–17 years who were known to child protection services, through either being subject to a child concern report, intake enquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*
4. *SUDI is a research category applying to infants only, where the death was sudden with no immediately obvious cause. The category is not a cause of death, which will be counted within the relevant cause, and will not add to the total.*

## Natural causes

**Table A.4:** Summary of deaths from natural causes of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All natural cause deaths** | | | | | | |
| Disease and morbid condition | 280 | 272 | 337 | 324 | 321 | 25.6 |
| **Category** | | | | | | |
| Perinatal conditions | 129 | 121 | 162 | 188 | 169 | 12.8 |
| Congenital anomalies | 74 | 80 | 69 | 65 | 64 | 5.9 |
| Neoplasms | 24 | 27 | 37 | 27 | 31 | 2.4 |
| Infections[a] | 8 | 14 | 18 | 15 | 20 | 1.3 |
| Other disease or morbid conditions NEC | 45 | 30 | 51 | 29 | 37 | 3.2 |
| **Sex** | | | | | | |
| Female | 131 | 131 | 156 | 145 | 126 | 23.7 |
| Male | 149 | 139 | 180 | 171 | 193 | 27.0 |
| Indeterminate | 0 | 2 | 1 | 8 | 2 | . . |
| **Age category** | | | | | | |
| Under 1 year | 204 | 209 | 240 | 250 | 246 | 3.8 |
| 1–4 years | 24 | 18 | 34 | 25 | 22 | 10.0 |
| 5–9 years | 13 | 13 | 30 | 13 | 21 | 5.4 |
| 10–14 years | 16 | 19 | 17 | 16 | 18 | 4.9 |
| 15–17 years | 23 | 13 | 16 | 20 | 14 | 8.4 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 48 | 33 | 63 | 72 | 66 | 50.3 |
| Non-Indigenous | 232 | 239 | 274 | 252 | 255 | 23.0 |
| **Geographical area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 4 | 7 | 14 | 6 | 14 | 28.8 |
| Outer regional | 58 | 42 | 49 | 51 | 40 | 29.9 |
| Inner regional | 46 | 56 | 84 | 54 | 69 | 27.0 |
| Major cities | 172 | 163 | 187 | 210 | 193 | 23.8 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 71 | 65 | 100 | 105 | 101 | 36.8 |
| Q5 (least disadvantaged) | 45 | 27 | 29 | 20 | 22 | 12.1 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 21 | 25 | 32 | 27 | 21 | 24.5 |

*Data source: Queensland Child Death Register (Aug 2025)*

*Rate per 1,000 live births.*

*. . Not calculated.*

*a 'Infections' is a hybrid category composed of ICD-10 Chapter I, Certain infectious and parasitic diseases; ICD-10 Chapter VI, Diseases of the nervous system, codes G00–G09 only; ICD-10 Chapter X, Diseases of the respiratory system, codes J00–J22 only; Chapter XXII, Codes for special purposes, codes U07.1–U07.2 only.*

*NEC Not elsewhere classified.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting for age under 1 year which is per 1,000 live births.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to the child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

# Transport

**Table A.5:** Summary of transport-related deaths of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All transport deaths** | | | | | | |
| Transport | 31 | 33 | 28 | 20 | 23 | 2.3 |
| **Incident type** | | | | | | |
| Motor vehicle | 19 | 19 | 13 | 6 | 16 | 1.2 |
| Pedestrian | 4 | 5 | 10 | 6 | 4 | 0.5 |
| *Low-speed vehicle run-over* | 3 | 4 | 8 | 3 | 1 | 0.3 |
| Motorcycle | 5 | 5 | 4 | 5 | 0 | 0.3 |
| Quad bike | 2 | 2 | 0 | 2 | 1 | 0.1 |
| Bicycle | 1 | 0 | 1 | 0 | 2 | 0.1 |
| Other | 0 | 2 | 0 | 1 | 0 | * |
| **Sex** | | | | | | |
| Female | 14 | 9 | 6 | 3 | 9 | 1.4 |
| Male | 17 | 24 | 22 | 17 | 14 | 3.0 |
| **Age category** | | | | | | |
| Under 1 year | 1 | 0 | 0 | 1 | 1 | * |
| 1–4 years | 5 | 7 | 7 | 3 | 3 | 2.0 |
| 5–9 years | 4 | 5 | 2 | 1 | 5 | 1.0 |
| 10–14 years | 5 | 9 | 6 | 6 | 3 | 1.6 |
| 15–17 years | 16 | 12 | 13 | 9 | 11 | 6.0 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 3 | 4 | 7 | 4 | 3 | 3.7 |
| Non-Indigenous | 28 | 29 | 21 | 16 | 20 | 2.1 |
| **Geographical area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 4 | 1 | 3 | 2 | 0 | 6.4 |
| Outer regional | 8 | 10 | 6 | 3 | 4 | 3.9 |
| Inner regional | 9 | 10 | 8 | 7 | 8 | 3.7 |
| Major cities | 9 | 10 | 10 | 6 | 10 | 1.2 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 13 | 5 | 7 | 7 | 5 | 3.1 |
| Q5 (least disadvantaged) | 0 | 0 | 0 | 1 | 1 | * |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 5 | 7 | 10 | 0 | 3 | 4.9 |

*Data source: Queensland Child Death Register (Aug 2025)*

* *Rates have not been calculated for numbers less than 4.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Low-speed vehicle run-over is a subset of the 'pedestrian' category; hence, summing categories will exceed the total.*
3. *Quad bike includes side-by-side vehicles.*
4. *The 'other' incident type category can include deaths involving aircraft, horse riding and specialised industrial vehicles.*
5. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland.*
6. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
7. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

# Drowning

**Table A.6:** Summary of drowning deaths of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All drowning deaths** | | | | | | |
| Drowning | 10 | 10 | 10 | 10 | 10 | 0.8 |
| **Incident type** | | | | | | |
| Pool | 2 | 3 | 4 | 3 | 6 | 0.3 |
| *Private pool* | 2 | 3 | 4 | 3 | 6 | 0.3 |
| Non-pool | 8 | 7 | 6 | 7 | 4 | 0.5 |
| *Bath* | 3 | 2 | 4 | 3 | 1 | 0.2 |
| *Beach or ocean* | 0 | 1 | 0 | 0 | 1 | * |
| *Dynamic waterway* | 1 | 0 | 0 | 3 | 2 | 0.1 |
| *Object containing water* | 0 | 0 | 0 | 0 | 0 | * |
| *Rural water hazard* | 3 | 2 | 1 | 0 | 0 | 0.1 |
| *Static inland waterway* | 1 | 1 | 1 | 0 | 0 | * |
| *Other non-pool water hazard NEC* | 0 | 1 | 0 | 1 | 0 | * |
| **Sex** | | | | | | |
| Female | 6 | 3 | 7 | 4 | 4 | 0.8 |
| Male | 4 | 7 | 3 | 6 | 6 | 0.8 |
| **Age category** | | | | | | |
| Under 1 year | 2 | 1 | 2 | 3 | 0 | 2.6 |
| 1–4 years | 5 | 6 | 5 | 3 | 5 | 1.9 |
| 5–9 years | 1 | 1 | 2 | 3 | 1 | 0.5 |
| 10–14 years | 1 | 1 | 0 | 1 | 1 | 0.2 |
| 15–17 years | 1 | 1 | 1 | 0 | 3 | 0.6 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 4 | 2 | 2 | 1 | 2 | 2.0 |
| Non-Indigenous | 6 | 8 | 8 | 9 | 8 | 0.7 |
| **Geographical area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 0 | 0 | 0 | 1 | 0 | * |
| Outer regional | 3 | 3 | 1 | 2 | 2 | 1.4 |
| Inner regional | 5 | 4 | 5 | 0 | 3 | 1.5 |
| Major cities | 2 | 3 | 4 | 7 | 4 | 0.5 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 4 | 5 | 4 | 5 | 2 | 1.7 |
| Q5 (least disadvantaged) | 1 | 0 | 1 | 0 | 0 | * |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 5 | 5 | 4 | 3 | 1 | 3.5 |

*Data source: Queensland Child Death Register (Aug 2025)*

* *Rates have not been calculated for numbers less than 4.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *'Other' non-pool water hazards include septic tank and flood-related incidents.*
3. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rates for age under 1 year which are per 100,000 births.*
4. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
5. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

# Other non-intentional injury

**Table A.7:** Summary of other non-intentional injury-related deaths of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All other non-intentional injury deaths** | | | | | | |
| Other non-intentional injury | 14 | 20 | 7 | 21 | 7 | 1.2 |
| **Incident type** | | | | | | |
| Threats to breathing | 9 | 5 | 6 | 3 | 2 | 0.4 |
| Exposure to inanimate mechanical forces | 1 | 3 | 0 | 0 | 0 | 0.1 |
| Accidental poisoning | 1 | 3 | 0 | 2 | 1 | 0.1 |
| Deaths from fire | 0 | 2 | 0 | 7 | 1 | 0.2 |
| Falls | 0 | 3 | 0 | 4 | 0 | 0.1 |
| Contact with venomous animals and plants | 1 | 2 | 0 | 0 | 1 | 0.1 |
| Other incidents | 2 | 2 | 1 | 5 | 2 | 0.2 |
| **Sex** | | | | | | |
| Female | 7 | 3 | 1 | 4 | 4 | 0.7 |
| Male | 7 | 17 | 6 | 17 | 3 | 1.6 |
| **Age category** | | | | | | |
| Under 1 year | 5 | 4 | 4 | 2 | 0 | 5.0 |
| 1–4 years | 4 | 3 | 2 | 9 | 4 | 1.8 |
| 5–9 years | 1 | 3 | 0 | 1 | 1 | 0.4 |
| 10–14 years | 1 | 5 | 0 | 5 | 0 | 0.6 |
| 15–17 years | 3 | 5 | 1 | 4 | 2 | 1.5 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 5 | 6 | 3 | 5 | 1 | 3.6 |
| Non-Indigenous | 9 | 14 | 4 | 16 | 6 | 0.9 |
| **Geographical area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 2 | 0 | 1 | 1 | 0 | 2.6 |
| Outer regional | 2 | 7 | 4 | 9 | 2 | 3.0 |
| Inner regional | 0 | 1 | 2 | 5 | 3 | 1.0 |
| Major cities | 10 | 12 | 0 | 6 | 2 | 0.8 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 5 | 7 | 3 | 9 | 2 | 2.2 |
| Q5 (least disadvantaged) | 2 | 4 | 0 | 0 | 0 | 0.5 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 7 | 6 | 5 | 11 | 2 | 6.0 |

*Data source: Queensland Child Death Register (Aug 2025)*

* *Rates have not been calculated for numbers less than 4.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rates for age under 1 year which are per 100,000 births.*
3. *Other incidents includes exposure to animate mechanical forces; exposure to electrical current, radiation and extreme ambient air temperature/pressure; and exposure to forces of nature.*
4. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
5. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

# Suicide

**Table A.8:** Summary of suicide deaths of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All suicide deaths** | | | | | | |
| Suicide | 30 | 22 | 20 | 19 | 24 | 1.9[a] |
| **Sex** | | | | | | |
| Female | 12 | 8 | 9 | 8 | 12 | 3.6 |
| Male | 18 | 14 | 11 | 11 | 12 | 4.6 |
| **Age category** | | | | | | |
| 10–17 years[b] | 30 | 21 | 20 | 19 | 24 | 4.1 |
| 5–9 years | 0 | 1 | 0 | 0 | 0 | * |
| 10–14 years | 6 | 6 | 11 | 6 | 8 | 2.1 |
| 15–17 years | 24 | 15 | 9 | 13 | 16 | 7.6 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 4 | 8 | 4 | 2 | 6 | 9.6 |
| Non-Indigenous | 26 | 14 | 16 | 17 | 18 | 3.6 |
| **Geographical area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 1 | 1 | 1 | 1 | 1 | 7.7 |
| Outer regional | 6 | 3 | 2 | 4 | 4 | 5.0 |
| Inner regional | 7 | 11 | 4 | 3 | 6 | 5.6 |
| Major cities | 16 | 7 | 12 | 10 | 13 | 3.3 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 10 | 5 | 8 | 5 | 11 | 7.1 |
| Q5 (least disadvantaged) | 4 | 0 | 3 | 3 | 1 | 1.9 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 4 | 8 | 6 | 4 | 7 | 12.4 |

*Data source: Queensland Child Death Register (Aug 2025)*

* *Rates have not been calculated for numbers less than 4.*

a *Overall suicide rates are calculated per 100,000 children aged 0–17 years in Queensland. All other rates are calculated per 100,000 children aged 10–17 years in Queensland.*

b *Includes deaths of children aged under 10 years.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*
5. *Data relating to method of death are available to genuine researchers by request.*

# Fatal assault and neglect

**Table A.9:** Summary of deaths from assault and neglect of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All fatal assault and neglect deaths** | | | | | | |
| Fatal assault and neglect | 3 | 10 | 8 | 3 | 4 | 0.5 |
| **Category of fatal assault and neglect** | | | | | | |
| Intra-familial | 2 | 8 | 6 | 3 | 4 | 0.4 |
| *Domestic homicide* | 0 | 1 | 1 | 1 | 2 | 0.1 |
| *Fatal child abuse* | 1 | 5 | 2 | 1 | 2 | 0.2 |
| *Fatal neglect* | 0 | 2 | 3 | 1 | 0 | 0.1 |
| *Neonaticide* | 0 | 0 | 0 | 0 | 0 | * |
| *Other intra-familial assault NEC* | 1 | 0 | 0 | 0 | 0 | * |
| Extra-familial | 1 | 2 | 2 | 0 | 0 | 0.1 |
| *Intimate partner homicide* | 0 | 0 | 0 | 0 | 0 | * |
| *Peer homicide* | 1 | 2 | 0 | 0 | 0 | * |
| *Acquaintance homicide* | 0 | 0 | 0 | 0 | 0 | * |
| *Stranger homicide* | 0 | 0 | 2 | 0 | 0 | * |
| **Sex** | | | | | | |
| Female | 2 | 2 | 3 | 1 | 4 | 0.4 |
| Male | 1 | 8 | 5 | 2 | 0 | 0.5 |
| **Age category** | | | | | | |
| Under 1 year | 0 | 2 | 1 | 2 | 2 | 2.3 |
| 1–4 years | 2 | 4 | 2 | 1 | 1 | 0.8 |
| 5–9 years | 0 | 1 | 3 | 0 | 0 | 0.2 |
| 10–14 years | 0 | 1 | 1 | 0 | 1 | * |
| 15–17 years | 1 | 2 | 1 | 0 | 0 | 0.4 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 1 | 3 | 4 | 0 | 0 | 1.4 |
| Non-Indigenous | 2 | 7 | 4 | 3 | 4 | 0.4 |
| **Geographic area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 0 | 0 | 0 | 0 | 0 | * |
| Outer regional | 1 | 4 | 3 | 0 | 0 | 1.0 |
| Inner regional | 0 | 2 | 2 | 2 | 2 | 0.7 |
| Major cities | 2 | 4 | 3 | 1 | 2 | 0.3 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 1 | 4 | 6 | 2 | 1 | 1.2 |
| Q5 (least disadvantaged) | 0 | 0 | 1 | 0 | 0 | * |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 2 | 7 | 5 | 1 | 3 | 3.5 |

*Data source: Queensland Child Death Register (Aug 2025)*

* *Rates have not been calculated for numbers less than 4.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rates for age under 1 year which are per 100,000 births.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

## Unexplained causes

**Table A.10:** Summary of deaths from unexplained causes of children aged 0–17 years in Queensland, 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 100,000 |
| **All deaths from unexplained causes** | | | | | | |
| Unexplained causes | 30 | 41 | 37 | 23 | 13 | 2.4 |
| **Cause of death** | | | | | | |
| Sudden infant death syndrome (SIDS) | 17 | 21 | 20 | 13 | 2 | 24.1 |
| Undetermined cause (infants) | 10 | 11 | 13 | 8 | 7 | 16.2 |
| Undetermined cause (1–17 years) | 3 | 9 | 4 | 2 | 4 | 0.4 |
| **Sex** | | | | | | |
| Female | 13 | 19 | 11 | 7 | 3 | 1.8 |
| Male | 17 | 22 | 26 | 16 | 10 | 3.0 |
| **Age category** | | | | | | |
| Under 1 year | 27 | 32 | 33 | 21 | 9 | 40.3 |
| 1–4 years | 1 | 6 | 2 | 1 | 1 | 0.9 |
| 5–17 years | 2 | 3 | 2 | 1 | 3 | 0.2 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 8 | 13 | 11 | 7 | 5 | 7.9 |
| Non-Indigenous | 22 | 28 | 26 | 16 | 8 | 1.8 |
| **Geographic area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 0 | 1 | 1 | 1 | 1 | 2.6 |
| Outer regional | 8 | 6 | 4 | 1 | 0 | 2.4 |
| Inner regional | 6 | 8 | 11 | 3 | 4 | 2.8 |
| Major cities | 16 | 25 | 21 | 18 | 8 | 2.3 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 11 | 19 | 16 | 8 | 4 | 4.8 |
| Q5 (least disadvantaged) | 2 | 1 | 4 | 2 | 2 | 0.9 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 9 | 11 | 10 | 7 | 10 | 9.1 |

*Data source: Queensland Child Death Register (Aug 2025)*

** Rates have not been calculated for numbers less than 4.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 100,000 children (in the sex/age/Indigenous status) in Queensland, excepting rates for SIDS, undetermined causes (<1 year) and age under 1 year which are per 100,000 live births.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged 0–17 who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

# Sudden unexpected deaths in infancy (SUDI)

**Table A.11:** Summary of SUDI in Queensland 2020–25

| | 2020–21 | 2021–22 | 2022–23 | 2023–24 | 2024–25 | 5-year average |
|---|---|---|---|---|---|---|
| | *n* | *n* | *n* | *n* | *n* | Rate per 1,000 |
| **All sudden unexpected deaths in infancy (SUDI)** | | | | | | |
| SUDI (infants) | 34 | 44 | 40 | 27 | 29 | 0.6 |
| **Cause of death** | | | | | | |
| **Explained causes** | **7** | **10** | **7** | **5** | **6** | **0.1** |
| Unrecognised infant illness | 2 | 6 | 3 | 3 | 6 | 0.1 |
| Sleep accident | 5 | 3 | 4 | 2 | 0 | 0.0 |
| Fatal assault | 0 | 1 | 0 | 0 | 0 | * |
| **Unexplained causes** | **27** | **32** | **33** | **21** | **8** | **0.4** |
| Sudden infant death syndrome (SIDS) | 17 | 21 | 20 | 13 | 2 | 0.2 |
| Undetermined | 10 | 11 | 13 | 8 | 6 | 0.2 |
| **Cause of death pending** | **0** | **2** | **0** | **1** | **15** | **0.1** |
| **Sex** | | | | | | |
| Female | 17 | 21 | 11 | 9 | 11 | 0.5 |
| Male | 17 | 23 | 29 | 18 | 18 | 0.7 |
| **Aboriginal and Torres Strait Islander status** | | | | | | |
| Aboriginal and Torres Strait Islander | 12 | 15 | 14 | 9 | 12 | 1.7 |
| Non-Indigenous | 22 | 29 | 26 | 18 | 17 | 0.4 |
| **Geographic area of usual residence (ARIA+)** | | | | | | |
| Remote and very remote | 1 | 2 | 1 | 2 | 2 | 0.9 |
| Outer regional | 8 | 9 | 9 | 2 | 3 | 0.8 |
| Inner regional | 7 | 9 | 13 | 5 | 9 | 0.8 |
| Major cities | 18 | 23 | 17 | 18 | 15 | 0.5 |
| **Socio-economic status of usual residence (SEIFA)** | | | | | | |
| Q1 (most disadvantaged) | 12 | 24 | 19 | 12 | 14 | 1.3 |
| Q5 (least disadvantaged) | 3 | 1 | 2 | 2 | 2 | 0.2 |
| **Known to the child protection system** | | | | | | |
| Known to child protection | 13 | 11 | 13 | 8 | 14 | 2.5 |

*Data source: Queensland Child Death Register (Aug 2025)*

* *Rates have not been calculated for numbers less than 4.*

1. *Data presented are current in the Queensland Child Death Register as at August 2025 and thus may differ from previously published reports.*
2. *Rates are averaged over 5 years and calculated per 1,000 births (in the sex/Indigenous status) in Queensland.*
3. *ARIA+ and SEIFA exclude the deaths of children whose usual place of residence was outside Queensland.*
4. *The number of children known to child protection represents the number of children whose deaths were registered in the reporting period, who were known to child protection services within the 1-year period prior to their death. The denominator for calculating rates is the 5-year average number of children aged under 1, who were known to child protection services, through either being subject to a child concern report, intake inquiry, notification, investigation and assessment, ongoing intervention, orders or placement, in the 1-year period prior to the reporting period.*

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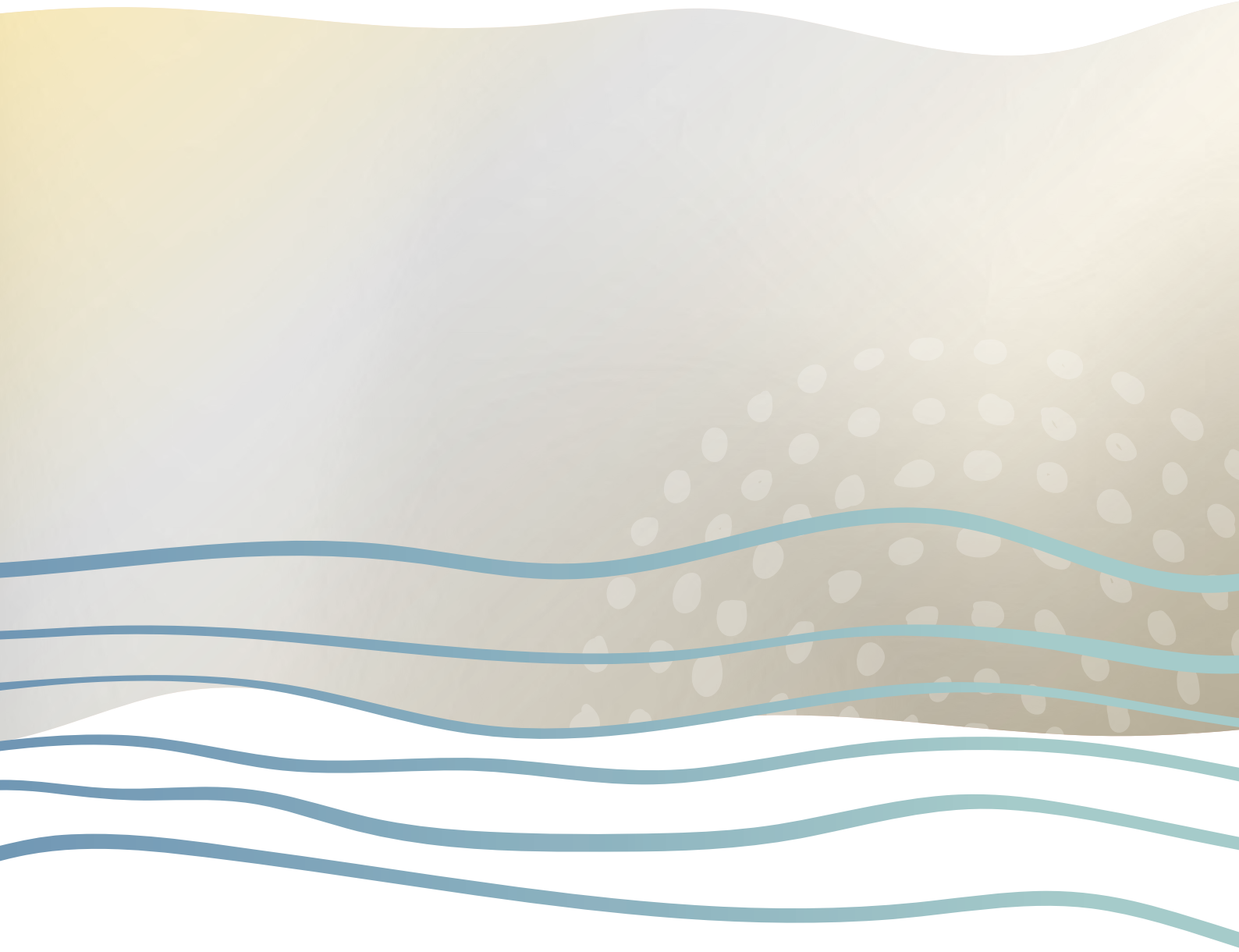

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