Annual Report

Deaths of children and young people Queensland 2023–24

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 2023 to 30 June 2024. The Queensland Family and Child Commission (QFCC) 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 QFCC has been charged by government to review and improve the systems that protect and safeguard Queensland's children.

Accessibility

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

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31 October 2024

Attorney-General
1 William Street
BRISBANE QLD 4000

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 2023 to 30 June 2024, with a particular focus on external (non-natural) causes.

Yours sincerely,

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

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Acknowledgements

The Queensland Family and Child Commission (QFCC) 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 QFCC acknowledges the special rights of children which are recorded in the United Nations Convention on the Rights of the Child (UNCRC), guided by its four key principles: devotion to the best interests of the child; the right to life, survival and development; respect for the views of the child; and non-discrimination.

The QFCC 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 Registry of Births, Deaths and Marriages; the Coroners Court of Queensland; Queensland Police Service; Queensland Health; Department of Child Safety, Seniors and Disability Services; the Australian Bureau of Statistics (ABS); Queensland Paediatric Quality Council; Queensland Ambulance Service; Queensland Treasury; 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 QFCC 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
Phone 13 11 14

Beyond Blue
Phone 1300 22 4636

Kids Helpline (for 5–25 year olds)
Phone 1800 55 1800

Principal Commissioner's message

The death of a child is a profound loss that reverberates through families, communities, and our society. Each life lost is a reminder of the importance of safeguarding the health and well-being of Queensland's children.

In the 12 months to 30 June 2024, the deaths of 422 children and young people aged 0–17 years were registered in Queensland. My deepest sympathies go out to the families and friends affected by these losses.

This year marks my third year as Principal Commissioner, and during this time, the details of more than 1,200 child deaths have crossed my desk. It's a sobering reminder of the importance of the Queensland Child Death Register, which has documented over 9,000 child deaths in its 20 years of operation. The Register is not merely an administrative tool, but a critical resource driving change. By analysing this data, we identify trends, support research, and inform policy improvements to create safer homes, roads, and systems of care.

Additionally, our data is driving significant safety initiatives. For example, the Australian Competition and Consumer Commission has introduced new safety standards for infant sleep products, informed by our child death data. The Department of Transport and Main Roads also launched child car restraint guides, benefiting from our insights on road crash data.

In partnership with the Queensland Paediatric Sepsis Program, we completed Australia's first population-based study on childhood sepsis deaths. This work has already prompted positive responses from key government agencies, and we are committed to ensuring its recommendations translate into real-world practice and policy.

We were also privileged to host the Australia and New Zealand Child Death Review and Prevention annual conference for the second consecutive year, fostering collaboration among professionals in child death research, review, and prevention.

These efforts highlight the importance of child death research in creating safer environments for children and ensuring they have the opportunity to lead healthy, fulfilling lives.

Kind regards

Luke Twyford
Principal Commissioner
Queensland Family and Child Commission

Executive summary

In the 12-month period from 1 July 2023 to 30 June 2024, the deaths of 422 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, 2023–24

422
child deaths in Queensland 2023–24*

314
children died of **natural causes** such as congenital and perinatal conditions

30
children had a cause of death that was **not yet determined** at the time of reporting

70
children died from **external causes**, including:

- **20** from transport incidents
- **10** from drowning
- **19** from other non-intentional injuries
- **19** from suicide
- **2** from fatal assault and neglect

8
children's deaths remained **unexplained**[2] even after comprehensive investigation:

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

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

** By date of death registration.*

Recent increase in natural cause deaths

The 314 deaths from natural causes in 2023–24 was the second highest number in an 8-year period which contributed to the high total number of child deaths in the period (422). In contrast the 70 deaths from external causes in 2023–24 was the lowest since 2015–16 and second lowest for any year since 2004–05. The largest contributor to the increase in natural causes was deaths from perinatal conditions. Further analysis found that this increase primarily occurred across two underlying causes of death: disorders related to short gestation and low birth weight, not elsewhere classified (P05–P08); and other conditions originating in the perinatal period (P90–P96).

The increase does not appear to be due to deaths from coronavirus (COVID-19)—only 5 child deaths have been directly attributed to COVID-19 in Queensland—although the pandemic may have had indirect impacts on child health and mortality.

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.

Trends in child mortality

Notwithstanding the increased number of child deaths in the last 2 years, there has been an overall decrease in child mortality rates since the Child Death Register commenced operation in 2004 (down 2.0% per year on average). The trend has been driven, largely, by decreases in deaths from natural causes.

Transport-related child mortality has decreased 3.4% per year on average. However, higher numbers of transport deaths in the previous 3 years have seen these rates begin to increase. There were 20 transport-related deaths in 2023–24.

A slowly increasing trend in the rate of youth suicide is evident over time, however, the numbers have decreased in the last 3 years. Nineteen suicides were recorded in the last year, continuing to be below the higher numbers seen in 2018–19 (37) and 2020–21 (30). Further analysis suggests the suicide rate has increased more in young females than in young males.

Sudden unexpected deaths in infancy (SUDI) continue to represent a considerable proportion of infant deaths. There were 27 sudden unexpected infant deaths in Queensland in 2023–24, considerably lower than 2022–23 (40). This is the lowest number in 5 years and the second lowest for any year since 2004–05.

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.

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	Drowning	Transport
5–9 years		Cancers and tumours	Nervous system diseases	Transport
10–14 years		Suicide	Cancers and tumours	Transport
15–17 years		Suicide	Transport	Cancers and tumours

** In the 5-year period 2019–20 to 2023–24.*

Vulnerable groups

Some children are more vulnerable to experiencing adversity—including experiences that increase risk of death—than others. Aboriginal and Torres Strait Islander children, and children who are known to the child protection system (Child Safety[3]), are consistently and significantly over-represented in child mortality statistics.

Aboriginal and Torres Strait Islander children were over-represented in child deaths. Ninety-one deaths in 2023–24 were of Aboriginal and Torres Strait Islander children. Of these, 67 died from natural causes (diseases and morbid conditions), 11 from external causes, 2 were unexplained deaths and 11 were pending a cause of death at the time of reporting.

3 Department of Child Safety, Seniors and Disability Services.

The mortality rate for Aboriginal and Torres Strait Islander children was 2.6 times higher than for non-Indigenous children (79.8 deaths per 100,000 Aboriginal and Torres Strait Islander children aged 0–17 years, compared with 30.4 deaths per 100,000 non-Indigenous children (5-year average)). For external causes of death specifically, the Aboriginal and Torres Strait Islander mortality rate was 3.1 times the non-Indigenous rate (5-year average).

Fifty-three of the 422 children who died in 2023–24 were known to Child Safety in the 12 months prior to their deaths, a decrease from 72 deaths in 2022–23. Children are considered known to Child Safety if they were the subject of an intake call or intervention in the preceding 12 months. It is important to note that only 4 child deaths occurred for children in care of the child safety system.

The mortality rate for children known to Child Safety was almost twice the Queensland child mortality rate (5-year average). Children known to Child Safety were almost 4 times more likely to die of external causes than the total child population in Queensland.

This and previous annual reports have found child mortality rates for children known to Child Safety to be consistently higher than the rates for all children, especially for deaths from external causes. Children who are at an increased risk of child maltreatment are often from families with higher levels of economic disadvantage, poor parental mental health and problematic substance misuse and social instability, all of which are risk factors for adverse childhood outcomes—including death. The over-representation of children coming to the attention of the child protection system can therefore, at least in part, be explained by the often-multiple risk factors present in these children's lives.

Child death prevention activities

During 2023–24, the QFCC responded to 25 external requests for child death data, including the provision of data for or regarding:

- a coronial investigation into caustic ingestion injuries and consideration of regulating dangerous household products
- potential hazards in infant sleep devices to inform consideration of the Australian cot and portacot standard
- potential hazards in child and infant clothing to inform discussion on industry best practice guides
- drowning prevention research and reporting by the Royal Life Saving Society of Australia.

The QFCC 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
- Queensland Government Suicide Prevention Network
- Suicide Prevention Oversight Group
- QPQC Infant Mortality Sub-Committee
- QPQC Steering Committee
- Queensland Government Births and Deaths Working Group
- Road Safety Research Network
- QPQC genetic working group.

The QFCC 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

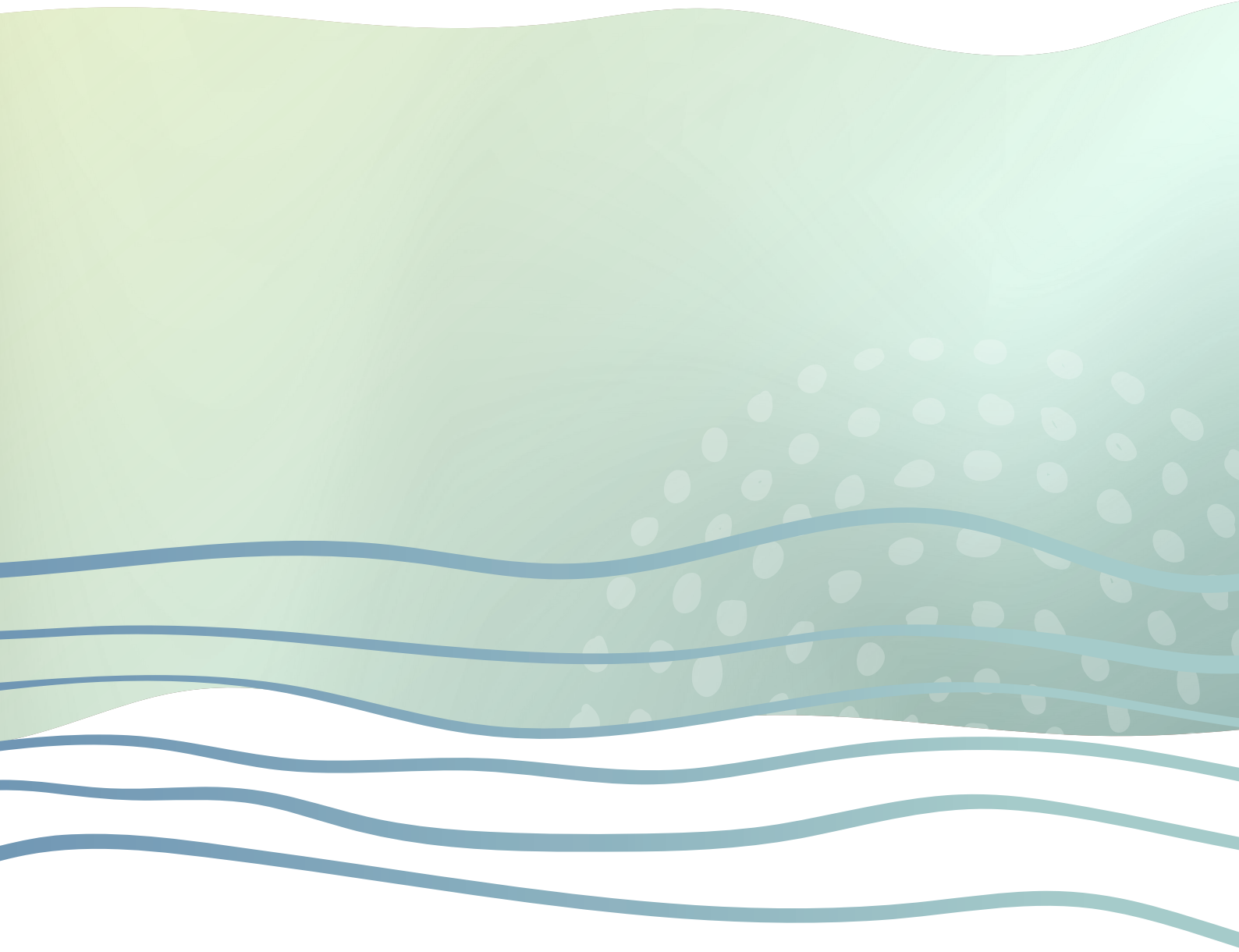
The ***Safer pathways through childhood framework*** sets the direction of the QFCC's child death prevention functions over the next 5 years. The Action Plan for the coming year can be found on the QFCC's website: **www.qfcc.qld.gov.au/safer-pathways-through-childhood**

The QFCC worked in partnership with the Queensland Paediatric Sepsis Program at Children's Health Queensland to complete Australia's first population-based study to better understand the true incidence of childhood deaths from sepsis. The ***Queensland paediatric sepsis mortality study*** was released in February 2024 and identifies opportunities for practice improvements that can lead to better identification of sepsis in children.

Collaborative partnerships

This report includes chapters on categories of death and identifies trends and findings that may require deeper investigation. The QFCC values the expertise of others and would welcome opportunities to work with stakeholders undertaking related initiatives.

Data for prevention activities	Resources available at www.qfcc.qld.gov.au/about-us/publications/child-death-reports-and-data
The QFCC 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 QFCC can provide detailed child death data to genuine researchers and organisations at no cost. Email **child_death_prevention@qfcc.qld.gov.au**	Annual report resources • 20-year summary tables • fact sheets • Australian child death statistics 2022 • Appendices B to G *Safer pathways through childhood framework 2022–2027*



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