

Media release

NSW infant and child death rates are declining overall but there are inequalities for some groups of infants and children

27 November 2023

The NSW Child Death Review Team's (CDRT) *Biennial report of the deaths of children in New South Wales: 2020 and 2021, incorporating reviewable deaths of children*, was tabled in Parliament by NSW Ombudsman Paul Miller today. The report details how infant and child mortality rates in NSW fell between 2007 and 2021.

The decline has occurred across most causes of death – including from natural causes and external causes such as transport, drowning and other unintentional injury-related causes. The infant (under 1 year) death rate decreased by 28% and the death rate declined by 24% for children aged 1 to 17 years. However, the falling infant and child mortality rates are not equal across some groups or across NSW.

'It is pleasing to be able to report that infant and child mortality rates in NSW are, overall, continuing to decline in NSW,' said Mr Miller. 'However, there remains much more to be done to prevent the deaths of children in NSW.'

'There continue to be significant inequalities in mortality for some children. Consistent with previous reports, children from Aboriginal and Torres Strait Islander families, those living in regional and remote areas, those living in the most socioeconomically disadvantaged areas, and those with a child protection history are generally at higher risk of death than their peers.'

The report also finds while the leading cause of death differed by age, natural causes (including congenital conditions and cancer) result in more deaths than external causes (including accident, homicide, and suicide) for children.

For infants, the leading cause of death was perinatal conditions (including prematurity); and for children aged 1-9 years, the leading cause of death was cancer.

However, among all individual cause categories, suicide has become the leading cause of death for children and young people aged 10 to 17 - with the rate of suicide increasing by 68% over the 15-year period. Mr Miller said that:

'No single factor or combination of factors can predict suicide. However, there are a range of recognised factors associated with suicide risk, including proximal events, individual factors, family and relationship breakdown, school-related challenges, and self-harm behaviours. The more risk factors a young person has in their life, the greater their risk of suicide. Some young people appear to be particularly vulnerable to suicide – Aboriginal and Torres Strait Islander children, those with poor access to mental health services, those with an eating disorder, and LGBTIQ+ young people.'

The Ombudsman also tabled the *Reviews of deaths of children in care and certain other children – reviewable deaths in 2020 and 2021* as an annexure to the Report. 31 of the 950 deaths (9 in 2020 and 22 in 2021) covered by the Report were reviewable by the Ombudsman because the child had died as a result of abuse or neglect or suspected abuse or neglect (22), or had been living in care (12) (including 3 cases where both applied).

The reviewable deaths work of the Ombudsman focuses on how agencies and service providers identified and responded to risks and vulnerabilities evident in the lives of the children who died. The Ombudsman also makes, and tracks the implementation of, recommendations to improve those responses in future.

The Ombudsman also tabled a CDRT research report *Infant deaths from severe perinatal brain injury in NSW, 2016-2019: key thematic observations*. The research report discusses issues identified in a preliminary study of 101 infant deaths from severe perinatal brain injury over a 4-year period.

‘On behalf of the CDRT and the NSW Ombudsman, I wish to convey my sincere condolences to the families and friends of the infants, children and young people who have died, and whose deaths are considered in this report,’ said Mr Miller. ‘It is our responsibility that, in reviewing these deaths, we learn from them and use that knowledge to make a difference.’

The full report is available on the [NSW Ombudsman website](#).

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