ACT Children & Young People
Death Review Committee

Biennial Report 2024/2025

The ACT Children and Young People Death Review Committee (the Committee) is established under the *Children and Young People Act 2008* (ACT) to work towards reducing the number of deaths of ACT children and young people. The Committee reports directly to the Minister for Children, Youth and Families.

The Committee aims to investigate what can be learned from a child's or young person's death to help prevent similar deaths occurring in the future. To achieve this aim, we maintain the ACT Children and Young People Deaths Register, a register of all deaths of ACT children and young people who die before they turn 18 years of age. The information on the Register is used to learn about why and under what circumstances children and young people die in the ACT.

We make recommendations about reform to legislation, policies, practices and services to government and non-government organisations. The Committee also undertakes research and analysis in relation to serious injuries, to understand any contributing factors of a specific cause of death in children and young people.

The Committee does not investigate or determine the cause of death of a particular child or young person, nor do we place blame or seek to identify underperformance of individuals.

The Committee is keen to receive advice and feedback from interested ACT residents.

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

Lifeline: Phone: 13 11 14

Beyond Blue: Phone: 1300 224 636

Kids Helpline (for 5–25-year-olds): Phone: 1800 551 800

13YARN [Thirteen YARN] for Aboriginal and Torres Strait Islander people: Phone: 13 92 76

Aboriginal and Torres Strait Islander peoples should be aware that this report contains data about deceased children and young people.

Enquiries about this publication should be directed to:
ACT Children and Young People Death Review Committee
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Website: ACT Children & Young People Death Review Committee

Please Note: Further details about the children and young people mentioned within this report will not be released.

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ACT Children & Young People Death Review Committee

Letter of transmission

Minister for Children, Youth and Families
ACT Legislative Assembly
London Circuit
CANBERRA ACT 2601

Dear Minister

As chair of the ACT Children and Young People Death Review Committee, I am pleased to present you with the *Children and Young People Death Review Committee 2024/2025 Biennial Report*.

This report fulfils the Committee's statutory obligations under s 727S of the *Children and Young People Act 2008* (ACT).

I hereby present the report for tabling in the Legislative Assembly and request that you make the report public.

Yours sincerely



Ms Megan Mitchell, AM
Chair
25 June 2026

Chair's foreword

The ACT Children and Young People Death Review Committee (the Committee) is pleased to present its 12th report to the ACT Legislative Assembly. It is presented in line with the requirements of Pt 19A.4 s 727S of the *Children and Young People Act 2008* (ACT) (the Act).

First, I would like to extend our sincere condolences to the families, friends and communities who knew and loved the children and young people whose deaths are contained within this report. Through research and analysis of patterns and trends, and by highlighting the circumstances relating to these deaths, the Committee aims to effect change that will help prevent and reduce deaths of children and young people in the ACT.

From 1 July 2024, the Committee also began collecting death data from young adult (18–24 years), to better understand emerging patterns and potential points of preventable harm as young people transition into adulthood. This expanded dataset allows for earlier identification of trends and risk factors, such as health, service engagement, social circumstances and system contact. By monitoring these deaths alongside child and young person data, the Committee aims to build a more comprehensive picture of the vulnerabilities experienced during late adolescence and early adulthood. Over time, this work will strengthen the evidence base needed to inform policy, guide cross-agency responses and improve outcomes for children, young people and young adults in the ACT.

The Committee has continued to work closely with the ACT Health and Community Services Directorate Epidemiology Section in reviewing and analysing the severity, patterns and emerging trends of injuries experienced by children, young people and young adults in the ACT. This collaboration provides access to detailed population-level data that supports a deeper understanding of the causes, circumstances and outcomes associated with both unintentional and intentional serious injuries. Through this partnership, the Committee has the potential to identify shifts in injury severity, monitor changes over time and examine the impact of demographic, social and environmental factors. These insights are critical to informing the Committee's review priorities, strengthening prevention efforts and supporting cross-agency strategies aimed at reducing harm and improving safety outcomes for children, young people and young adults across the ACT.

During this reporting period, the Committee focused on 2 priority areas. The first relates to information sharing, privacy and consent, examining how existing legislative and policy frameworks operate in practice and the extent to which they support safe, timely and coordinated responses for children, young people and families. The second area focuses on transport-related deaths and serious injuries in the ACT, with work underway to better understand contributing factors, system interfaces and opportunities for prevention. Together, the research streams aim to strengthen the evidence base that informs the Committee's recommendations and enhance efforts to reduce preventable harm. We thank the organisations assisting us with this research. The Committee is continuing work on these projects and anticipates releasing both reports in 2026 and 2027.

We thank the ACT Government directorates for their time, continued partnerships and responsiveness in reviewing and responding to our recommendations. Finally, I commend the Secretariat and Committee members for their contributions over the past 2 years, and their exemplary work in producing this report and drawing out the critical insights needed to guide our future efforts.

Ms Megan Mitchell AM
Chair, ACT Children and Young People Death Review Committee

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Acknowledgements

The ACT Children and Young People Death Review Committee (the Committee) acknowledges the Traditional Custodians of the land on which we work and pay our respect to Elders past and present. We recognise the enduring connection of Aboriginal and Torres Strait Islander peoples to Country, culture and community.

The Committee acknowledges the significant disadvantage experienced by many Aboriginal and Torres Strait Islander families and communities and the profound impact this has on the lives of children and young people. We also recognise the challenges and impacts that arise when systems do not respond to the needs of Aboriginal and Torres Strait Islander families, or work together effectively, and how this can compound disadvantage and vulnerability. This understanding informs and shapes our work, guiding our commitment to ensuring that our reviews, recommendations and actions contribute to reducing inequities and improving outcomes for Aboriginal and Torres Strait Islander children, young people and their families.

Looking forward, the Committee is committed to working in genuine partnership with Aboriginal and Torres Strait Islander communities, listening deeply and embedding cultural safety and equity in all aspects of our work. We strive to contribute to a future where every child and young person is safe and can thrive.

The Committee acknowledges the profound grief and loss experienced by families, friends and communities following the death of a child or young person. Every death is a devastating tragedy, and we recognise the enduring impact the loss of a child has on those who loved and cared for them.

While reviewing the deaths of children and young people is inherently challenging and emotionally demanding, it remains a privilege for the Committee to perform this work. Through careful examination of the circumstances surrounding each death, the Committee seeks to improve understanding of the factors that contribute to risk and support efforts aimed at preventing future harm. In doing so, we honour the lives of the children and young people who have died.

The Committee wishes to acknowledge and thank the following partner organisations, whose support is essential to enabling the Committee to carry out its functions:

- Australian and New Zealand Child Death Review and Prevention Group
- Access Canberra — Births, Relationships and Deaths
- ACT Coroner's Office
- ACT Emergency Services
- ACT Family and Federal Court
- ACT Policing
- Canberra Health Services
- Chief Minister, Treasury and Economic Development Directorate
- City and Environment Directorate
- Education Directorate
- Health and Community Services Directorate
- National Coronial Information System.

We also acknowledge the many community members, organisations and individuals who continue to support the Committee's work. Their insights, collaboration and commitment play a vital role in improving the safety and wellbeing of children and young people.

Executive summary

The ACT Children and Young People Death Review Committee's (the Committee) core purpose is to contribute to the reduction of preventable deaths and serious injuries among children and young people in the ACT. It does this by systematically reviewing deaths, identifying patterns and trends, and making evidence-based recommendations to improve legislation, policy, practice and service delivery. This report presents a comprehensive overview of the Committee's data analyses, death reviews and priority initiatives undertaken to strengthen understanding of, and responses to, child and youth mortality and serious injury in the ACT.

Established in 2012, the Committee maintains the ACT Children and Young People Deaths Register (the Register). From July 2012 to 31 December 2025, the Register recorded a total of 784 deaths of children and young people aged under 18 years. Given the relatively small number of deaths that occur in the ACT each year, data is analysed and reported in 5-year aggregate periods to promote statistical reliability, protect privacy of families and minimise the risk of identifying individuals. Findings should therefore be interpreted with appropriate caution.

In accordance with section 727S of the *Children and Young People Act 2008*, this report fulfils the Committee's statutory reporting obligations. It presents findings and analyses relating to deaths of children and young people, reviews progress in implementing recommendations from previous reports and outlines the Committee's forward work priorities.

During the 2021–2025 reporting period, 207 deaths of children and young people aged under 18 years were recorded on the Register. Of these, 24 deaths are awaiting coronial findings and are therefore excluded from most analyses in this report. Of the remaining 183 deaths, 55 children and young people did not normally reside in the ACT.

Deaths in infancy continues to account for the majority of child deaths in the ACT over the period 2021–2025. Infants under one year of age represented 84.1% of child deaths, with 85.7% of these occurring in the neonatal period (< 28 days). Among ACT-resident child deaths, medical causes accounted for just over half (52.3 %), with extreme prematurity contributing a further 41.4%. The ACT Perinatal and Maternal Mortality Committee produces 5-yearly reports that characterise this population in more detail.

These findings reflect both population characteristics and the role of ACT hospitals as regional referral centres for high-risk pregnancies from surrounding NSW regions. While mortality rates in the ACT fluctuate from year to year due to the small population size, longer-term trends indicate that they are broadly comparable with national rates.

Over the 5-year period, a total of 40 deaths of ACT resident children and young people aged 1–17 years were recorded. Of these, 12 died in other jurisdictions and 13 are open coronial matters. Males accounted for 62.5% of deaths, consistent with national and international patterns. Among older children and young people (over 1 year of age), deaths due to injury and poisoning (5.5%), cancers (4.7%), and diseases of the nervous system (6.3%) were more prominent. Deaths attributed to intentional self-harm occurred during the reporting period but were few in number and are not reported separately in this report, to minimise the risk of identification.

Aboriginal and Torres Strait Islander children and young people accounted for 7.0% of ACT resident deaths during the reporting period. Given the small numbers involved, these findings should be interpreted with caution. Although this proportion is higher than the representation of Aboriginal and Torres Strait Islander children and young people in the ACT population (4.1%), the data alone cannot explain the complex individual, family, community and cultural contexts in which these deaths occurred.

Rather, the findings reinforce the importance of understanding broader social and systemic influences and supporting the health and wellbeing of Aboriginal and Torres Strait Islander children, young people and families through culturally safe, strengths-based and community-led approaches.

The number of injury-related deaths among children and young people decreased during the reporting period. Due to the very small number of cases and the associated risk of identification, detailed information about these deaths cannot be publicly reported. To support prevention efforts, the Committee has supplemented its analysis of deaths with a review of serious injury hospitalisations among children, young people and young adults aged 0–24 years. This analysis highlights clear age-related patterns, with serious injuries increasing during adolescence and early adulthood and head injuries representing the most common injury type across age groups. These findings reinforce the importance of targeted prevention strategies focused on transport safety, sport and recreation, and risk-taking behaviours.

The majority of children and young people who died (92.1%) were not known to Children Youth and Families (CYF) within the 3 years prior to their death. Of those who were known to CYF, most were the subject of child concern reports only, with very small numbers subject to higher-level statutory intervention. Detailed figures are suppressed to protect privacy.

A key component of this report is the review of progress against 18 recommendations made in previous special reports. The Committee notes substantive progress in several areas, including regulatory reforms to improve swimming pool safety, which it considers largely achieved. Other priority areas such as youth suicide prevention, information sharing and privacy, assessment of cumulative risk, and consistency in assessing parenting capacity require ongoing monitoring. While a range of positive initiatives and programs have been implemented, the Committee emphasises the importance of robust evaluation to determine their effectiveness in improving outcomes for children and young people.

The Committee continues to strengthen its understanding of issues affecting children and young people through strategic partnerships within the ACT and nationally through the Australian and New Zealand Child Death Review & Prevention Group. This includes active participation in cross-jurisdictional work to support the development of a national child death data collection.

Looking ahead, the Committee has identified a forward work program that includes thematic reviews on information sharing, privacy and consent, to ensure appropriate information sharing occurs when a child or young person is at serious risk, and transport-related deaths and serious injuries, to inform educational and regulatory interventions. This will occur alongside continued monitoring of overall trends in child, young person and young adult deaths. Through this work, and in partnership with government, services and the community, the Committee seeks to strengthen the evidence base for prevention and contribute to reducing preventable deaths and serious harm among children and young people in the ACT.

Report Structure

Chapter 1 provides an overview of all registered deaths of children and young people who were residing in the ACT or were in the ACT when they died.

Chapter 2 examines the deaths of all ACT residents aged 0–17 years excluding those children and young people who died in the ACT, but who normally resided interstate or elsewhere. The chapter provides demographic and individual characteristic analyses.

Chapter 3 focuses on infant (0–365 days) deaths. It includes ACT and non-ACT resident deaths.

Chapter 4 focuses on the deaths of ACT resident children and young people (1–17 years old).

Chapter 5 examines the deaths of ACT resident children and young people (0–17 years old) known to Children, Youth and Families.

Chapter 6 examines injury-related deaths on the Committee's Register.

Chapter 7 details the recommendations made by the Committee since its establishment and the progress of these towards implementation.

Chapter 8 details the Committee and its governance. It lays out the legislative requirements of this report and future priorities.

The **appendixes** provide further information for reading, understanding and interpreting the findings in this report, including relevant population, data tables and advice provided by directorates in relation to the recommendations.

Introduction

This biennial report covers the period 1 January 2021 to 31 December 2025, unless otherwise specified. It presents data on the deaths of all children and young people who died in the ACT as well as children and young people who usually reside in the ACT, but who died elsewhere.

As in previous years, the Committee has reported the incidence of death over a 5-year period. This is due to the small number of deaths that occur in the jurisdiction each year. Conducting and reporting on analyses over a 5-year period brings a level of stability to the data, allows for generalisations to the broader population and minimises the risk of identification of any individual.

This report provides a review of the Committee's progress of its recommendations since its establishment, outlines the Committee's activities during the 2024–25 reporting period and sets out the program of work to be undertaken during 2026.

This biennial report is a legislated requirement of the Committee and can be used as a catalyst or foundation for further investigations. To increase transparency and to enable greater use of, and reporting on, the findings of this report, it is important to clarify the methods used.

Coronial counts

In previous reports, the number of deaths being heard by the Coroner has been reported in different ways. This was largely due to confidentiality concerns arising from the small number of cases and determinations on causes of death. Reporting on coronial cases by the Committee is also impacted by 2 factors: the legislative requirement not to comment on open coronial matters and the delays in finalising coronial cases.

The legislation stipulates that the Committee must not report on the causes of death in those cases being heard in the Coroner's Court at the time of publishing. However, this stipulation does not exclude reporting the total numbers of deaths, including those currently before the Coroner. As such, where total numbers are documented in this report, they will include open coronial cases. These open coronial cases are excluded from subsequent analyses referring to cause of death or chapters that focus on specific populations, as the Committee is unable to code a death until a coronial process is completed.

In the context of coronial inquests into the deaths of children and young people, there are 2 main sources of delay (depending on the case): the need for expert medical and/or forensic investigation and the requirement to 'pause' coronial proceedings where there are related criminal proceedings underway. Where coronial inquests remain open beyond the 5-year reporting period of the Committee's report, data about those cases will not be captured. In such circumstances, comment will be made on specific cases in the subsequent years' report and future relevant thematic reviews, noting that information about coronial findings where public hearings have been held is ordinarily in the public domain.

Cause of death classification

Since the inception of the ACT Children and Young People Deaths Register (the Register), the indicative cause of death, or main underlying cause of death, was reported and analysed in the following categories: extreme prematurity; medical causes; transport; unintentional injury or accident; suicide;

drowning; co-sleeping; fatal assault and neglect; drug overdose; sudden infant death syndrome (SIDS) and undetermined; and unascertained. The Committee now also reports on cause of death within the International Classification of Diseases (ICD) framework, in line with World Health Organization standards (WHO, 2026). This report will continue the format adopted in the previous reports and include both the indicative causes of death and the ICD code(s) and categories. Version, or 'revision', 10 of the ICD codes (ICD-10) is used in this report.

Reporting fewer than 5 cases

Given the small number of child or young person deaths in the ACT and the broad range of causes of those deaths, there will often be only one or two individuals who have died in a particular category. The same can be true when reporting on a small sub-sample of the cohort. The ACT is a small community, and individuals may be identified through the reporting of these low numbers. Therefore, where the number in a category is less than 5 and an individual may be identified, the symbol • is used in tables to indicate that deaths have occurred but not how many. In some instances, further data have been suppressed to prevent calculation of figures. However, the suppression of data will not occur when it significantly impacts on the Committee's ability to report population trends. In these instances, calculation of counts may be possible. The identity of a child or young person who has died will not be disclosed in this report. The suppressed data remain included in total figures and in counts aggregated over 5 years.

Date-of-death reporting for the Register

For this report, the Committee has determined it will use the actual date of death of each child or young person in the ACT, rather than the date of death registration unless otherwise indicated. This provides an actual number of child and young person deaths for the reported 5-year period. The time between the actual date of death and the date of death registration can be substantial and, in that time, there may have been changes to, or knowledge of, the relevant circumstances. Adjustments to the Register may occur if information is updated, for example, due to late registration of deaths or if more accurate details have been identified and made available to the Committee.

While every effort has been made to compare deaths in the ACT and nationally by year of occurrence, year of registration of ACT deaths may be required for comparisons with national death data which is often reported by year of registration only. This will be acknowledged in footnotes, where appropriate.

As the Committee is using the actual date of death rather than the date of death registration, there may be discrepancies between the information in this report and information reported by the ACT Registrar of Births, Relationships and Deaths – previously ACT Births, Deaths and Marriages – and remains legislated under the *Births, Deaths and Marriages Registration Act 1997* (*Cth*), the Australian Bureau of Statistics (ABS), other agencies and other Australian jurisdictions.

Confidence intervals

Many of the line graphs in this report include 95% confidence intervals. Confidence intervals are the vertical lines above and below a data point that show how confident we are that the values calculated are close to the true values and not due to random fluctuation or other random biases in the data. The shorter the vertical line, the more confidence we have. This is especially important when comparing data from small groups, such as those in this report. Measurements from a large group will have smaller

confidence intervals than measurements from a smaller group because the effect of random errors reduces as the group (or sample) size increases.

When confidence intervals from 2 different groups (such as the ACT and Australian populations) overlap, we cannot say with confidence that there is a real difference between the groups. When the confidence intervals do not overlap, we can be confident that the difference is statistically significant and not just due to chance.

Data quality

The Committee continues working to improve data quality so that factors contributing to reported deaths can be more accurately identified. Anecdotal information reported by members indicate that official causes of death do not always reflect the full story. Cases that have been subject to the rigour of a coronial inquest provide excellent information to the Committee. Once timely, complete and more reliable information is available for all deaths, improvements to systems and processes can be identified to prevent or reduce deaths in the future.

The database used to maintain the Register continues to be challenging in terms of complexity, reliability and capacity to effectively interrogate. The Committee continues to explore options to address these database issues and potential resolutions.

Data sources

Unless otherwise stated, all figures reported in this document are sourced from the Register, which comprises information from:

- ACT Births, Relationships and Deaths register—also known as ACT Births, Deaths and Marriages
- ACT Coroner's Court
- Ombudsman Western Australia
- South Australia Child Death and Serious Injury Review Committee
- Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- NSW Ombudsman
- Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity
- Northern Territory Office of the Coroner
- Queensland Family and Child Commission
- National Coronial Information System.

The Committee also has provisions to exchange data with ACT Child, Youth and Family Services, ACT Policing, ACT Emergency Services Agency and the Federal Circuit and Family Court of Australia.

Data comparisons with previous reports must consider coronial findings released since those publications, enabling causes of death to be reported.

Time periods

The Committee uses counts aggregated over 5 years due to the relatively small number of child and young person deaths in the ACT. The Committee reports death counts and mortality rates of infants, children and young people in the ACT over the most recent period of 5 years (2021–2025) and over the

15 most recently published years of death data (2010–2024 or 2011–2025, where available). Using 15 years of data allows the Committee to better identify patterns and trends.

The ABS publishes national death data for the most recent year around September of the following year. This means the ABS data for 2025 will be released around September 2026. To allow a comparison of national and ACT death data, the period from 2009 to 2024 will be used in this report where 2025 birth and death data are not yet available.

Mortality rates

Mortality rates are calculated to allow meaningful comparisons over time and between populations by taking population size into account. Simply counting the number of deaths can be misleading, as an increase or decrease may reflect changes in the population rather than a real change in risk. Using rates helps show whether the likelihood of death has actually changed. The infant mortality rate is defined as the number of infant deaths per 1,000 live births, while age-specific mortality rates for older children are calculated as the number of deaths per 10,000 children and young people in a specified age group who are residents of the ACT.

Interpreting data with caution

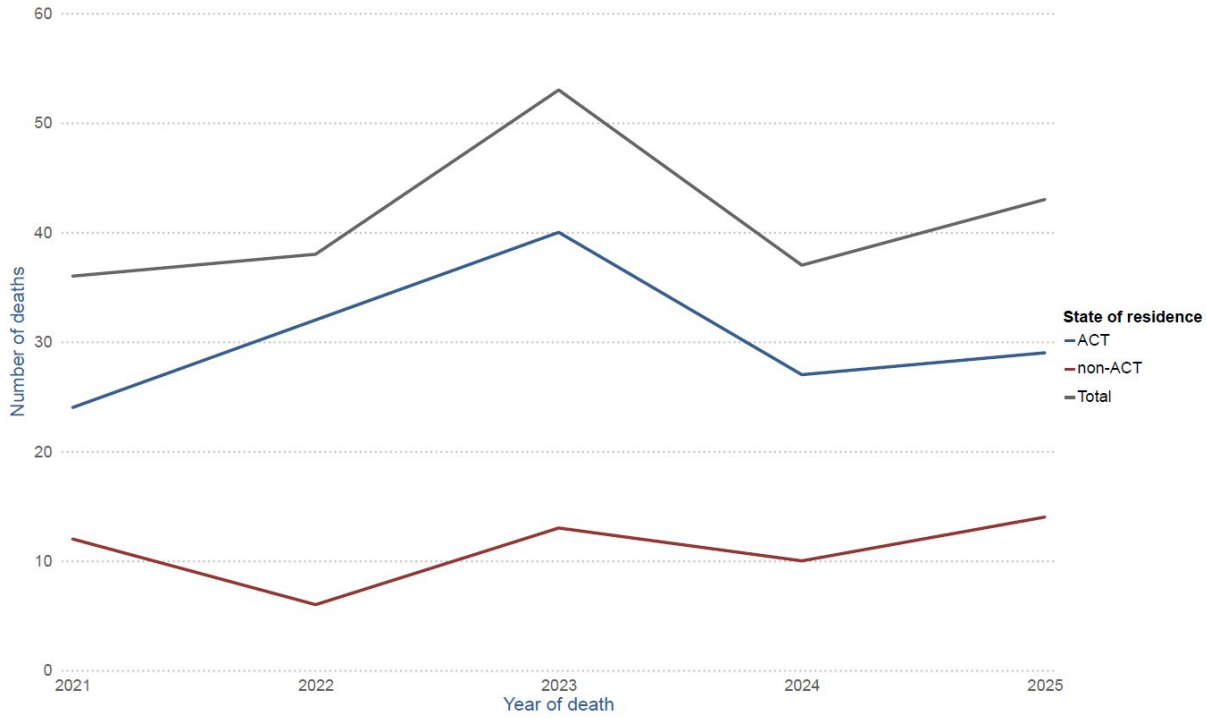
As outlined above, and common to most demographic data, there are data quality issues with death data that could be improved. Sometimes when comparing data from different populations and/or sources, the time periods may not match precisely, the criteria for data collection may differ slightly, or the data may change over time as coronial matters are resolved and death data are updated. All these factors influence the accuracy of the data and how well they compare with other data.

The phrase ‘should be interpreted with caution’ is often used when dealing with small sample sizes and small numbers within a particular category and where data quality issues may be apparent. This report uses the phrase ‘should be interpreted with caution’ frequently, as the counts of births, deaths and the population are small, known to fluctuate year to year and have data quality issues, meaning data can easily be misinterpreted if such factors are not taken into consideration.

Chapter 1 Overview of all ACT deaths

This chapter provides an overview of **all registered deaths of children and young people (including open coronial matters)** that **occurred in the ACT or involved ACT residents** who died interstate or elsewhere during in the reporting period of 1 January 2021 to 31 December 2025 (See Figure 1.1).

Figure 1.1: ACT resident and non-ACT resident child deaths, ages 0–17 years, 2021–2025



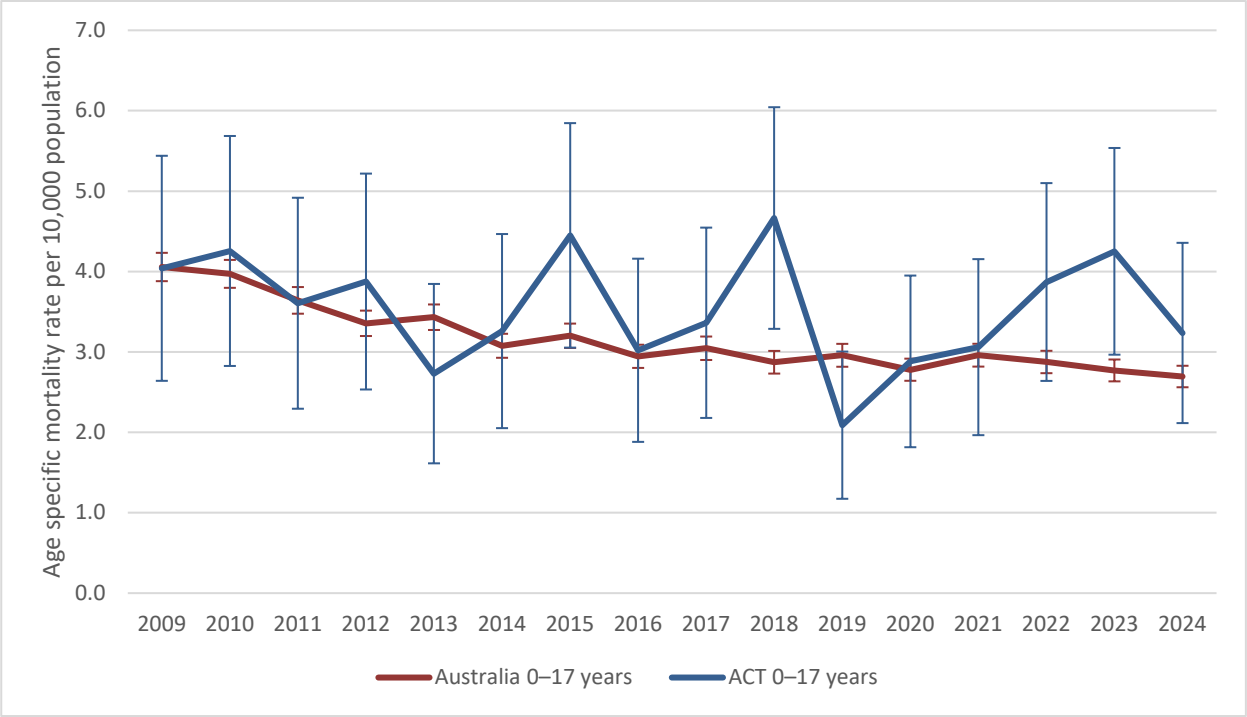
Includes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Includes all deaths of non-ACT residents that occurred in the ACT only.

In total, 207 children and young people died in the 5-year period 2021–2025. Of these, 152 were children and young people who normally resided in the ACT and 55 usually resided interstate. Of the 152 ACT residents, 23 of these deaths occurred outside the ACT.

As of 12 January 2026, there were 24 cases from 2021–2025 before the Coroner in the ACT or in other jurisdictions relating to the deaths of children and young people on the Register, including both ACT resident and non-ACT resident deaths. During the 2024–2025 reporting period, 11 cases were referred to the ACT Coroner.

Age-specific mortality rates for ACT residents and Australian residents aged under 18 years from 2009 to 2024 are shown in Figure 1.2. The size of any population changes over time and therefore looking at the number of deaths alone can make it hard to determine if trends are changing. To avoid this problem, age-specific death rates have been used, in this case, 0–17 years. Figure 1.2 shows that the ACT mortality rate has fluctuated from a high of 4.7 per 10,000 people in 2018 to a low of 2.1 in 2019, with rates for other years falling within this range. Fluctuations in rates and wider confidence intervals are expected in smaller jurisdictions with small numbers of deaths occurring. The ACT rate does not differ significantly from the Australian rate for most years in this period, noting that the ACT rate was significantly higher than the Australian rate in 2018 and 2023.

Figure 1.2: Age-specific mortality rates for children and young people aged 0–17 years, ACT and Australia, 2009–2024



Data Source: Committee calculations for age-specific mortality rates from ABS estimated resident population and death data:

- ABS (2026a) Deaths, Year of registration, Age at death, Age-specific death rates, Sex, States, Territories and Australia [Deaths, Year of registration, Age at death, Age-specific death rates, Sex, States, Territories and Australia]: ACT and Australia, accessed 16 March 2026 (currently available to 2024 only).

ACT residents and non-ACT residents

The Committee collects information relating to the deaths of all children and young people who normally reside in the ACT, whether their deaths occurred in the ACT or elsewhere. This means that information on the Register relating to ACT residents who died outside of the ACT is often provided by similar committees in those jurisdictions. Information is shared between committees to ensure that each jurisdiction has accurate records for their population.

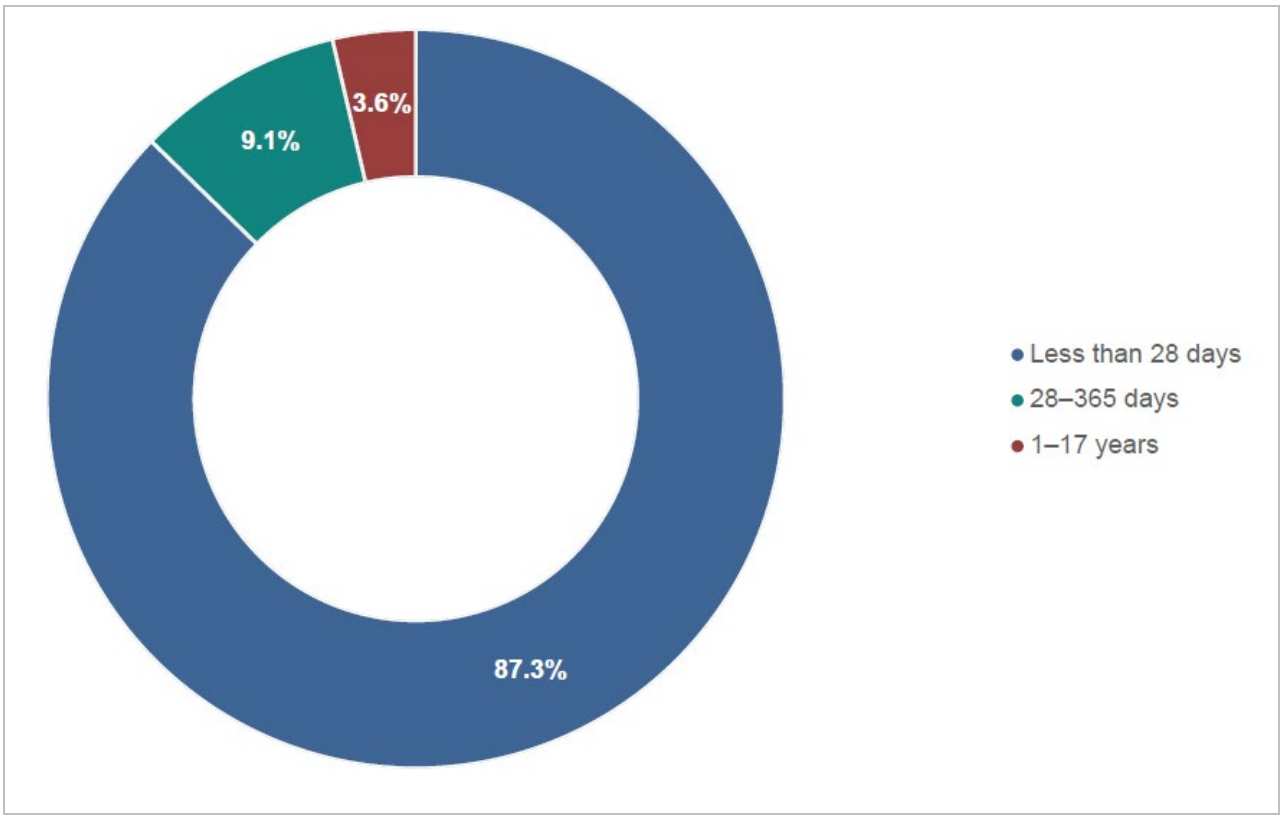
Of all deaths over the 5-year period 2021–2025, 26.6% (55) were not residents of the ACT. More than 90% of non-ACT resident deaths were residents of NSW. The ACT provides high-risk obstetric services and newborn intensive care services to babies from the ACT and surrounding NSW regions. As such, many neonatal deaths of residents from surrounding NSW regions occur in the ACT.

Distribution of non-ACT resident child deaths occurring in the ACT

PAST 5 YEARS (2021–2025)

Over the 5-year period 2021–2025, 87.3% of all non-ACT resident deaths were babies (neonates) aged under 28 days, some of whom were born at a pre-viable gestational age (Figure 1.3). Including infants aged 28–365 days, 96.4% of all non-ACT resident deaths in the territory were infants under one year of age.

Figure 1.3: Non-ACT resident deaths by age group, percentage of non-ACT resident deaths 0-17 years, 2021–2025

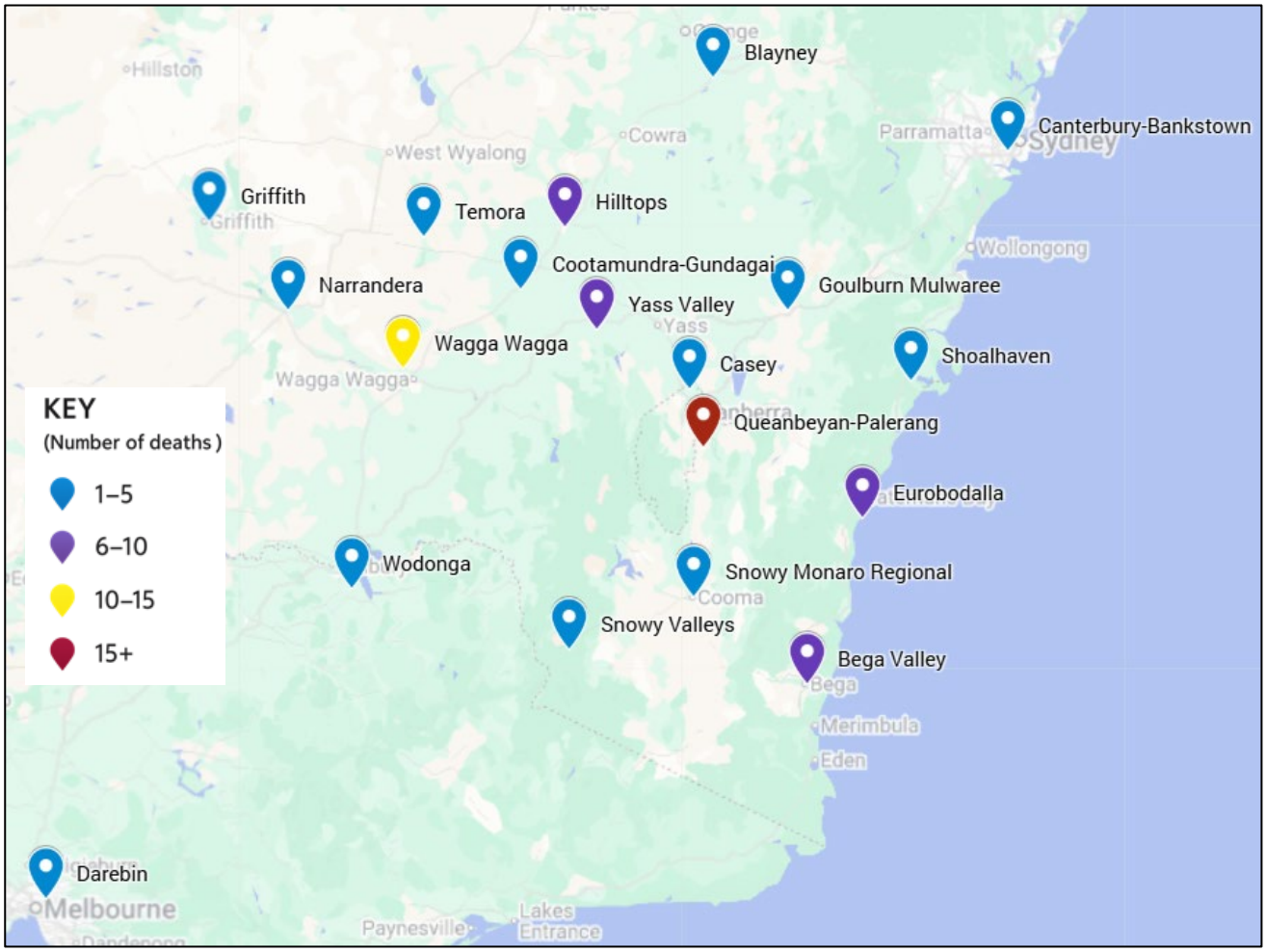


Includes open coronial cases.
Due to small numbers, deaths in the 1–17 year age groups were combined.
Includes all deaths of non-ACT residents that occurred in the ACT.

PAST 15 YEARS (2011–2025)

The Committee has analysed interstate resident deaths over a 15-year period (2011–2025) to identify where in NSW and beyond these children and young people usually lived (Figure 1.4). In the 15 years to 2025, 25.4% of registered deaths in the ACT were non-ACT resident children and young people. Of the non-ACT resident children, 33.3% resided in communities within the surrounding regions of the ACT, including Queanbeyan, Jerrabomberra, Googong, Bywong, Burra, Carwoola, Bungendore and Braidwood. For almost all deaths, The Canberra Hospital was the nearest principal referral hospital, offering a range of highly specialised service units. Principal referral hospitals are generally located in major cities (AIHW, 2015).

Figure 1.4: Distribution of non-ACT resident deaths, 0–17 years, 2011–2025



Includes open coronial cases.
Includes all deaths of non-ACT residents that occurred in the ACT.

Between 2011 and 2025, 79.5% of non-ACT resident children and young people who died in the ACT were under the age of 28 days. Of all ACT-resident and non-ACT-resident deaths occurring in the ACT over the 2011–2025 period, 63.1% were under the age of 28 days. Of the non-ACT resident children and young people who died in the ACT in the 2011–2025 period, 88.9% were under one year of age, whereas this number was 74.9% for all children, regardless of state or territory of residence.

The different age profile of non-ACT residents compared to all deaths on the Register over the period 2011–2025 is indicative of the use of neonatal intensive care and other infant specialist medical services by residents of the surrounding NSW regions. The more detailed analysis of infant deaths in Chapter 3 considers both residents and non-residents of the ACT, to capture the care provided by the ACT health system to the surrounding regions.

Chapter 2 All ACT resident deaths

This chapter reports on the **registered deaths of ACT residents (0–17 years of age) that occurred in the ACT or interstate in the last 5 years** (that is, excluding interstate residents who were included in Chapter 1).

It examines the incidence and causes, as well as other demographic and individual characteristics, of those deaths of ACT residents under the age of 18 years.

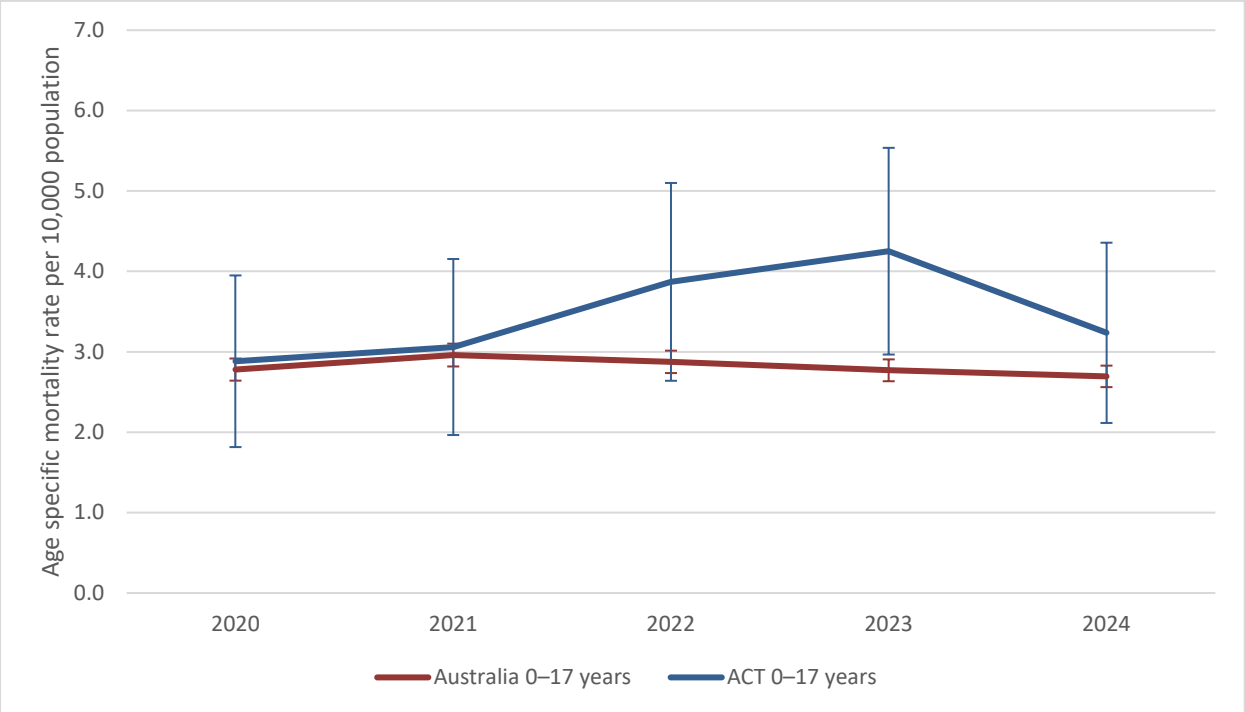
Table 2.1: Deaths of ACT resident children and young people, 2021–2025

Deaths[a]	Number
Total ACT resident deaths	152
ACT residents who died elsewhere	23
Open ACT resident coronial cases	24

[a] Coronial cases appear in more than one category.
Includes only ACT residents aged 0–17 years who died in the ACT or elsewhere.

Figure 2.1 shows the age-specific mortality rates for the ACT and Australia for the period 2020–2024. Being a small jurisdiction, the ACT annual mortality rate for children and young people fluctuated, from a low of 2.8 deaths per 10,000 population in 2020 to a high of 4.2 in 2023. The Committee continues to monitor trends over time.

Figure 2.1: Age-specific mortality rates for children and young people aged 0–17 years (per 10,000 population), ACT and Australia, 2020-2024



Includes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.

Data Source: Committee calculations for infant mortality rates from ABS birth and death data using year of death:

- ABS (2026b), Deaths, Year of registration, Age at death, Age-specific death rates, Sex, States, Territories and Australia accessed 17-19 March 2026 (data currently available to 2024 only).

Including open coronial cases, 129 ACT residents under the age of 18 years died in the ACT and 23 ACT residents died elsewhere in the 2021–2025 period, giving a total of 152 ACT resident deaths. With open coronial cases excluded, there were 128 ACT resident deaths between 2021 and 2025; 108 died in the ACT and 20 died elsewhere.

The following discussion relates to the **128 children and young people** normally a **resident in the ACT** who died in the last 5 years and **excludes** the 24 deaths of ACT residents before the Coroner as of 12 January 2026.

Characteristics of ACT children and young people who died

Examining the demographic and individual characteristics of **ACT resident** children and young people who died between 2021 and 2025 allows comparisons between groups and identification of trends within the population. Examined here are sex, Aboriginal and Torres Strait Islander status, age and cause of death for ACT residents in the 5 years from 2021 to 2025.

Sex

The Committee acknowledges that sex and gender are distinct concepts; however, for the purposes of this report, sex is used as recorded in administrative and health datasets to ensure consistency, comparability and data completeness, consistent with national reporting practices and guidance from the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the National Health and Medical Research Council (AIHW 2023; ABS 2021; NHMRC 2024).

In the period 2021–2025, 62.5% of recorded ACT resident deaths under the age of 18 years were male. Over the 5-year period, the percentage of deaths of male children ranged from 51.4% to 81.0%; these are statistical fluctuations due to the small numbers involved. The Committee continues to monitor this over time.

Aboriginal and Torres Strait Islander children and young people

In 2025, 6.9% of the Australian population aged under 18 years was estimated to identify as Aboriginal or Torres Strait Islander (ABS, 2026e). In the ACT, the proportion was lower, at around 4.1%, having increased slightly since 2021 (3.5%) (ABS, 2026e).

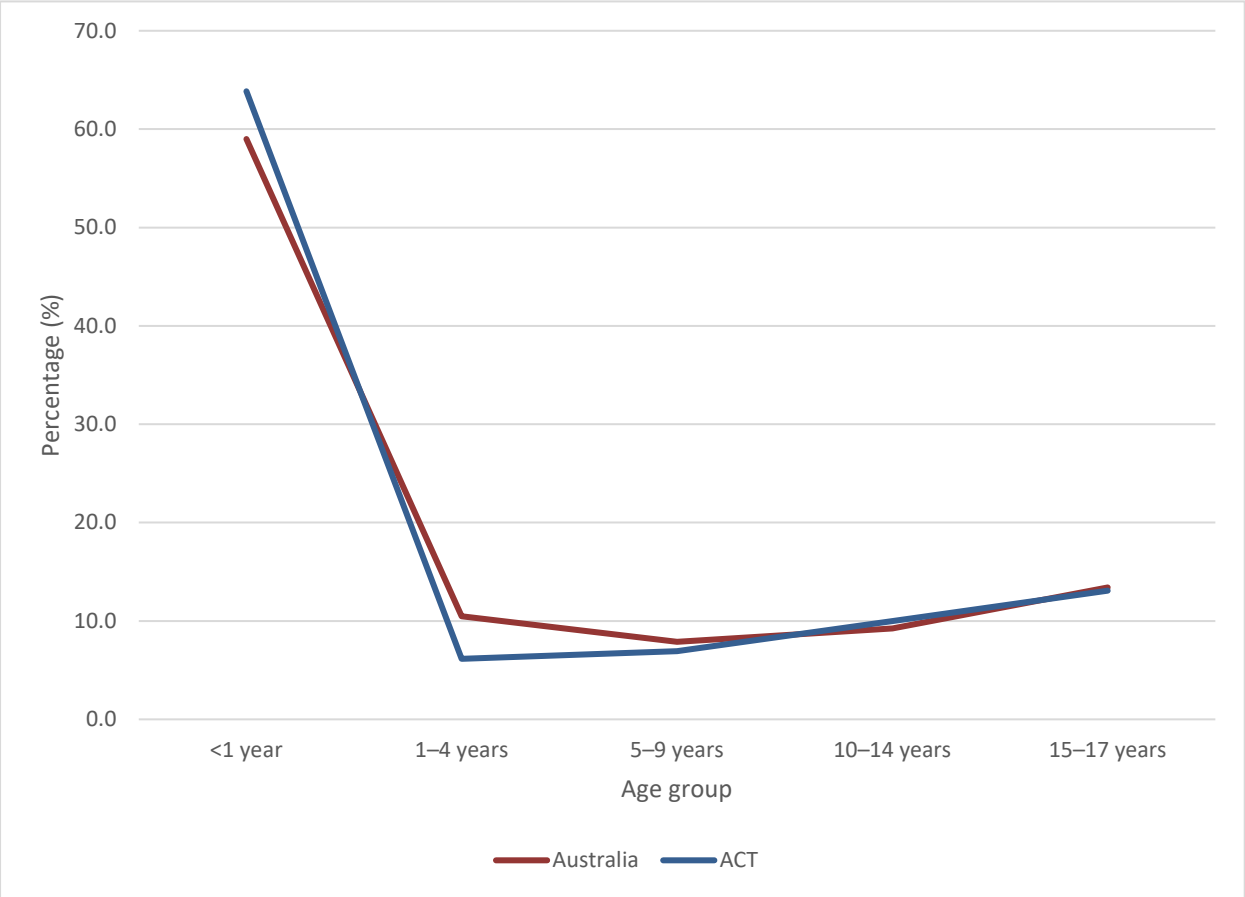
Of the total ACT resident deaths under 18 years of age in 2021–2025, 7.0% were Aboriginal and/or Torres Strait Islander children or young people. Excluding open coronial cases, there were 20 deaths of Aboriginal and/or Torres Strait Islander children in 2021–2025. Of these, 9 were ACT residents and 11 were from outside the ACT, with all non-ACT deaths occurring during the neonatal period (less than 28 days). Over half of the deaths (12; 60%), were due to extreme prematurity and 7 (35%) were due to medical causes. However, these figures should be interpreted with caution due to small numbers and should not be compared with other data.

Age

Mortality risk varies across infancy, childhood and teenage years. Figure 2.2 shows the higher proportion of deaths occurring at less than one year of age followed by a reduction through the primary school years, with an increase again in adolescence and late teens.

The age group with the highest mortality risk is infants younger than 28 days, referred to as neonates. In the ACT, neonate deaths include babies born with signs of life, even when the gestational age is less than 20 weeks or the baby weighs less than 400 grams. Almost half of ACT resident (49.0%) and Australian (45.4%) child and young person deaths between 2020 and 2024 were neonatal deaths (ABS, 2026c).

Figure 2.2: ACT and Australian child and young person deaths by age as a percentage of total deaths under 18 years, 2021-2024



Data Source: Committee calculations for infant mortality rates from ABS birth and death data using year of death:

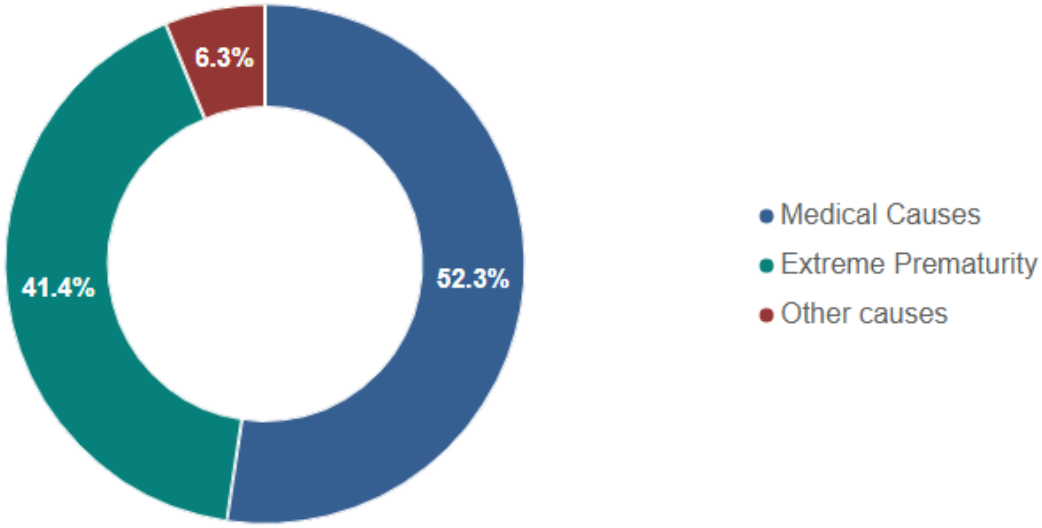
- ABS (2026b), Deaths, Year of registration, Age at death, Age-specific death rates, Sex, States, Territories and Australia accessed 17-19 March 2026 (data currently available to 2024 only).

Cause of death

Figures 2.3 and 2.4 show the causes of all ACT resident child and young person deaths for the 5-year period 2021–2025. They include both indicative causes (Figure 2.3) and those categories outlined in the International Classification of Diseases, Tenth Revision (ICD-10) (Figure 2.4). A full list of tables relating to relevant causes of death are included in Appendix A.

Medical causes accounted for more than half (52.3%) of all ACT resident deaths under 18 years of age, and deaths attributed to extreme prematurity accounted for an additional 41.4% of all deaths. There were less than 5 suicide deaths, and these were included in the 'other causes' category in Figure 2.4.

Figure 2.3: Indicative cause of death of ACT resident children and young people, percentage of total deaths 0–17 years, 2021–2025



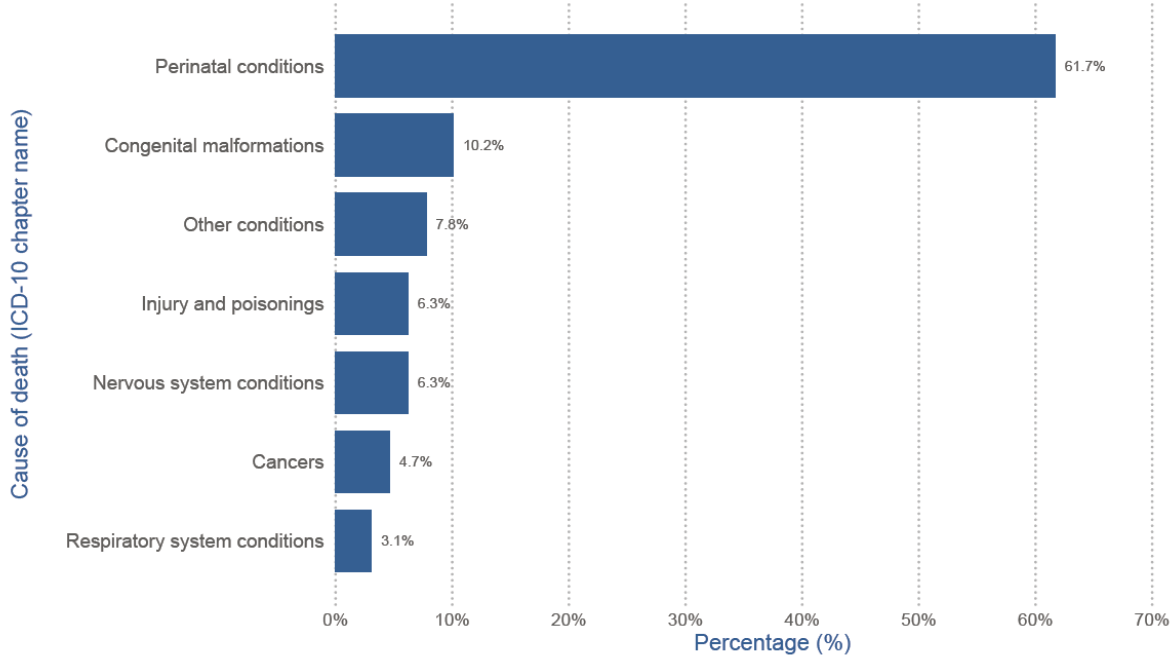
Excludes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Other causes include transport, drowning, sudden infant death syndrome and undetermined, and unintentional injury/accident.

The ICD-10 classification system has been adopted by the international community as a common framework to analyse the health of populations in terms of causes of illness and mortality (WHO, 2011). As a classification system, it provides a common framework, making it an invaluable tool for jurisdictions to determine health and population policy. The ICD-10 also serves as an international benchmark, allowing the World Health Organization to develop national and international mortality and morbidity statistics.

The ICD-10 consists of 22 chapters of broadly defined causes of mortality and morbidity, and each chapter consists of cause of death codes providing progressively finer detail (WHO, 2016). Due to small counts in the ACT data, causes of death in this report is defined at the broadest chapter level of the ICD-10 classification system.

Nearly two-thirds (61.7%) of ACT resident deaths under the age of 18 were due to conditions originating in the perinatal period (Figure 2.5). One in ten (10.2%) deaths under the age of 18 years were due to congenital malformations, and all of these were infant deaths (deaths under one year of age).

Figure 2.4: Leading cause of death (ICD-10) for ACT resident children and young people, percentage of total deaths 0-17 years of age, 2021–2025



Excludes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Other conditions include diseases of the circulatory system, endocrine, nutritional and metabolic diseases, certain infectious and parasitic diseases, external causes of mortality and morbidity, and symptoms, signs and other abnormal clinical findings not elsewhere defined.
Injury and poisonings includes intentional self harm.

Deaths by injury and poisonings, which accounted for 5.5% of all ACT registered deaths under 18 years, were more prominent in older children and young people. Deaths attributed to cancers (4.7% of all ACT deaths under 18 years) were most common among children aged 10–14 years. Diseases of the nervous system accounted for 6.3% of deaths; however, the deaths were more evenly dispersed across age groups. Respiratory system diseases accounted for 3.1% of deaths under 18 years.

Chapter 3 Infant deaths

This section looks at mortality among infants (0–365 days of age) in the ACT. It examines the incidence and causes of infant deaths, as well as other demographic and individual characteristics, with a focus on neonatal deaths (under 28 days). This chapter considers both ACT and non-ACT resident deaths and excludes open coronial matters when discussing demographics and cause of death.

Table 3.1: Breakdown of infant deaths, 2021–2025

Deaths	Number	Per cent
Total [a]	**165**	**100.0**
ACT residents who died in the ACT	101	61.2
ACT residents who died elsewhere	11	6.7
Interstate residents who died in the ACT	53	32.1
Cases before the Coroner	11	6.6

Notes: Includes open coroners' cases. These figures do not sum due to coronial cases appearing in multiple categories.

Health services in the ACT provide care for families with high-risk pregnancies from the surrounding regions, as the ACT is often the closest neonatal intensive care unit. This section of the report considers all deaths of infants, including interstate resident deaths in the ACT. The Committee has also considered infant mortality rates from 2009 to 2024, to review patterns over a longer period.

Infant mortality rates differ from age-specific mortality rates in that the numbers of deaths are compared to the number of live births each year and are reported as the rate per 1,000 live births. Age-specific mortality rates reported elsewhere in this report are per 10,000 population and cannot be compared to infant mortality rates.

The Committee works closely with the ACT Maternal and Perinatal Mortality Committee to review the causes of neonatal deaths. While the analyses in this report examine the numbers of deaths within this cohort, more detailed analyses are available through the reports of the ACT Maternal and Perinatal Mortality Committee, which can be found on the ACT Government website: https://www.act.gov.au/open/epidemiology-publications#Mortality and the Mothers and Babies dashboard: https://www.act.gov.au/directorates-and-agencies/act-health/data-statistics-and-surveys/healthstats-act/statistics-and-indicators.

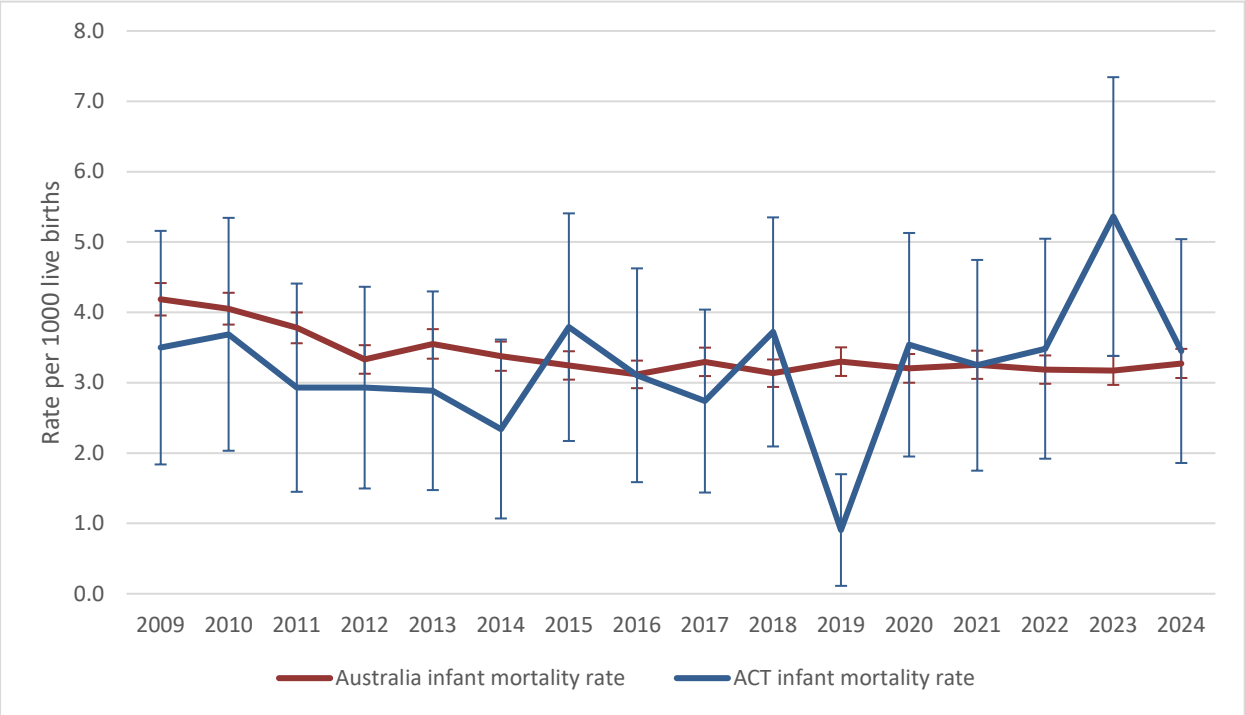
Three hospitals (two public and one private) in the ACT provide maternity services to ACT residents and those of the surrounding regions of NSW. Women in surrounding areas are often referred to the Centenary Hospital for Women and Children, at The Canberra Hospital, for tertiary-level maternal and neonatal care for high-risk pregnancies and births. Rates of neonatal deaths in the ACT are higher than those for ACT residents alone, due to ACT hospitals providing support to high-risk pregnancies from surrounding areas. Late terminations of pregnancy for severe and lethal congenital abnormalities and other medical conditions are included in the Committee's data collection.

The discussion below refers to analyses using different methods, depending on the topic. For infant mortality rates, it only includes ACT residents. For other topics, it includes both ACT residents and people who died in the ACT but lived elsewhere to provide information about overall mortality in the ACT.

Over the period 2009–2024, the infant mortality rate in the ACT fluctuated between 0.9 per 1,000 live births in 2019 and 5.4 in 2023. The national rate remained more stable, with some fluctuations but an overall decline from 4.1 per 1,000 live births in 2008 to 3.3 in 2024. The year-on-year fluctuations within the ACT are consistent with small jurisdictions having small numbers of deaths. The ACT rate was

statistically different from the Australian rate in 2019, when it was significantly lower. It did not differ significantly from the Australian rate in other years.

Figure 3.1: Infant mortality rates (per 1,000 births), ACT and Australia, 2009–2024



Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Infant mortality rates are the number of deaths of infants aged <=365 days, per 1,000 live births, in the ACT or in Australia based on year of registration.
Data Source: Committee calculations for infant mortality rates from ABS birth and death data using year of death:

- ABS (2026d), Deaths, Australia, [Infant deaths and Infant mortality rates, Year of registration, Age at death, Sex, States, Territories and Australia]: ACT and Australia, accessed 19 March 2026 (data currently available to 2024 only).

Characteristics of infants who died

The following discussion describes the age and cause of death for infants who died in the 5-year period 2021–2025.

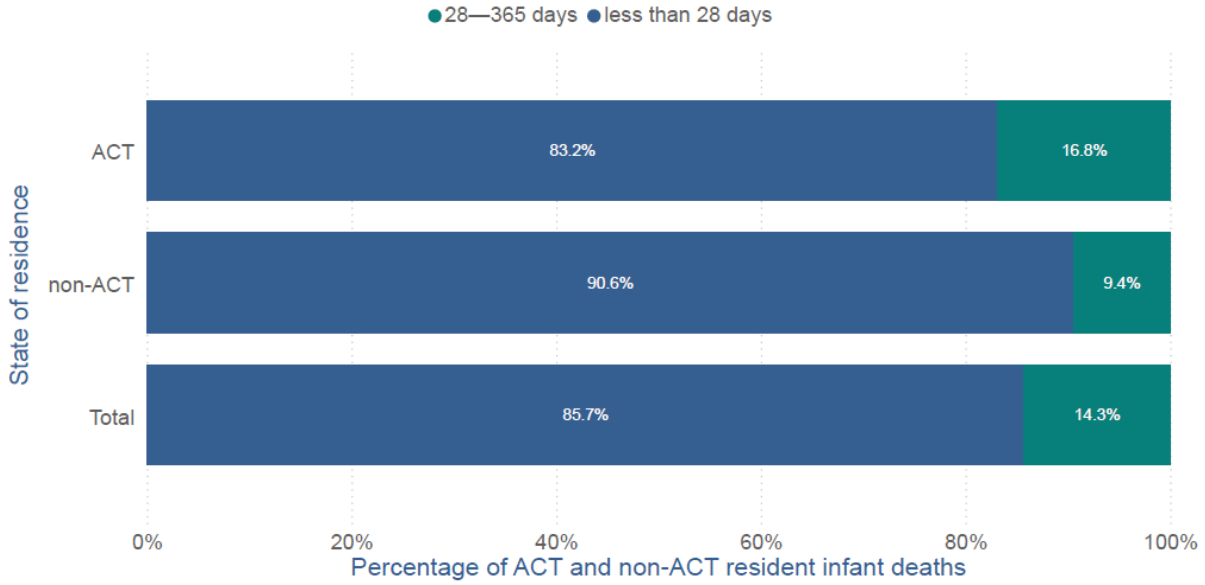
The following discussion relates to the **154 infants** who were either ACT residents (who died in the ACT or elsewhere) or non-ACT residents who died in the ACT in the last 5 years and **excludes** open coronial matters. This section provides figures for both ACT and non-ACT resident deaths, to capture overall mortality.

Age

Over the 5 years to 2025, 85.7% of infant deaths on the Register occurred during the neonatal period (0–28 days) (Figure 3.2). This equated to 83.2% of ACT resident infants and 90.6% of non-ACT resident infants. Of these neonatal deaths, most occurred within the first 7 days of life. There was a higher

percentage of neonatal deaths for non-ACT resident deaths than ACT resident deaths, likely due to clinical referral pathways for families with high-risk pregnancies from surrounding regions of NSW.

Figure 3.2: Age of death by place of residence, 2021–2025, percentage of total infant deaths

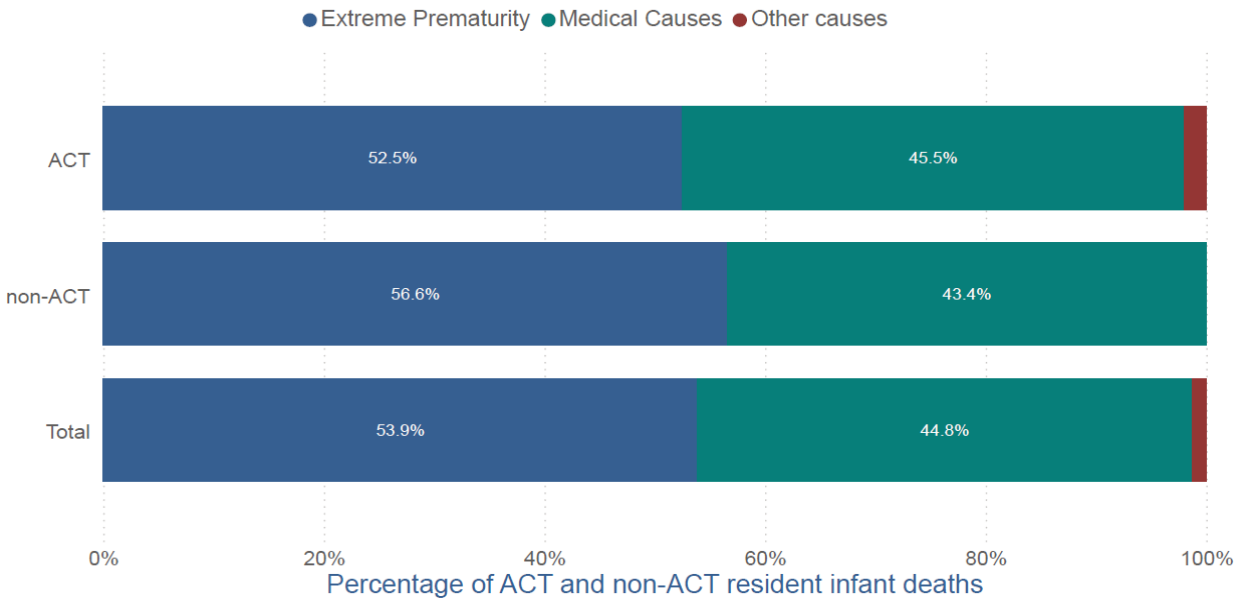


Excludes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Includes all deaths of non-ACT residents that occurred in the ACT only.

Cause of death

Considering all deaths of infants in the ACT, the main indicative cause of death for children under one year of age from 2021 to 2025 was extreme prematurity (53.9%), followed by medical causes (44.8%) (Figure 3.3). Most deaths in the <28 days age group (56.8%) were attributed to extreme prematurity.

Figure 3.3: Indicative cause of death for infants <one year of age who died in the ACT, by place of residence, 2021–2025



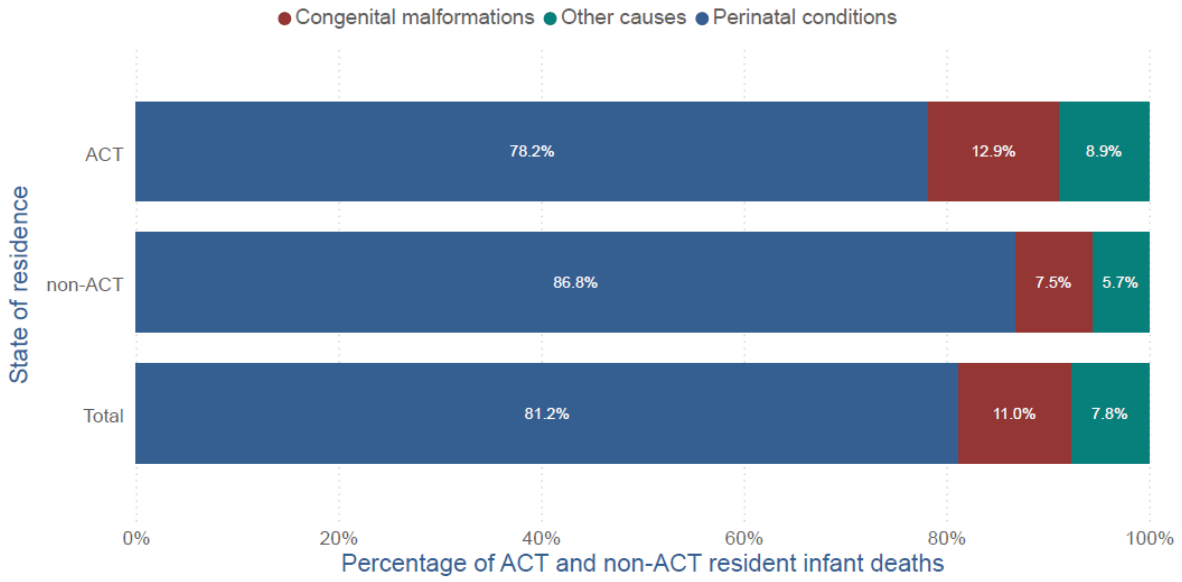
Excludes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Includes all deaths of non-ACT residents that occurred in the ACT only.

Some babies are born very early and are too small to survive outside of the womb or to be offered intensive care support. This can happen for many different reasons. As these deaths contribute to the numbers of deaths related to extreme prematurity, it is important to note that at the time of this report being written, in the ACT, 23 weeks gestation was the earliest gestation at which families were able to choose intensive care support for their baby.

The ICD-10 defines the category of 'certain conditions originating in the perinatal period' as deaths whose cause originated in that period, even though the death may occur later in life. These can include, but are not limited to, complications during labour and delivery, infections specific to the perinatal period, blood disorders and concerns, other internal disorders (e.g., endocrine or respiratory disorders), and temperature regulation (WHO, 2010).

Perinatal conditions were the major cause of death (78.2%) for ACT resident infants (Figure 3.4). Of the NSW resident (non-ACT resident) infant deaths that occurred in the ACT, 86.8% were attributed to perinatal conditions. Congenital malformations, deformations and chromosomal abnormalities were the second-most prevalent cause for both ACT and non-ACT resident infant deaths (11.0% of all infant deaths occurring in the ACT).

Figure 3.4: ICD-10 causes of death for infants < one year of age who died in the ACT, by place of residence, 2021–2025



Excludes open coronial cases.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Includes all deaths of non-ACT residents that occurred in the ACT only.
Other causes include the ICD-10 chapters Injury and poisonings, Diseases of the circulatory system, Diseases of the nervous system, Diseases of the respiratory system, Neoplasms (cancers), Endocrine, nutritional and metabolic diseases, sudden unexpected death in infancy, sudden infant death syndrome, poisoning and certain other consequences of external causes, and symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified.

There were 12 deaths attributed to other causes for the 2021–2025 reporting period. All perinatal conditions and congenital malformations deaths on the Register were infants under one year of age.

Chapter 4 Children and young people deaths

This chapter provides information on the registered deaths of ACT resident children and young people (1–17 years old) that occurred in the ACT or elsewhere in the last 5 years, 2021–2025. It will examine the incidence and causes, as well as other demographic and individual characteristics, of those deaths.

Between 2021 and 2025, 40 ACT resident children and young people died in the ACT or in other Australian jurisdictions. Of these, 12 died in other jurisdictions and 13 are open coronial matters.

Characteristics of children and young people who died

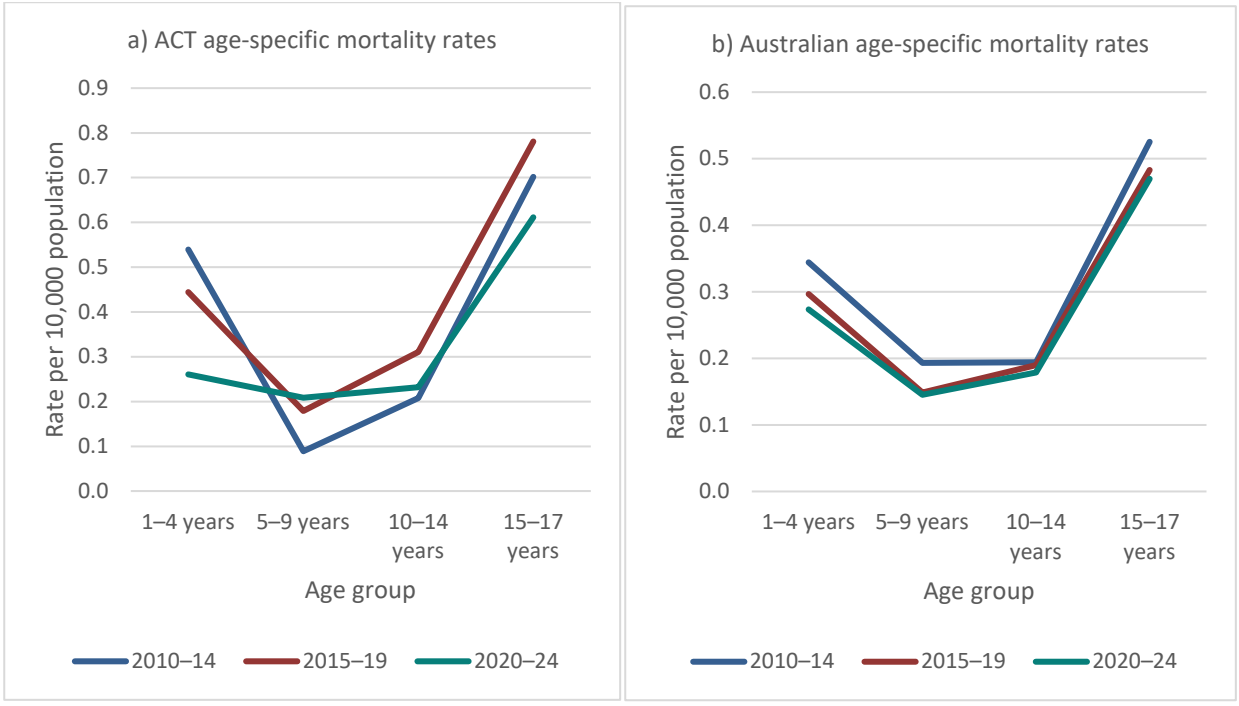
The following discussion describes the age, sex and cause of death for children and young people who died.

Age

In Figure 4.1, age-specific mortality rates have been combined into 3 periods of 5 years each to give sufficient numbers to report by age group. The mortality rates decrease between the 1–4- year age group and the 5–9-year age group, which is usually the age group with the lowest mortality rates among 1–17-year-olds. The proportion of child and young person deaths increases during adolescence. Figure 4.1 shows that both the ACT and Australian mortality rates followed a similar pattern.

There has been a slight decrease in the mortality rate for the 1–4 years age group in the ACT over time. Mortality rates for the remaining age groups remained relatively stable.

Figure 4.1: Age-specific mortality rates, ACT and Australia, 2010–2024



Includes open coronial cases.

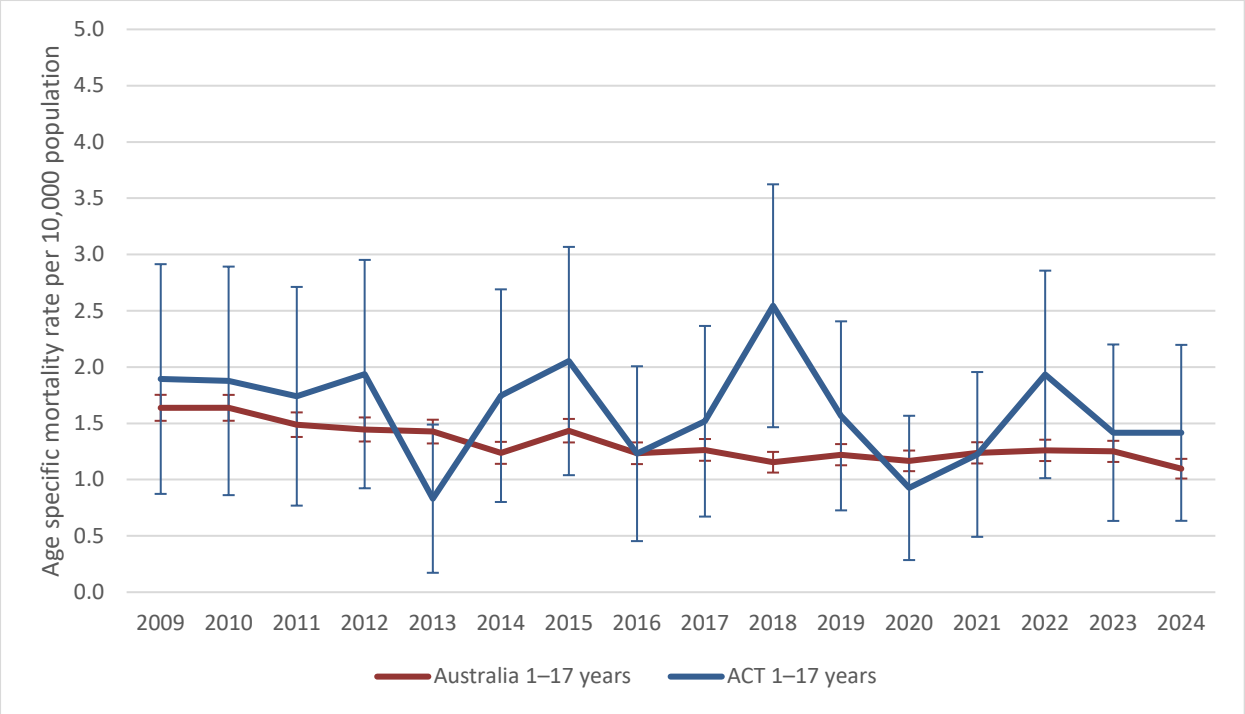
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.

Data Source: Committee calculations for age-specific mortality rates from ABS estimated resident population and death data:

- ABS (2026a), Deaths, Australia, Deaths, Year of registration, Age at death, Age-specific death rates, Sex, States, Territories and Australia accessed 16 March 2026 (data currently available to 2024 only).

When observed per year, the age-specific mortality rates for children and young people aged 1–17 years in the ACT fluctuates (Figure 4.2) while the Australian rate remains more stable.

Figure 4.2: Age-specific mortality rates for children and young people aged 1-17 years (per 10,000 population), ACT and Australia, 2009–2024



[a] The rates in this table are not directly comparable to previous reports due to a change in data sources. ASMR = age-specific mortality rate per 10,000 population.

Includes open coronial cases.

Deaths include ages 1–17 years over the 2009–2024 period.

Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.

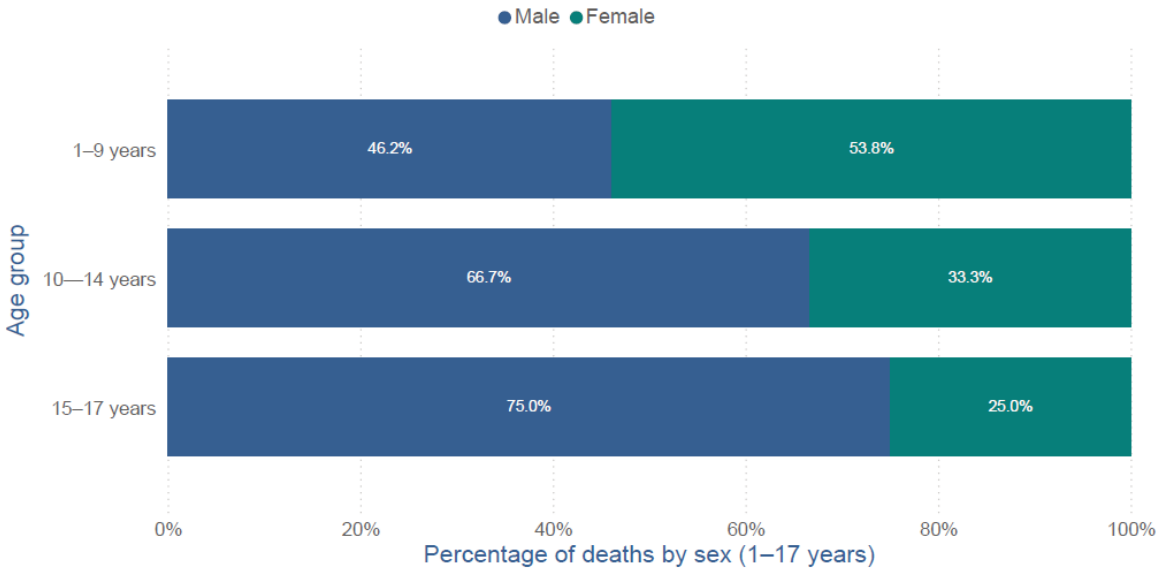
Data Source: Committee calculations for age-specific mortality rates from ABS estimated resident population and death data:

- ABS (2026a), Deaths, Australia, Deaths, Year of registration, Age at death, Age-specific death rates, Sex, States, Territories and Australia accessed 16 March 2026 (data currently available to 2024 only).

Sex

For the 2021–2025 period, more than half (62.5%) of the 40 ACT resident child and young person deaths aged 1–17 years were male. The highest percentage of males compared to females was in the 15–17-year-old age group, with 75.0% of deaths in this age group being male (Figure 4.3). However, numbers of deaths were small, so results should be interpreted with caution.

Figure 4.3: Percentage of male and female ACT resident child and young person deaths by age group, 2021–2025



Includes open coronial cases.

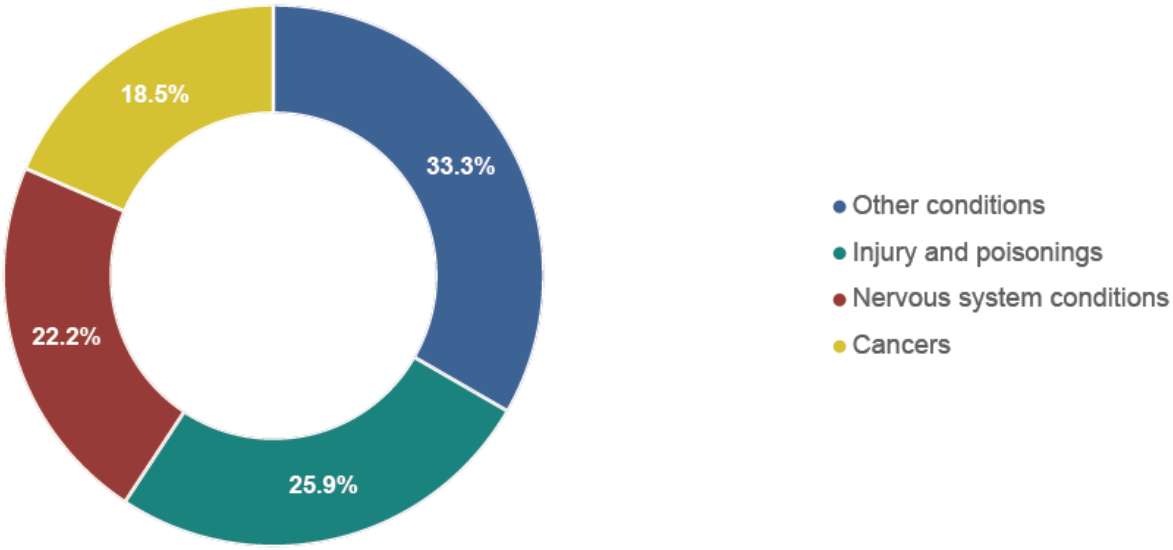
Deaths include ages 1–17 years over the 2021–2025 period.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Percentages are of total deaths for males and females and for ages 1–17 years.
Proportions for the 1–4 year and 5–9 year age groups were combined due to small cell counts.

Cause of death

This section reports the causes of death for the 27 children and young people who died between 2021 and 2025, excluding open coronial cases. The most common causes of death were categorised according to ICD-10 classification.

'Injury, poisoning and certain other consequences of external causes' (25.9%) and nervous system conditions (22.2%) were the most common causes of death (Figure 4.4). Injury and poisoning as a cause of death increased with age, and there were no deaths attributable to this cause in children under 10 years of age. One-quarter of deaths in the 10–14-year age group and half in the 15–17-year age group were attributed to injury and poisoning. Just under one-in-five deaths were attributed to cancers (18.5%). Other conditions represented 33.3% of deaths of children and young people aged 1–17 years. Due to small number of deaths, other conditions have been combined to include respiratory system conditions, circulatory system diseases, congenital malformations, external causes of mortality and mobility, and symptoms, signs and abnormal findings not elsewhere classified.

Figure 4.4: Child deaths, ages 1–17 years, by ICD-10 grouping, percentage of total 2021–2025



Excludes open coronial cases.
Deaths include ages 1–17 years over the 2021–2025 period.
Includes all deaths of ACT residents that occurred either in the ACT or elsewhere.
Other conditions include respiratory system conditions, circulatory system diseases, congenital malformations, external causes of mortality and mobility, and symptoms, signs and abnormal findings not elsewhere classified.
Injury and poisonings includes intentional self harm.

Chapter 5 Children known to Children, Youth & Families

This chapter provides an overview of the registered deaths of children in the last 5 years (2021–2025) that involved ACT residents who were known to child protection services (defined below). It does not consider open coronial matters.

There are 2 reasons the Committee focuses on the children known to Children, Youth and Families (CYF) within the Health and Community Services Directorate (HCSD) of the ACT Government. First, it is a requirement of the legislation, by way of reporting, whether within 3 years before their death, the child or young person, or a sibling of the child or young person, was the subject of a report that the Director-General decided, under s 360(5), was a child protection report. Second, the CYF statutory services are often involved when difficulties arise in a child's life and may indicate vulnerability.

Known to CYF

When a report is initially made to CYF, it is known as a 'child concern report' (CCR), which is a record of information regarding the child or young person made by either a voluntary or mandatory reporter. In the ACT, where the person contacting the Directorate believes that a child is at risk, this is classified as a notification. CYF then conducts an initial assessment of the issues raised in the child concern report and, if this assessment allows the Director-General to form a reasonable belief that a child or young person is in need of protection, a 'child protection report' (CPR) is recorded in accordance with s 360(5) of the Act. A second stage of assessment is then undertaken, and if it is believed that a child may be in need of care and protection, CYF determines whether further involvement is necessary. This may include a care and protection appraisal (a planned process of enquiry into a family situation). The Committee considers if a child (or their sibling/s) had a child concern or other report made to CYF within 3

Children and young people known to CYF may have experienced a range of risk factors within their lives, including domestic and family violence, parental substance use, mental illness and involvement with the criminal justice system. The following discussion considers whether both the child or young person and their siblings were known to CYF within 3 years of the child or young person's death.

Most (92.1%) ACT resident children and young people who died between 2021 and 2025 were either not known to child protection services or had no data recorded about them. Of the ACT resident children and young people who died and were known to CYF in the 2021–2025 period, most (81.8%) had child concern reports recorded (that is, any report made to CYF). A smaller percentage of these children (18.2%) had child protection reports recorded (that is, a second stage of assessment conducted by CYF to establish if there is a reasonable belief that a child is in need of care and protection) or an appraisal (that is, an investigation undertaken).

There were less than 5 children or young people who died between 2021 and 2025 who were reported as being in the care of the Director-General.

Chapter 6 Injury-related deaths and serious injuries

This chapter examines deaths among ACT resident children and young people and the work undertaken by the Committee in reviewing these deaths. The chapter also includes information on trends in relation to injury-related hospitalisations classified as serious.

The death of any child or young person in the ACT is a tragedy and sometimes is not preventable. However, the purpose of the Committee is to review all child and young person deaths, consider the circumstances surrounding the deaths and make recommendations to address any systemic social or environmental issues associated with these deaths.

While the Committee reviews all deaths of children and young people in the ACT, often the greatest learnings for system improvements can be identified through those deaths that were not attributed to natural causes. Injury-related deaths include, but are not limited to, transport-related fatalities, fatal assault and neglect, drowning and unintentional injury or accident.

Fortunately, the recorded number of injury-related deaths in the ACT is small. Due to these low numbers and the Committee's requirement not to disclose the identity of any individual on the Register, the ability to report on these cases is limited.

Serious injuries that did not result in death have been included in this chapter to highlight the trends of serious injury of children and young people.

Cause of death

The Committee is unable to release detailed data on injury-related deaths of children and young people between 2021 and 2025 due to the small number of cases which creates a significant risk of identifying individuals, either directly or indirectly. Releasing such information could compromise the privacy of the children, young people and their families, particularly when combined with other publicly available details. To uphold confidentiality obligations and ethical standards, and in line with data protection principles, the Committee must therefore withhold this data from publication.

Injury-related hospitalisations

Injury is the leading cause of death among Australians aged 1–24 years. In 2025, injury-related deaths resulting from land transport accidents, accidental drowning and accidental poisoning alone accounted for more than 28% of all deaths in that age group, while 22% were the result of unintentional self harm (suicide) (ABS, 2025).

Injury is also a major contributor to physical disability and psychological trauma among children and young people. Given this, the Committee requested a detailed statistical analysis of injury-related hospitalisation among young people in the ACT, with a focus on injury severity. The HCSD Epidemiology Section then developed a statistical dashboard that enabled this analysis.

Injury severity was classified using the International Classification of Injury Severity Score, applying age-specific survival risk ratios derived from ICD-10-AM injury diagnoses to categorise injuries as minor (SRR > 0.99), moderate (SRR 0.941–0.99) or serious (SRR < 0.941) (Pollock et al. 2023). For example, the diagnostic code *S12.0–Fracture of first cervical vertebra* received an SRR of 0.97037037 and would be

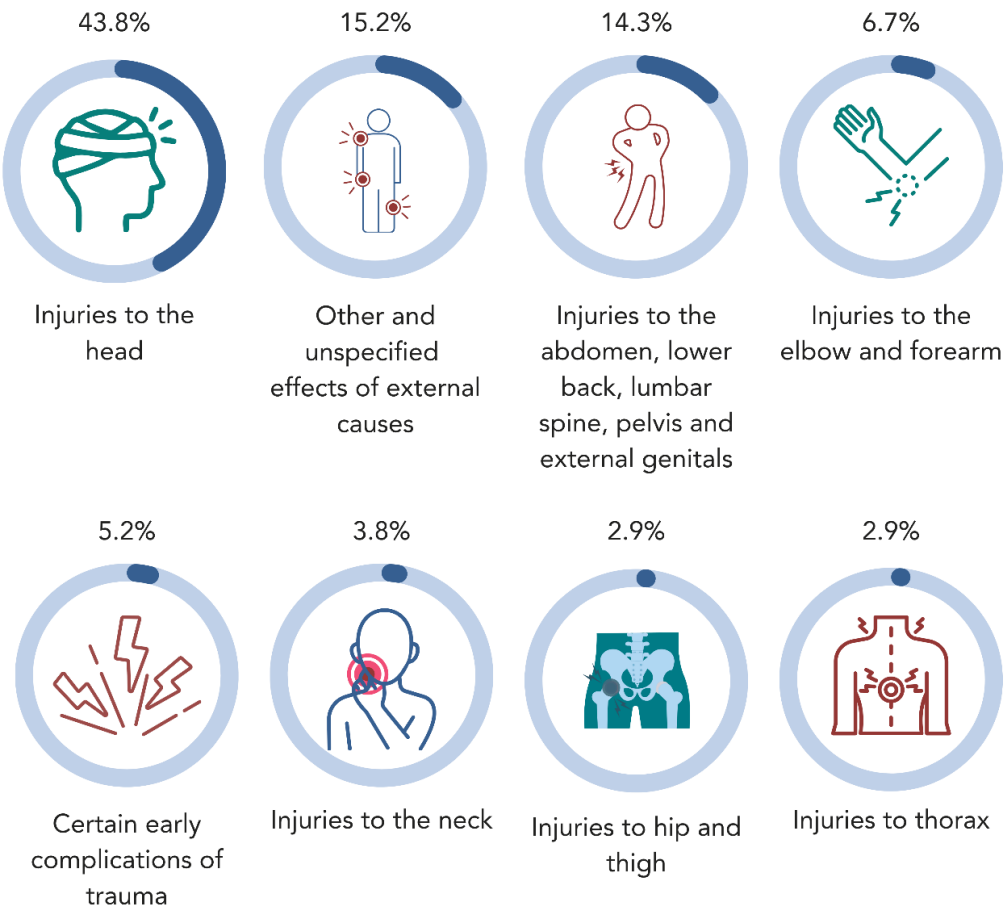
classified as a moderate injury. This indicates that, on average, patients hospitalised with this injury have around a 97.0% chance of surviving the injury, or alternatively, a 3.0% risk of death.

Data for injury-related hospitalisations presented throughout this report will focus on those classified as serious. It should be noted that as multiple ICD-10-AM codes are allocated per hospitalisation, e.g. for people experiencing multiple injuries, percentages within each section may not add up to 100 per cent.

Injury type

Injury data for the period July 2021 to June 2025 (2020/21–2024/25) shows clear variations by age group and injury type, with injuries to the head accounting for the largest proportion of serious injuries across all ages (Figure 6.1). Injuries to the head were the most frequently recorded serious injury for young people aged 0–24 years, with a total of 92 cases (43.8%). Of these, 54 were identified as male and 38 as female. This was followed by 32 cases (15.2%) classified as 'other and unspecified effects of external causes' (includes *T66–T78: Conditions caused by external physical, environmental, or situational factors*) and injuries to the abdomen, lower back, lumbar spine, pelvis and external genitalia (30 cases or 14.3%). Smaller numbers of serious injuries were recorded across a range of other body regions, including the upper and lower limbs, thorax and complications of trauma.

Figure 6.1: Leading cause of serious injury as a proportion of all serious injuries, persons aged 0–24 years, ACT, 2020-21 to 2024-25



Source: ACT Admitted Patient Care Dataset
ICD-10 codes are as follows: injuries to head (S00-S09), other and unspecified effects of external causes (T66-T78), injuries to abdomen, lower back, lumbar spine, pelvis and external genital (S30-S39), injuries to the elbow and forearm (S50-S59), certain early complications of trauma (T79), injuries to the neck (S10-S19), injuries to the thorax (S20-S29) and injuries to the hip and thigh (S70-S79).

Age-related differences

Infants and young children (0–12 years)
Injury-related hospitalisations classified as serious among children aged 0–12 years were relatively low throughout the period 2020/21 to 2024/25, with only 10 hospitalisations recorded. While injuries to the head were present in this age group, they occurred far less frequently than among adolescents. Injuries to the abdomen, spine and pelvis were uncommon, with only isolated cases recorded. The majority of cases were classified as 'other and unspecified effects of external causes'.

Early adolescents (13–18 years)
Children aged 13–18 years accounted for a substantial proportion of serious injuries, particularly head injuries, which represented the largest single category within this age group (44.2%). Injuries to the abdomen, lower back and pelvis (13.5%) were also more prominent than in younger children.

This pattern could suggest increased exposure to mechanisms associated with higher injury severity, such as transport-related incidents, sporting activities and risk-taking behaviours that typically increase during adolescence.

Older adolescents and young adults (19–24 years)
Young people aged 19–24 years experienced the highest number of serious injuries overall, particularly head injuries, which accounted for the majority of cases in this age group (45.9%). Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals were also more common, accounting for around 14.9% of all serious injury-related hospitalisations for this age group.

The concentration of serious injuries in this age group is consistent with increased independence, mobility and participation in higher-risk activities, including driving and other transport-related exposure.

Place of occurrence

Over the period 2020/21 to 2024/25, place of occurrence was coded as unspecified (unknown) location on 23.4% (49 cases) of serious injury-related hospitalisations among children and young people aged 0–24 years. Excluding these records, 31.1% of serious injury-related hospitalisations for this cohort occurred on the street or highway (65 cases), followed by those that occurred in areas classified as schools, other institutions and public administrative areas such as health centres, churches, youth centres and libraries (26 cases or 12.5%).

For younger children aged 0–12 years, excluding cased coded as unspecified (unknown) location, the most common location for serious injuries to occur was in the home (6 cases or 60.0%), while for those aged 13–18 years and 19–24 years it was the street and highway (18 (34.6%) and 46 cases (31.3%), respectively).

Activity

Of those cases where an activity was specified, the most common activity undertaken when serious injury occurred for children and young people aged 0–24 years in the ACT over the period 2021–2025 was team ball sports (26.8% or 15 cases), followed by wheeled non-motored sports (22.3% or 13 cases).

Cause of hospitalisation

The leading cause of serious injury-related hospitalisations in the ACT for children and young people aged 0–24 years over the period 2020/21–2024/25 was slipping, tripping, stumbling and falls (45 cases or 21.5%), motorcycle rider injured in transport accidents (26 cases or 12.4%), assault (25 cases or 12.0%) and intentional self harm (20 cases or 9.6%).

Accidental non-transport drowning and submersion (6 cases) was the leading cause of serious injury-related hospitalisations for children aged 0–12 years (60.0%), while the leading cause for young people aged 13–18 years was slipping, tripping and falls (10 cases or 19.2%) and motorcycle rider injured in transport accident (8 cases or 15.4%). Among those aged 19–24 years, the leading cause of serious injury-related hospitalisation was slipping, tripping, stumbling and falls (34 cases or 23.1%).

While the number of serious injuries in the ACT remains relatively small, the data demonstrates clear age-related patterns, with injury burden increasing markedly during adolescence and early adulthood. The predominance of head injuries across all age groups reinforces the importance of prevention strategies focused on, in particular:

- transport safety
- sports and recreational injury prevention
- risk-taking behaviours among adolescents and young adults.

Given the small case numbers, these findings should be interpreted cautiously. However, when considered alongside injury-related death data and broader population trends, the analysis provides valuable insight into patterns of serious harm and supports the Committee's continued focus on injury prevention as children transition into adolescence and adulthood.

Chapter 7 Recommendations review

Under s 727B of the Act, one of the Committee's statutory functions is to provide expert advice and make recommendations on legislation, policies, practices and services for implementation by government and non-government bodies. Section 727B also requires the Committee to monitor the implementation of its recommendations. The Committee last formally reported on the implementation status of its recommendations in its 2022 Annual Report.

This recommendations review is informed by written updates from the relevant ACT Government directorates outlining their progress in responding to the Committee's recommendations. Copies of the responses are included at **Appendix D**. The Committee notes that, in some instances, recommendations arising by other reviews overlap with its own.

This review considers recommendations made directly to government through reports issued under section 727T of the Act, as well as those provided through direct correspondence with directorates. The 18 recommendations examined originate primarily from the following 3 special reports:

1. *Retrospective Report* (2004–2013)
   This report assessed long-term patterns and trends in the deaths of children and young people using a social determinant of health approach. It identified priority areas for future work and, among other matters, recommended improvements to inter-agency information sharing across the ACT Government.

2. *Changing the Narrative for Vulnerable Children: Strengthening ACT Systems* (2018)
   This qualitative review examined the deaths of 11 children aged from birth to 3 years who died before 2014 and who were subjected to closed coronial inquiries. The review sought to identify risk factors present in the lives of individual families prior to the death of a child and the interventions that had been used to attempt to address risk factors, with a view to informing policy, program and practice improvements. The Committee made 19 recommendations; the ACT Government fully accepted 9 and agreed in principle to the remaining 10.

3. *Review of Children and Young People Who Have Died as a Result of Intentional Self-Harm* (2021)
   This report examined the deaths of 8 young people who died by suicide between 2017 and 2019. Its purpose was to analyse systemic factors contributing to youth suicide and to provide insights to support services, schools, families and peers in preventing future incidents. Eight recommendations were made.

Further, the Committee has, from time to time, raised issues of safety directly with the relevant directorates, drawing on inquiries in other states and territories.

This review considers how government has addressed recommendations through policy and program initiatives. Whether those strategies have been effectively implemented — and whether they have led to improved outcomes for ACT children — is best determined through a dedicated evaluation process.

The Committee recognises that any changes need to be implemented within the broader context of government priorities and resourcing.

Indicators of change

The purpose of monitoring recommendations is to determine how the ACT has progressed and whether changes have been made that could potentially improve outcomes for children and young people. A number of recommendations provided to government have been accepted, while others are 'accepted in principle.' The following section provides a thematic review of the recommendations and an assessment of progress.

Based on the information provided by the government and relevant directorates, each of the recommendations has been assigned a progress marker as follows:

Achieved	Achieved	The recommendation has been addressed, or the Committee is satisfied that the intent of the recommendation has been met and will no longer seek progress reports on the recommendation.
Ongoing	Requires ongoing monitoring	Actions have or will be implemented that are intended to meet the intent of the recommendation but there is no current evidence to assess the impact of the action.
Not achieved	Not achieved	The recommendation has not been addressed.

Reducing risks to children in and around the home

The Committee's recommendations

The Committee made several recommendations relating to the safety of children in and around the home to reduce the risks associated with swimming pools through the following recommendations:



1. A system of registration of pools in the ACT to improve fencing compliance.
2. Pool compliance and safety inspections at the change of ownership or tenancy.
3. Regular CPR training for homeowners with pools and display of signage in pool areas.
4. Fencing requirements being imposed on all swimming pools in the ACT, regardless of when they were constructed.

Progress on recommendations

Swimming pool regulation

The City and Environment Directorate (CED) informed the Committee that the ACT Government remains strongly committed to reducing deaths and serious injuries resulting from drownings and near-drownings in home swimming pools. In support of this commitment, significant regulatory reforms were introduced through the *Building (Swimming Pool Safety) Legislation Amendment Act 2023*, which commenced on 1 May 2024.

These reforms were implemented to establish a strengthened regulatory framework requiring all ACT home swimming pools and spa pools capable of holding more than 30 centimetres of water to have a barrier that meets modern safety standards by 1 May 2028. The ACT Government implemented a transition period to assist owners meet these new requirements, including opportunities to apply for partial or full exemptions in specific circumstances.

Since the commencement of the regulation on 1 May 2024, new offence provisions apply for failing to maintain pool barriers and for leaving pool gates unsecured. Owners must also disclose the compliance status of pool barriers when selling or leasing a property. From 1 May 2028, all barriers must be fully compliant. Guidance materials and resources to support these changes are available on the CED website. Offences for not having a fully compliant barrier will commence on 1 May 2028, providing time for necessary upgrades to be completed.

The CED reported that the ACT Government chose not to adopt a pool registration system or mandate CPR training or signage. These recommendations were not adopted due to existing building approval records already supporting compliance activities and owner obligations highlighted through the CED website. Furthermore, CPR awareness and pool safety resources continue to be promoted through the Backyard Lifeguard campaign.

Our comments

The Committee acknowledges that the regulatory reforms addressed several long-standing recommendations from the Committee, including the adoption of modern fencing standards for all pools, strengthened maintenance obligations, improved compliance pathways, and enhanced inspection and enforcement capability. These changes represent meaningful progress toward a safer regulatory environment for children and young people.

The Committee also notes the government's decision not to proceed with a pool registration system or to mandate CPR training and signage. The government's rationale, including the adequacy of existing building approval records and ongoing CPR awareness efforts through the Backyard Lifeguard campaign is noted. **The Committee will continue to observe the effectiveness of these approaches in achieving the intended safety outcomes**.

While not all recommendations were adopted in the form originally proposed, the Committee accepts that the recommendations have been substantively achieved through the regulatory reforms. Therefore, the Committee is satisfied that these approaches collectively support reducing the risk of drowning and near-drowning incidents among children and young people in the ACT.

Implementing and evaluating youth suicide prevention programs

The Committee's recommendations

The Committee's Intentional Self Harm report identified significant gaps in access to appropriate services for young people, particularly following a suicide attempt, and emphasised the need for a whole-of-community approach to youth suicide prevention. To address these concerns and strengthen support for young people at risk, the Committee made the following recommendations:

Implement and evaluate youth suicide prevention programs

Achieved

1. Involve young people with lived experiences of suicide in suicide prevention service design and delivery.
2. Evaluate current youth mental health and suicide prevention programs to determine effectiveness, including in meeting demand.
3. Implement information campaigns that target young people at risk and include practical intervention skills for peers and family.
4. Implement and evaluate the Connecting with People program, including in education and non-government organisation settings.
5. Implement a support plan process in clinical settings that actively engages young people following a suicide attempt.
6. Implement evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.
7. Training staff from relevant organisations on responsible information sharing.

Progress on recommendations

The Committee received responses relating to the progress on recommendations from HCSD and Canberra Health Services (CHS).

Involving young people with lived experiences

The Mental Health and Suicide Prevention Division, HCSD, has articulated the commitment to embedding lived and living experience in mental health and suicide prevention policy, design and delivery for children and young people, to ensure responses are informed and community focused.

Key developments include:

- **ACT Child and Youth Mental Health Sector Alliance (CYMHSA):** A cross-sector collaboration platform, established with the Youth Coalition of the ACT and Capital Health Network, to strengthen system responses
- **Youth Reference Group (YRG) (2023):** Young people aged 16–25 providing lived experience input to support co-design of projects and development of *Our Say* (2024) to improve engagement and reduce consultation fatigue
- **Youth at Risk of Developing Mental Ill Health project (2022):** Extensive co-design of projects in 2024–2025, involving 450 participants from over 60 organisations, including young people, consumers, carers and sector representatives
- **co-design initiatives (2025):**
    - commissioning of the Youth Coalition to design an aftercare service for 12–15-year-olds experiencing suicidal distress
    - commencement of co-design for an Aboriginal and Torres Strait Islander Youth Mental Health Service Model, in partnership with communities and Aboriginal Community Controlled Organisations, empowering communities to drive health outcomes.

Evaluating current youth mental health and suicide prevention programs

HCSD reports the continued delivery of the Youth Aware of Mental Health (YAM) program, which is funded in the ACT until December 2029. YAM is an evidence-based mental health and suicide prevention initiative for young people aged 14 to 16 years. Delivered by Mental Illness Education ACT (MIEACT), the program is provided to Year 9 students across public, independent and Catholic high schools in the ACT. YAM aims to reduce depression and suicidal ideation and promote positive coping strategies and healthy lifestyle choices among young people.

HCSD reports that the program's effectiveness has been well established internationally, and a 2023 evaluation by the Black Dog Institute contributed to its adoption across public secondary schools by the NSW Department of Education.

Implementing information campaigns

HCSD outlined their ongoing commitment to the following key youth-focused mental health awareness initiatives that aim to improve mental health literacy, promote help-seeking behaviour and support early intervention:

- **YAM:** This prevention program utilises interactive role-play and facilitated, student-led discussions on wellbeing, stress and crisis, self-help strategies, depression and suicidal thoughts, peer support and pathways to help.
- **MindMap:** This is an online mental health navigation and triage portal for young people, parents and carers in the ACT, operated by Marymead and CatholicCare, providing service information, referrals and interim support for those on waitlists.
- **Community awareness activities:** Participation in Mental Health Week and R U OK? Day in 2024 and 2025 improved access to mental health information and raised awareness among young people and families.

Implementing and evaluating the Connecting with People program

The Connecting with People (CwP) program was implemented by CHS in March 2021. CwP uses an evidence-informed, compassion-based suicide prevention and risk-mitigation approach focused on building a shared language to improve understanding and responses to suicidal distress. Following its initial implementation, HCSD expanded delivery into the non-government mental health sector by engaging the Mental Health Community Coalition in April 2024. Since June 2024, 20 CwP training sessions have been delivered, with 208 mental health care workers participating across 3 program modules.

To support sustainability, 8 mental health professionals have been trained to continue delivering the program across ACT workplaces through to April 2027. HCSD report that preliminary quantitative and qualitative evaluation indicates strong engagement and overall satisfaction with the training.

Implementing a support plan process in clinical settings that actively engages young people following a suicide attempt

The Child and Adolescent Mental Health Services (CAMHS) Hospital Liaison Team undertakes safety planning for young people presenting to the Emergency Department, developing a safety plan in collaboration with the young person and their parent or guardian. These plans include key crisis and support contacts and are formally documented in the young person's clinical record, with copies provided to both the young person and their parent or guardian.

Implementing evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide

The CAMHS Hospital Liaison Team coordinates follow-up for young people within 7 days of hospital discharge. These post-discharge reviews are intended to support continuity of care during a period of increased clinical vulnerability. Where a young person is already engaged with a CAMHS community team, follow-up is provided by that team. Alternatively, referral may be made to the Adolescent Intensive Home Treatment Team to deliver follow-up care. This team provides short-term, post-hospital support for young people following a suicide attempt, including in-home outreach, intensive case management and therapeutic support for up to 4 weeks. Services are delivered in the young person's home or in community settings during business hours.

For young people requiring more immediate follow-up within 24 hours of discharge, referrals are directed to the relevant CAMHS teams involved in their care, including CAMHS community teams or the Adolescent Intensive Home Treatment Team. Where required outside business hours, follow-up may be provided through Access Mental Health or the CAMHS weekend team.

The HCSD continues to promote the development of universal aftercare supports for young people in the ACT. This includes commissioning the Youth Coalition to lead a co-design process for an aftercare service for young people aged 12 to 15 experiencing suicidal crisis or distress, with outcomes intended to inform future service development.

Training staff from relevant organisations on responsible information sharing

CHS reports a range of policies, procedures and guidelines that support appropriate information sharing involving young people, including policies relating to information privacy, child protection, clinical records management and the sharing of clinical information with general practitioners.

Staff are supported through training on responsible information sharing in health care, including Confidentiality and Privacy Training and Champion Privacy Training. In addition, it is reported that CAMHS clinicians seek informed consent from young people and their parent, carer or guardian through a documented consent-to-share-information process. This consent is recorded in the clinical record and enables information sharing with relevant professionals and community-based supports to facilitate coordinated and shared care.

Our comments

The Committee welcomed the detailed response provided by HCSD and CHS and acknowledges the breadth of activity reported against the Committee's recommendations. The Committee notes the ACT Government's articulated commitment to strengthening the systematic embedding of lived and living experience across youth mental health and suicide prevention policy, service design and delivery, with a particular focus on children and young people.

The Committee considers the establishment and ongoing operation of the ACT Child and Youth Mental Health Sector Alliance (CYMHSA), including its Youth Reference Group (YRG), to be a substantive mechanism supporting this commitment. The Committee acknowledges the role of the YRG in contributing youth lived experience to sector development and notes the publication of *Our Say: Youth lived experience frequently asked questions* as a practical initiative to improve engagement practices.

The Committee welcomed the advice regarding further co-design initiatives, including commissioning the Youth Coalition to lead the design of an aftercare service for young people aged 12 to 15 and the commencement of work to co-design an Aboriginal and Torres Strait Islander Youth Mental Health Service Model in partnership with Community and Aboriginal Community Controlled Organisations. The Committee considers these developments to align with its recommendations and remains interested in how these initiatives translate into accessible, sustainable and culturally safe services.

In relation to program implementation and evaluation, the Committee notes the continued delivery of the YAM program across ACT secondary schools and acknowledges the evidence base cited in support of the program. The Committee welcomed the advice of the long-term funding commitment through to December 2029 and encourages ongoing local monitoring and evaluation to ensure the program continues to meet the needs of diverse cohorts of young people in the ACT.

The Committee also notes the range of youth-focused awareness and information initiatives reported, including YAM, MindMap and broader community awareness campaigns. The Committee considers these initiatives important components of a prevention-focused approach and encourages continued

evaluation of reach, accessibility and impact, particularly for young people experiencing heightened vulnerability or barriers to engagement.

With respect to workforce capability and suicide prevention practice, the Committee acknowledges the expansion of the CwP program across the non-government sector, including reported participation rates and early evaluation findings. The focus on sustainability through training of facilitators is considered an important step in embedding shared-practice approaches across the service system.

The Committee notes the information provided regarding safety planning, follow-up and assertive outreach arrangements for young people following a suicide attempt. The Committee considers the reported approaches broadly consistent with its recommendations and emphasises the importance of timely follow-up, continuity of care and effective coordination across services, particularly during periods of heightened risk following hospital discharge.

Finally, the Committee acknowledges the reported policies, training and consent processes supporting responsible information sharing involving young people. **The Committee notes that the ACT Government provided no indication of what guidance or training exists for staff in circumstances where a risk presents and consent for information sharing may be dispensed with. The Committee will continue to proactively seek advice on progress in relation to this matter.** The Committee reiterates the importance of ensuring timely information-sharing practices balance privacy with the need for coordinated, person-centred care and support for young people and their families.

Overall, the Committee considers that the government response demonstrates substantive progress against the intent of the Committee's recommendations. The Committee notes advice from HCSD and CHS that the recommendations are considered suitable for closure. Notwithstanding this position, **the Committee will continue to monitor implementation outcomes, particularly the extent to which policy commitments and co-design processes translate into sustained, measurable improvements in access, quality, safety and outcomes for children and young people across the ACT mental health and suicide prevention system.**

Reviewing the practice of addressing the risk factors in children's lives

The Committee's recommendations

A key finding of the Committee's *Changing the Narrative* report was the prevalence of cumulative risk among children who had died. *Cumulative risk* refers to the presence of multiple, co-occurring risk factors in a child's life that together increase the likelihood of adverse outcomes. In response, the Committee made the following recommendations to strengthen the identification and management of cumulative risk factors:

Review the practice of addressing the risk factors in children's lives

Ongoing

1. Review current practice models for prenatal reports:
    - Ensure early intervention strategies across CHS and HCSD are maximised prior to birth, including access to general practitioners and routine prenatal health checks, with non-attendance actively followed up.

- Strengthen engagement with culturally appropriate services for Aboriginal and Torres Strait Islander families and for culturally and linguistically diverse communities.

2. Review current practice for identifying and responding to cumulative harm:

    - Examine existing legislation to assess whether it adequately protects children in circumstances where individual risks do not meet statutory thresholds for intervention, but where cumulative harm is evident.

    - Enhance workforce capability through improved training and mandatory refresher courses to ensure practitioners fully understand the scope of their legislative powers. Training programs should be evaluated for effectiveness.

3. Establish a targeted review mechanism:

    - Implement a mechanism to identify and review cases involving children reported to Children, Youth and Families on 4 or more occasions, where there is a combination of key risk factors, including domestic and family violence, substance misuse, housing instability and limited parental engagement with services.

In response to the *Changing the Narrative report*, the ACT Government agreed in principle to Recommendations 1 and 2 and agreed to Recommendation 3.

Progress on recommendations

Primarily, the recommendations from the *Changing the Narrative* report relate to HCSD.

Review current practice models for prenatal reports and Review current practice for identifying and responding to cumulative harm

HCSD reports an increased focus on early support and prevention approaches that prioritise keeping children safe within their families and diverting from court-based child protection intervention, where possible.

Key reforms include:

- **early support and prevention:** reallocation of resources to prevention and earlier engagement with families to reduce risks and avoid statutory intervention

- **Family Response and Engagement (FRE) teams:** provision of early, non-statutory support in partnership with families, including assistance to access health services, counselling, community programs and practical supports such as housing and education

- **specialist FRE teams:** establishment of a prenatal FRE Team to support earlier intervention and a First Nations Family Response and Engagement Unit focused on culturally safe, self-determination-based practice, family-led decision-making and tailored support for Aboriginal and Torres Strait Islander families

- **Signs of Safety framework:** adoption in June 2024 of the Signs of Safety practice framework to support consistent risk assessment, safety planning and decision-making through collaborative, strengths-based engagement with children, families and their networks

- **Children, Young People and Families Preferred Providers Panel:** establishment of the CYPF Panel in late 2024 to promote consistent, high-quality service delivery, with services being phased in through to 2026 and including cultural clauses to support work with Aboriginal and Torres Strait Islander children, young people and families.

These measures are intended to strengthen a coordinated continuum of support, including early intervention, family preservation and restoration, and extended care and aftercare up to age 21, to improve stability and support children to remain safely with, or return to, their families wherever possible.

Establish a targeted review mechanism

Next Steps for Our Kids 2022–2030 is the ACT Government's overarching reform agenda for children, young people and families, with a vision that children and young people in the ACT are safe, strong, connected and able to live thriving lives. The strategy places a strong emphasis on earlier and culturally safe supports for Aboriginal and Torres Strait Islander families, with self-determination as a core principle and a focus on integrated service delivery. It also prioritises early intervention, family strengthening, trauma-responsive and restorative practice, improved trust and transparency, partnerships with community, and a continuum of support aimed at reducing escalation into statutory systems and addressing key risk factors in children's lives.

The ACT Aboriginal and Torres Strait Islander Children's Forum (AACF) supports these reforms by bringing together Aboriginal Community Controlled Organisations, service providers and ACT Government representatives to strengthen culturally responsive practice across the system. In 2025, AACF members reviewed and updated cultural clauses and practice guidelines in provider contracts, with implementation underway. In 2026, the Forum is expected to focus on developing a shared cultural accountability tool and further building cultural capability across the sector through coordinated training and professional development.

Our comments

The Committee acknowledges the advice provided by HCSD on actions taken in response to its recommendations to review practice models for prenatal reports, strengthen responses to cumulative harm and establish mechanisms to better identify and support children and families experiencing multiple, compounding risk factors.

The Committee notes HCSD's reported shift towards earlier, prevention-focused approaches that prioritise keeping children safe within their families and diverting from statutory child protection intervention, where appropriate. The expansion of FRE teams, including the establishment of a specialist prenatal FRE Team, reflects a focus on earlier engagement with families and improved coordination with health services and non-government organisations. These developments are broadly consistent with the Committee's recommendations to maximise early intervention opportunities and better address risks before escalation into statutory systems.

The Committee also notes the establishment of the First Nations Family Response and Engagement Unit and its stated focus on self-determination, culturally safe practice and tailored supports for Aboriginal and Torres Strait Islander children and families. The Committee considers this an important reform to strengthen culturally appropriate engagement and family-centred responses, including for families already involved with HCSD.

In relation to identifying and responding to cumulative harm, the Committee acknowledges HCSD's adoption of the Signs of Safety (SofS) practice framework. The Committee notes that the framework provides a structured approach to assessment and safety planning, emphasising observable behaviour, shared understanding with families and networks, and a strengths-based, evidence-informed approach to decision-making. These features align with the Committee's recommendation for more consistent assessment practices that support professional judgement about parenting capacity and children's wellbeing. However, the Committee notes advice that implementation remains at an early stage, with further work required to embed the framework consistently across policy, procedures and system workflows. At this stage, evidence of system-wide application and impact remains limited.

The Committee further notes the establishment of the CYPF Panel, which aims to promote consistent, high-quality, capability-based service delivery and a coordinated continuum of support for children and families. The Committee acknowledges the potential of these arrangements, including cultural clauses and wrap-around supports, to improve stability, continuity of care and family preservation outcomes.

The Committee welcomed the advice of the significant structural changes through legislation, workforce capacity and the broader reform agenda under *Next Steps for Our Kids 2022–2030.* The Committee recognises the significance of this whole-of-system framework in supporting early intervention, integration and trauma-responsive practice. However, **the information provided does not clearly demonstrate the establishment of a specific mechanism to identify and review individual children who have experienced multiple reports in conjunction with identified co-existing risk factors, as originally recommended.** The Committee acknowledges the role of the AACF in strengthening culturally responsive practice across the system, including its work to review cultural clauses and practice guidelines and its planned focus on cultural accountability and sector capability building. The Committee therefore considers this aspect of the recommendation to be only partially addressed.

Overall, the Committee recognises that HCSD has undertaken substantial reform activity aligned with the direction and intent of its recommendations, particularly in relation to early support, culturally safe practice and strengthening family-centred responses. **While progress is evident, the Committee considers that further implementation, consistency and evidence of impact are required before the recommendations can be regarded as fully realised in practice.**

Improving consistency in assessing parenting capacity

The Committee's recommendations

In our *Changing the Narrative* report, the Committee identified the need for a more consistent, evidence-based approach across HCSD to the assessment of families. The Committee emphasised that assessment processes should support sound professional judgement and decision-making about a parent's capacity to meet a child's developmental and wellbeing needs, rather than focusing narrowly on protection from harm. An approach of this nature would also provide clearer information for parents and practitioners about what children require to be safe, supported and able to thrive. The Committee therefore recommended that the ACT Government consider the following:

Improve consistency in assessing parenting capacity

Ongoing

1. The introduction of standardised empirically validated assessment tools for use in the prenatal and postnatal periods, in order to identify vulnerable families requiring further support. This should include necessary training for practitioners.

2. The establishment of a high-quality parenting capacity assessment service and support for parents with children where 4 reports have been received that identify the following risk factors: domestic and family violence, substance misuse, unstable housing and limited parental service engagement. These should include any prenatal reports about a child by CYF.

3. The need for information and reports from parents to be tested through accessing information from other services, particularly in regard to reports of parental drug and alcohol use or instances of domestic violence.

In 2019, the ACT Government agreed in principle to the Committee's recommendations related to enhancing parenting capacity and the use of culturally appropriate, standardised, empirically validated assessment tools.

Progress on recommendations

In June 2024, HCSD adopted the SofS practice framework as a structured approach to assessment and safety planning within child protection practice. The framework provides a consistent method for assessing parenting capacity, including how caregivers meet children's needs, respond to identified concerns and demonstrate protective behaviours over time.

HCSD report that the practice framework emphasises observable behaviours and patterns of care, rather than relying solely on stated intentions. Assessments consider the consistency, quality and sustainability of care, including how caregivers respond to and maintain safety during periods of stress or increased pressure.

Assessment is undertaken through a shared process with children, families and their networks, using clear and accessible language. This approach is intended to support transparency and an evidence-informed understanding of parenting capacity in relation to identified risks and safety needs.

Implementation of the framework is at an early stage, with further work required to strengthen alignment with policy settings, procedures and system workflows. HCSD reports that embedding SofS aims to support earlier intervention, place children's safety and wellbeing at the centre of practice, and strengthen connections to family, community, culture and identity.

Our comments

The Committee acknowledges advice from HCSD regarding the adoption of the SofS practice framework and notes the intended role of the framework in supporting a more structured and transparent approach to assessing parenting capacity. The Committee recognises the emphasis on observable behaviours and shared assessment with families and networks and the focus on children's safety and wellbeing as consistent with the intent of the Committee's recommendation.

However, the Committee notes that implementation of SofS remains at an early stage, with further work required to embed the framework consistently across policy, procedures and system workflows. As such, the Committee considers that, while progress has been made toward strengthening assessment practice, the recommendation has not yet been fully addressed in practice.

Given that the recommendation was agreed in principle, the Committee considers that ongoing monitoring is required to determine whether the use of SofS leads to improved consistency, quality and evidence-based decision-making across HCSD. In particular, the Committee remains interested in how the framework supports assessment of parenting capacity beyond immediate safety concerns, including children's developmental, relational and wellbeing needs, and how this is reflected in practice over time.

The Committee therefore acknowledges the steps taken to date, while noting that full implementation and demonstrated impact will be necessary before the intent of the recommendation can be considered met.

Chapter 8 Governance

The Committee is an independent statutory committee prescribed by legislation to review information about the deaths of children and young people in the ACT, identify emerging patterns and undertake research aimed at preventing or reducing the deaths of children.

This report is the main vehicle to share the findings of the Committee's research. From these analyses, the Committee recommends changes to legislation, policies, practices and services. The Committee also wishes to share these findings and maintain a dialogue with the ACT community, whose greater awareness of these issues may help reduce preventable deaths in the future.

Previous annual reports and additional reports on identified issues of concern can be found on the Committee's website: www.childdeathcommittee.act.gov.au

Who we are

Membership is prescribed by the Act and requires members to have qualifications, experience or expertise in one or more of the following:

- psychology
- paediatrics
- epidemiology
- child forensic medicine
- public health administration
- education
- engineering and child safety products or systems
- working with Aboriginal and/or Torres Strait Islander children and young people
- social work
- investigations
- mental health
- child protection
- coronial law and practice
- other qualifications, experience or expertise, or membership of an organisation, relevant to exercising the functions of a committee member
- is a police officer with experience in working with children and young people and families
- is a public servant working in the administrative until responsible for the *Education Act 2004.*

The Director-General, Health and Community Services Directorate and the Commissioner for Children and Young People are ex-officio appointments. Committee members are appointed by the Minister for Children, Youth and Families, and the Committee must have between 8 and 10 members in addition to the Chair. The Deputy Chair may undertake some of the roles of the Chair in their absence, including chairing of meetings.

Committee members 2026

CHAIR

Ms Megan Mitchel AM
(August 2022 – Current)
Social policy and Strategic human service delivery

DEPUTY CHAIR

Dr Judith Bragg
Paediatrics

EX-OFFICIO COMMITTEE MEMBERS

Director-General, Health and Community Services Directorate	**Ms Kareena Arthy**
Director-General, Health and Community Services Directorate	**Ms Catherine Rule** **(6 September 2021 – 31 October 2025)**
Children and Young People Commissioner	**Ms Jodie Griffiths-Cook**

COMMITTEE MEMBERS

Dr Mary Burke
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Dr Amanda Dyson
Paediatrics and Neonatology

Dr Louise Freebairn
Epidemiology

D/Superintendent Matthew Heather
ACT Policing – Officer in Charge, Criminal Investigations
Police officer with experience in working with children and young people and families

Emeritus Professor Morag McArthur
Social Work and Child Protection

Dr Bronwen Phillips
Epidemiology

Dr Catherine Sansum
(2012 – 26 March 2025)
Child forensic medicine

Mr Francis Ventura
(28 June 2024 – 23 January 2026)
Child Safety and Education Directorate

Ms Tej Kaur
Adviser
Executive Branch Manager, Education Directorate

Mr Christopher Simpson
Adviser
Executive Branch Manager, Health and Community Services Directorate

Our functions

The Committee has the following functions:

a) to keep a register of deaths of children and young people under Part 19A.3 of the Act
b) to identify patterns and trends in relation to the deaths or serious injuries of children, young people and young adults
c) to undertake research that aims to help prevent or reduce the likelihood of the deaths or serious injuries of children, young people or young adults
d) to identify, by the Committee or another entity, areas requiring further research arising from recognised patterns and trends
e) to make recommendations about legislation, policies, practices and services for implementation by the ACT Government and non-government bodies to prevent or reduce the likelihood of deaths or serious injuries of children, young people or young adults
f) to monitor the implementation of the Committee's recommendations
g) to report to the Minister under Part 19A.4 of the Act
h) to perform any other function given to the Committee under this chapter.

What do we do with the information on the Register?

Chapter 19A, Part 19A.4, s 727S of the Act requires that the Committee produce a biennial report on the following information about the deaths of children and young people included on the Register:

- total number of deaths
- age
- sex
- whether, within 3 years before their death, the child or young person, or a sibling of the child or young person, was the subject of a report the Director-General decided, under s 360(5), under a child protection report
- any identified patterns or trends, both generally and in relation to the child protection reports under s 360(5) of the Act.

The Committee respects the child or young person and their family's right to privacy. As per s 727S(3) of the Act, the Committee must not disclose the identity of a child or young person who has died or allow the identity of a child or young person to be established.

The Committee also issues reports and fact sheets to government, public organisations and the community on various topics, to raise awareness regarding child safety or to distribute child death prevention messages.

Committee matters 2024-2025

The Health and Community Services Directorate oversees the Committee's administrative, financial and human resource management. One Senior Research and Review Officer supports the Committee.

The Committee met a total of 8 times during 2024 and 2025.

The Committee continues to actively pursue system enhancements and long-term solutions in response to ongoing inadequacies identified within the current database, particularly regarding system functionality, to strengthen the overall quality and reliability of data provision.

From 1 July 2024, the Committee commenced the systematic collection of young adults (18–24 years) death data. The expansion of the Committee's dataset is intended to strengthen future understanding of the circumstances and factors contributing to the deaths of young adults, particularly those who have had contact with relevant government systems or services. The collection of this information enhances the Committee's capacity to identify emerging trends, inform policy and service improvements, and support whole-of-government and community efforts to improve the safety, wellbeing and life outcomes of young people transitioning into adulthood.

On 27 June 2025, the Committee lodged its submission to the ACT Legislative Assembly's Inquiry into Men's Suicide Rates. All submissions to the Inquiry can be accessed at *Inquiry into men's suicide rates - ACT Legislative Assembly*.

During the reporting period, the Committee commenced research in 2 priority areas:

1. information sharing, privacy and consent, focusing on how current legislative and policy frameworks support safe and coordinated responses for at risk children, young people and their families
2. transport-related deaths and serious injuries in the ACT, examining contributing factors, system interfaces and prevention opportunities.

Together, this work will strengthen the evidence base for the Committee's recommendations and support cross-agency efforts to reduce preventable harm.

The Committee also continued to work across the following areas:

- challenges associated with the completion of death certificates, noting that gaps in documentation can affect the quality and clarity of available mortality information
- collecting information about the circumstances and causes of death for children, young people and young adults in the ACT
- contributing, through its biennial report, to government and community, knowledge and understanding of the causes and circumstances of children and young people's deaths
- actively promoting the Committee's work with relevant ACT agencies and individuals and offering informed perspectives to assist in the prevention or reduction of deaths or injury
- maintaining links with interstate and national bodies undertaking similar work.

Committee membership

The Committee farewelled longstanding member Dr Catherine Sansum in March 2025. Over her 13 years of service, Dr Sansum made significant contributions to data quality and coding as a member of the data sub-committee, supported several major reviews and consistently advocated for the safety and wellbeing of children and young people in the ACT. The Committee sincerely thanks Dr Sansum for her dedication, expertise and enduring commitment to the Committee and its work.

During 2025, the Committee acknowledged the departure of Director-General Ms Catherine Rule from the Health and Community Services Directorate and expressed appreciation for her service and contribution.

The Committee also farewelled Mr Francis Ventura in January 2026. Mr Ventura's expertise in child safety and education, together with his thoughtful and informed contributions, have been of significant value to the Committee's work.

We extend our appreciation for their dedication and wish them well in their future professional endeavours.

The Committee also welcomed the appointment of Ms Kareena Arthy as Director-General of the Health and Community Services Directorate and member of the Committee.

Continuing work

Given the small size of the ACT, its specific population parameters and the distribution of health and community services, the Committee is in the unique position of being able to review and monitor the impact of systems on small groups of families as well as individual cases. This, and the involvement of Committee members in various parts of the system, allow us to identify and advocate for areas that need improvement to support the ACT's children and young people.

The Committee will continue to undertake in-depth and thematic reviews and provide these to government with relevant recommendations to improve legislation, systems and processes that aim to reduce deaths of children and young people in the ACT. The Committee will look at undertaking reviews into those deaths that are likely to provide significant insights or learnings.

The Committee will continue to increase public awareness of, and advocate for, issues that affect the health and safety of children and young people in the ACT by disseminating information through its biennial report and special reports, the Committee's website and the Committee's involvement at a national level with the Australian and New Zealand Child Death Review and Prevention Group.

Disclosure of information

Under s 727P of the Act, the Committee may exchange information with an entity that exercises a function under a law of state that corresponds or substantially corresponds to a function of the Committee. During 2024 and 2025, the Committee provided information to entities in Qld and NSW.

The NSW Child Death Review Unit includes deaths of children who normally reside in NSW but die in the ACT, as well as ACT resident children whose deaths occur in NSW. Consistent with this cross-jurisdictional arrangement, the Committee continues to share relevant information with the NSW Child Death Review Team to support accurate reporting and review processes. This work is undertaken under the information exchange agreement between the ACT and the NSW Child Death Review Team, made pursuant to s 34D(3) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

Since the establishment of this agreement, the Committee has continued to exchange information with NSW as required. During the current reporting period, information was provided in January, May, September and October in 2024 and in May and October in 2025.

These exchanges support the completeness and accuracy of child death data across both jurisdictions and contribute to national efforts to better understand and prevent child deaths.

The Committee is a member of the Australian and New Zealand Child Death Review and Prevention Group. In November 2024, the Committee provided ACT statistics for 2022, and in November 2025 it submitted the ACT statistics for 2023. These data sets will be included in the in the *Australian (and New Zealand) Child Death Statistics*.

Appendix A Data tables

Table A.1: Australia live births, deaths and infant mortality rates

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Births	303,318	301,617	309,582	308,065	299,697	305,377	311,104	309,142	315,147	305,832	294,369	309,996	300,684	286,998	292,318
Neonatal deaths[a]	842	805	726	763	714	707	700	744	737	727	706	745	695	660	719
Infant deaths[b]	1,229	1,140	1,031	1,094	1,012	991	970	1,019	988	1,009	943	1,009	958	911	957
IMR[c]	4.1	3.8	3.3	3.6	3.4	3.2	3.1	3.3	3.1	3.3	3.2	3.3	3.2	3.2	3.3

ACT live births, deaths and infant mortality rates

Year	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Births	5,152	5,121	5,461	5,545	5,552	5,542	5,152	6,207	5,374	5,520	5,368	5,543	5,455	5,222	5,218
Neonatal deaths[a]	15	9	14	10	11	14	12	14	19	5	14	16	9	23	14
Infant deaths[b]	19	15	16	16	13	21	16	17	20	5	19	18	19	28	18
IMR[c]	3.7	2.9	2.9	2.9	2.3	3.8	3.1	2.7	3.7	0.9	3.5	3.2	3.5	5.4	3.5

Data Source: ABS (2026d) Live births, infant deaths and infant mortality rates by State/Territory, Sex and Age [Data Explorer]: Infant deaths and Infant mortality rates, Year of registration, Age at death, Sex, States, Territories and Australia , accessed 19 March 2026.

[a] Neonatal deaths are deaths under 4 weeks (28 days) of age.

[b] Infant deaths are deaths under 1 year of age.

[c] IMR=infant mortality rates, calculated by the ABS using the number of infant deaths.

The following tables relate to deaths of all children and young people who died in the ACT regardless of usual place of residence

Table A.2: Annual deaths of children and young people including ACT residents who died elsewhere and interstate residents who died in the ACT, 2021–2025

Year [a]	All deaths[b]	ACT residents		non-ACT residents who died in the ACT	
Jan-Dec	Number	Number	Per cent	Number	Per cent
2021	36 (1)	24	66.7%	12	33.3%
2022	38 (7)	32	84.2%	6	15.8%
2023	53 (5)	40	75.5%	13	24.5%
2024	37 (6)	27	73.0%	10	27.0%
2025	43 (5)	29	67.4%	14	32.6%
Total 2021–2025	207 (24)	152	—	55	—
Mean (average)	41.4	30.4	73.4%	11	26.6%

[a] Figures not directly comparable to previous reports.
[b] Totals (All deaths) include open coronial cases. Number of open coronial cases appear in parentheses next to total number of deaths. Percentages are percentages of the total (all deaths) for the individual year.

Table A3: Key demographic characteristics of all deaths of children and young people in the ACT, 2021–2025

Characteristics	2021–2025 Deaths[a]	
	Number	Per cent
Total		
Persons 0–17 years of age	183	
Sex[b]		
Female	80	43.7%
Male	103	56.3%
Age[c]		
Less than 28 days	132	72.1%
28–365 days	22	12.0%
1–9 years	10	5.6%
10–14 years	13	7.1%
15–17 years	6	3.3%
Aboriginal and Torres Strait Islander status		
Aboriginal and/or Torres Strait Islander	20	11.0%
Neither Aboriginal nor Torres Strait Islander	●	●
Unknown	●	●

[a] Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.
[b] There were less than 5 children or young people who had their sex coded as undetermined. They have been randomly assigned to one or the other categories.
[c] Percentages may not total 100 due to rounding.

Table A.4: Indicative cause of death of all deaths of children and young people on the ACT Children and Young People Death Register, 2021–2025

Indicative cause of death	2021–2025 Deaths[a]	
	Number	Per cent
Total	183	
Medical causes	92	50.3%
Extreme prematurity	83	45.4%
Suicide	●	●
Unintentional injury/accident (including transport and drowning)	●	●
SIDS and or SUDIa	●	●

[a] SIDS=sudden infant death syndrome; SUDI=sudden unexpected death in infancy.
[a] Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.

Table A.5: ICD-10 grouping cause of death, ages 0–17 years, 2021–2025

ICD-10 grouping	2021–2025 Deaths[a]	
	Number	Per cent
Total	183	
Certain conditions originating in the perinatal period	125	68.3%
Congenital malformations, deformations and chromosomal abnormalities	17	9.3%
Injury, poisoning and certain other consequences of external causes	8	4.4%
Diseases of the nervous system	8	4.4%
Neoplasms (cancers)	6	3.3%
Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified	7	3.8%
Diseases of the respiratory system	5	2.7%
Diseases of the circulatory system	5	2.7%
Other causes	●	●

[a] Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.

The following tables relate to deaths of ACT resident children and young people only. They exclude deaths of children and young people from other jurisdictions

Table A.6: Demographic characteristics of ACT resident children and young people who died, 2021–2025

Characteristics	2021–2025 Deaths[a]	
	Number	Per cent
Total		
Persons 0–17 years	128	
Sex[b]		
Female	48	37.5%
Male	80	62.5%
Age		
< 28 days	84	65.6%
28–365 days	17	13.3%
1–9 years[c]	10	7.8%
10–14 years	11	8.6%
15–17 years	6	4.7%

[a] Figures do not include open coronial cases. Figures include ACT residents only, regardless of place of death.
[b] There was one case where sex was not coded as male or female, this case has been randomly coded for reporting purposes.
[c] Ages 1-4 and 5-9 years have been combined due to small cell counts.

Table A.7: Indicative cause of death, ACT resident children and young people, 2021–2025

Indicative cause of death	2021–2025 Deaths[a]	
	Number	Per cent
Total		
ACT resident deaths 0–17 years	128	
Medical causes	67	52.3%
Extreme prematurity	53	41.4%
Suicide	•	•
Unintentional injury/accident (including transport and drowning)	•	•
SIDS and or SUDIb	•	•

[a] Figures do not include open coronial cases. Figures include ACT residents only, regardless of place of death.
[b] SIDS=sudden infant death syndrome; SUDI=sudden unexpected death in infancy.

Table A.8: ICD-10 grouping cause of death, ACT resident children and young people, 2021–2025

ICD-10 grouping	2021–2025 Deaths[a]	
	Number	Per cent
Total	128	
Certain conditions originating in the perinatal period	79	62.7%
Congenital malformations, deformations and chromosomal abnormalities	13	10.2%
Diseases of the nervous system	8	6.3%
Injury poisoning and certain other consequences of external causes	7	5.5%
Neoplasms (cancers)	6	4.7%
Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified	5	3.9%
Diseases of the respiratory system	•	•
Diseases of the circulatory system	•	•
Endocrine, nutritional and metabolic diseases	•	•
Certain infectious and parasitic diseases	•	•

a Figures do not include open coronial cases. Figures include ACT residents only, regardless of place of death.

Table A.9: ACT and non-ACT resident infant deaths by age group and sex, 2021–2025

Characteristics	2021–2025 Deaths[a]	
	Number	Per cent
Total ACT Resident infant deaths	101	
Neonatal deaths under 28 days	84	83.2%
Infant deaths 28–365 days	17	16.8%
Sex		
Female	36	35.6%
Male	65	64.4%
Total Interstate Resident infant deaths	53	
Neonatal deaths under 28 days	48	90.6%
Infant deaths 28–365 days	5	9.4%
Sex		
Female	31	58.5%
Male	22	41.5%

[a] Figures do not include open coronial cases.
[b] Figures include ACT residents only, regardless of place of death.

Table A.10: Number of ACT notification reports of children aged 0–17 years who have died, 2021–2025

Child notification	2021–2025 Deaths[a]	
	Number	Per cent[b]
Child concern report only	8	6.3%
Child protection report or appraisal	●	●
Prenatal child concern report	●	●
Not known to CYF	118	92.2%

[a] Figures do not include open coronial cases. Figures include ACT residents only, regardless of place of death.
[b] Percentage does not sum to 100% due to suppression of small cells.

Appendix B Methods

Date-of-death reporting for the Register

For this report, the Committee has determined it will recognise the actual date of death of each child or young person in the ACT, rather than the registered date of death. This will provide an actual number of child and young person deaths for the reported 5-year period and allow for a more accurate reflection of what was occurring at the time of the child or young person's death; namely, the circumstances, risk factors, relevant agencies' policies and practices, and the political environment at that time. The time between the actual date of death and the registered date of death may be substantial and, in that time, there may have been changes in the aforementioned circumstances. However, there may need to be adjustments if additional deaths of children and young people are registered at a later time.

As the Committee is using the actual date of death rather than the registered date of death, there may be discrepancies between the information in this report and the information reported by the ACT Registrar of Births, Deaths and Marriages and by other Australian jurisdictions.

Fewer than 5 total deaths

When a particular cohort of children and young people has fewer than 5 total deaths, the exact number of deaths will not be reported where this could otherwise identify a child. This will ensure that the Committee complies with s 727S(3) of the Act and does not disclose the identity of a child or young person who has died or allow a child or young person who has died to be identified. The number of deaths will be reported as •, meaning the number of children and young people who died is fewer than 5 but greater than zero.

When a cause of death category has fewer than 5 deaths, this report will not provide more detailed information about the category's cohort. This is not only to ensure the Committee's compliance with s 727S(3) of the Act but also to ensure the child's, young person's and family's right to privacy is maintained.

In some instances, further data have been suppressed to prevent calculation of figures. Suppression of further data will not occur when it will considerably impact on the Committee's ability to report population trends. In these instances, calculation of figures may be possible but the identity of a child or young person who has died will not be disclosed or be able to be deduced.

Population estimates and rates

ACT and Aboriginal and/or Torres Strait Islander children and young people population figures are taken from the latest Australian Bureau of Statistics' estimated resident populations as at 30 June for each relevant year.

Rates are calculated using child death data contained in the Register and both ABS estimated and projected statistics of the ACT population. These rates are calculated per 10,000 children and young people by dividing the total number of deaths by the total population in each age group.

Appendix C Response to recommendations

City and Environment Directorate Response

ACT Government
City and Environment

Our ref: DG2026/00297

Ms Megan Mitchell AM
Chair
ACT Children and Young People Death Review Committee
HCSDChildDeathCommittee@act.gov.au

Dear Ms Mitchell

Thank you for your letter of 6 February 2026 regarding updates on the implementation of recommendations made by the ACT Children and Young People Death Review Committee in relation to home swimming pool safety. I apologies for the delay in responding.

The ACT Government remains strongly committed to preventing deaths and serious injuries from drownings and near-drownings in home swimming pools. I am pleased to provide an update on the regulatory reforms implemented through the Building (Swimming Pool Safety) Legislation Amendment Act 2023, which was notified on 15 November 2023 and commenced on 1 May 2024.

The reforms establish a strengthened regulatory framework that will require all ACT home swimming pools and spa pools capable of containing water to a depth of more than 30 centimetres to have a barrier compliant with modern safety standards by 1 May 2028. A transition period is in place to support owners to meet these new requirements, including the ability to apply for partial or full exemptions in defined circumstances.

Since 1 May 2024, offence provisions have commenced for failing to maintain pool safety barriers and for not keeping pool gates closed. At the sale or lease of a property with a pool, owners must disclose the compliance status of the pool barrier (from 1 May 2028, the pool barrier must be compliant). Further guidance and resources are available on the City and Environment Directorate (CED) website to support awareness and compliance.

Offences for not having a fully compliant pool safety barrier will commence on 1 May 2028, allowing time for owners to undertake necessary upgrades.

These reforms directly address several of the Committee's historical recommendations, particularly those involving:

- the application of modern fencing standards to all home swimming pools
- improved compliance processes at key regulatory touchpoints (for example, sale or lease)
- strengthened maintenance obligations
- increased inspection and enforcement capability.

The ACT Government did not progress a pool registration system or mandate CPR training or signage, as outlined in Appendix A to your letter. The project team found that existing

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building approval records provide sufficient data to support compliance programs, and that promotion of CPR awareness continues through the Government's Backyard Lifeguard campaign and website, which encourages CPR training and provides safety resources to pool owners.

Public consultation throughout the project played an important role in shaping the reforms, and CED will continue to engage with community members and stakeholders as implementation progresses.

In relation to your request for advice on recommendations suitable for closure, CED considers that the reforms introduced through the legislation package substantially action the Committee's recommendations concerning modernising safety standards and improving compliance mechanisms and are suitable for closure.

Thank you again for contacting me on this matter, I trust this information is of assistance.

Yours sincerely



Dave Peffer
Director-General

13 March 2026

Health and Community Services Directorate Response

No.	Recommendation / action	HCSD response
Information sharing and recording		

1	Improvements to information sharing and recording practices aimed at enabling:
	• Government and related services to improve the systems and culture for sharing information in the interests of protecting vulnerable children.
	  ○ To operate effectively there is a need for organisational and professional cultures with strong governance and practice leadership, which observe and understand the guiding legislation.
	  ○ The ACT jurisdiction should consider providing training to relevant organisations concerning appropriate information sharing. This includes greater funding to improve education around rights and responsibilities.
	• Service providers to use informal system for sharing of information, moving away from a penalty framework, including sharing information on health referrals, decisions and recommendations. Access by doctors to health notes during pre-court assessment period.
	• Better decision-making and better outcomes for individuals to reduce avoidable deaths of children and young people.
	• The assessment of risks when families move between jurisdictions.
	• The Directorate to ensure clients' documents are complete, information is recorded fully and accurately and that assessments are documented in a manner that records the justification of decisions made by professionals in regard to the safety of the child.
	• Ongoing engagement with the Commonwealth and other states jurisdictions with regards to the making of nationally consistent legislation and administrative arrangements, including the
		HCSD notes this recommendation was closed in the 2020 CYPDRC Annual Report

No.	Recommendation / action	HCSD response
	development of a national database, to enable the sharing of information related to the safety and wellbeing of children. • The Family Safety Hub should also look to discern patterns, trends and risk that can inform system improvements, identify systematic issues and assist with better service provision. • That current complaint processes in CYPS and ACT Together are reviewed to ensure that information is provided in ways that allow non-English speaking clients and those with literacy difficulties access to information.	
No.	**Recommendation / action**	**HCSD response**
Addressing the risk factors in children's lives		
2	Improvements in responding to risk factors through: • Reviewing current practice models following prenatal reports to maximise early intervention strategies across ACT Health and Community Services Directorate before the birth of a child, including access to GPs and prenatal health checks. Need to follow up non-attendance at appointments. o The engagement of culturally appropriate services for Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse families. • Establishing a mechanism to identify and review children who have been reported to CYPS where four reports or more have been made and where the following co-existing risk factors have been identified: o o domestic and family violence o substance misuse o unstable housing o limited parental service engagement. • Reviewing the capacity for current practices to identify and respond to cumulative harm through: o Review of the legislation to test whether it is sufficient in protecting children where risks do not meet current thresholds for intervention but where cumulative harm is identified.	HCSD supports families to keep children safe and with a priority to keep children with families. HCSD has seen a shift of focus and resources to an early support response with a focus on diversion from a court-based child protection intervention. The Family Response and Engagement Teams (FRE Team) • focuses on early support and diversion from a statutory response • works in partnership with families to support their needs and reduce risks to children • connect families with health providers and counselling and other community programs and/or practical support such as housing or access to education. A Specialist Prenatal FRE team has been established as part of the reforms to support earlier response and work with Health and NGOs. The First Nations Family Response and Engagement Unit First comprises Appraisals and Support Responses, the Family Group Conferencing Team, the Family Finding Team and the Family Connection and Restoration Team. The focus of the First Nations team is: • implementing self-determination in the child protection setting

No.	Recommendation / action	HCSD response
	○ Training and mandatory refresher courses for workers raise awareness of the full extent of their powers under legislation. Training programs should be evaluated to assess their effectiveness.	• delivering best practice culturally safe support to children, young people and families • providing tailored supports to help address identified issues to ensure each family has the best chance of providing a safe environment for children and young people. Early support helps address emerging issues and includes referrals to services as part of keeping families together so children can thrive. • supporting the work of the division, and not just at the front end — the unit implements and supports culturally safe practices with families engaged with HCSD. Signs of Safety HCSD adopted the Signs of Safety practice framework in June 2024. The framework provides a structured approach to assessing risk, understanding safety and planning with children, families and networks. Signs of Safety supports analysis of past harm, current danger and complicating factors, alongside strengths and existing safety. This information is brought together to inform assessment, planning and decision-making in relation to children's safety and wellbeing. The framework uses a shared assessment process and plain language to support open discussion with children, families and networks. This builds shared understanding of concerns and strengths and supports the identification of practical actions that reduce risk and strengthen safety. Safety planning focuses on identifying what need to change to increase safety in children everyday life and lived experience. Plans are developed with families and their networks, with an emphasis on behaviourally specific and observable actions that address identified safety concerns.

No.	Recommendation / action	HCSD response
		Next Steps for Our Kids 2022–2030 (Next Steps) An ACT Government reform agenda with the vision that children and young people in the ACT are safe, strong, connected and living their best life. Next Steps ensures a broader focus on earlier supports for Aboriginal and Torres Strait Islander families that is culturally safe, integrates service delivery and leads with self-determination as a core principle. The strategy also focuses on earlier support, family strengthening, trauma-responsive and restorative practice, improved trust and transparency, partnering with community, and a continuum of support, to reduce escalation into statutory systems and address key risk factors in children's lives. **Preferred Providers Panel** Established in late 2024, the Children, Young People and Families Preferred Providers Panel (CYPF Panel) improves safety and outcomes for vulnerable children by ensuring consistent, high-quality, capability-based service delivery. Services are being phased in progressively, with providers continuing to come on board across 2026. This approach is supporting a smooth transition and continuity of care. Panel Deeds include Cultural Clauses which set out the Territory's expectations for how providers work with Aboriginal and Torres Strait Islander children, young people, their families and community. **Continuum of support for children and young people** The Panel arrangements address risks associated with instability and transition points by providing coordinated, wrap-around support for families engaged with, or at risk of engagement with statutory services, from early childhood through to young adulthood, including extended care and after-care supports up to age 21.

No.	Recommendation / action	HCSD response
		The panel includes Sustaining Families services, delivering intensive family support, restoration and family preservation, with a focus on keeping children safely at home or restoring them to family wherever possible. ACT Aboriginal and Torres Strait Islander Children's Forum (AACF) The ACT Aboriginal and Torres Strait Islander Children's Forum (AACF), now in its second year of operation, brings together. ACCOs, service providers (including out-of-home care providers) and ACT Government officials to jointly implement reforms that strengthen culturally sensitive practice across mainstream services. AACF enables Aboriginal self-determination in driving policy and practice change so Aboriginal children grow up strong, safe and connected to culture, family and community. In 2025, AACF members reviewed and updated cultural clauses and policy practice guidelines in provider contracts, endorsed in November 2025, with implementation now underway. In 2026, AACF will focus on developing a shared Cultural Accountability tool and building cultural capability across the sector through shared training, professional development and showcasing culturally safe practice.
No.	**Recommendation / action**	**HCSD response**
Enhanced supports for families under pressure		
3	Enhanced supports for families under pressure that address: • The need for access to and connection with services that can assist families to avert crisis, with a clear and trusted access point for families at points of crisis. ○ Voluntary family support services should be provided by someone other than CYPS to avoid duality of roles.	HCSD notes this recommendation was closed in the 2020 CYPDRC Annual Report

No.	Recommendation / action	HCSD response

	• The provision of interim follow-up support from caseworkers where they make referrals for vulnerable families but are waiting for services to commence.
	• The need for services to be proactive in engaging parents to benefit from services, such as the National Disability Insurance Scheme, and the need for children and young people to be at the centre of decision-making about services.
	• The need for a case planner to provide continuity of relationships and direction for family, as well as to facilitate communication between service providers. This applies in the health setting too.
	• The awareness of professionals to recognise and respond to stress in families and to better understand the impact that this has on children when other risk factors are evident.
	• The need for innovative and evidence-informed approaches to working with individuals who have experienced intergenerational trauma, particularly in relation to:
	  ○ children who are identified as experiencing cumulative harm
	  ○ young parents who were engaged in statutory child protection services and/or corrective services
	  ○ male and female perpetrators of family violence.
	• The need for vulnerable families with an intergenerational history of abuse to be offered trauma-informed targeted parenting support prior to and following birth of their child in a non-stigmatising maternal health service.
	  ○ The ACT jurisdiction should consider the introduction of standardised empirically validated assessment tools to use in the pre- and post- natal periods in order to identify vulnerable families requiring further support. This should include necessary training for practitioners.	

Child-focussed practice		
4	Changes to services to make them more focussed on children by:	HCSD notes this recommendation was closed in the 2020 CYPDRC Annual Report

No.	Recommendation / action	HCSD response
	• Enabling access to comprehensive medico-psychosocial assessment for families with multiple and complex needs, with services prioritised to the child's assessed needs. • Moving the focus of services to the best interests of the child, in particular the child's safety and assessing whether the child's needs are being adequately addressed. • Shifting the focus to cumulative risk, rather than episodic risk, so that the family or child's need can be addressed holistically, rather than in an ad hoc piecemeal way, where the scale of the problem only becomes evident after an event. • Organisations and professionals working with young children need to be supported to recognise that all children, including very young children, have rights as set out in the United Nations Convention on the Rights of the Child (1989). Professionals need to be supported to build capacity, skills and knowledge to work, think and act in a way that supports the implementation of children's rights. • Building organisational and workplace cultures within the ACT that embrace a range of practices and attitudes that aim to keep the 'child in mind'. Further work is required to develop and support all professionals and adult services, such as Corrective Services, to be aware of and to act with the best interests of the child as a primary consideration.	
No.	**Recommendation / action**	**HCSD response**
Assessment of parenting capacity		
5	To enable CYPS to better assess parenting capacity: • The ACT jurisdiction should consider the introduction of standardised empirically validated assessment tools to use in the pre- and post-natal periods in order to identify vulnerable families requiring further support. This should include necessary training for practitioners. • The ACT jurisdiction should consider establishing a high-quality parenting capacity assessment service and support for parents with	HCSD adopted the Signs of Safety practice framework in June 2024. Signs of Safety provides a clear structure for assessing parenting capacity. It supports assessment of how caregivers meet children's needs, respond to identified concerns and demonstrate protective behaviours over time. The framework emphasises observable behaviour and patterns of care, rather than stated intentions alone. This includes considerations of the consistency, quality and sustainability of care and how caregivers'

No.	Recommendation / action	HCSD response
	children where four reports have been received about a child by CYPS, including any prenatal reports. • All information and reports from parents provided to services need to be tested through accessing information from other services, particularly in regard to reports of parental drug and alcohol use or instances of domestic violence.	response and maintain safe care during periods of stress or increased pressure. Assessment is undertaken through a shared process with families and their networks, using clear and accessible language. This supports a transparent and evidence-informed understanding of parenting capacity in relation to identified risks and safety needs Implementation remains at an early state with further work required to strengthen alignment with policy, procedures and system workflows. • Reforming our practice by embedding Signs of Safety (SofS): ○ SofS is a strengths-based practice framework ○ It provides earlier support to children, young people and families ○ Ensure they are safe, supported and connected to their culture and identity. Places the safety and wellbeing of children and young people at the centre.
No.	**Recommendation / action**	**HCSD response**
Staff training and development of decision-making capacity		
6	Enhanced training and development for staff working with families to ensure: • Improved interpretation of drug screen results to assess the impact of the drug use on the capacity to provide safety and care. This could be through training or practice directions. • That supervision of staff assists in critical reflection of casework, decision and practice and professional development. ○ Professional development opportunities such as supervision and in-service staff training should be provided in organisations working with vulnerable families to ensure that workers utilise current knowledge of the impact of gender in assessment and interventions and incorporate gender sensitive strategies into routine practice, particularly in relation to client experiences of trauma, domestic violence and service utilisation.	HCSD notes this recommendation was closed in the 2020 CYPDRC Annual Report

No.	Recommendation / action	HCSD response

	• The use of evidence-based decision-making in relation to the restoration of children to their parents. Need for clarification around when restoration is no longer considered in the best interests of the child.
	• Improvements to the way CYPS make judgements about the veracity of reports and comprehensiveness of reports, including need for comprehensive assessment of cumulative harm, particularly for older children where imminent risk may not be present.
	• The presumption of the mother as the 'protective parent' as observed in records and applied by workers is critically reviewed. The participation of bother parents/caregivers in assessments and interventions should be required where it is evident that both parents/caregivers are involved in the care of the child.
	• Good data is used to support judgements about weighting decisions with regards to the capacity of the parents as opposed to the vulnerabilities of the child.
	• That any internal merits review process implemented by CYPS:
	  ○ is underpinned by the key values of the best interest's principal, timeliness of decision-making, participation and transparency
	  ○ is codified by amending the Children and Young People Act 2008.
	• The ACT jurisdiction should consider establishing an external merits review mechanism that would hear matters not adjudicated by a court and that were not resolved through internal review.
	•	

Safe sleeping		
7	Provide families with information on safe sleeping through: • consistent guidelines agreed across the directorates and delivered through the continuum of services	HCSD notes this recommendation was closed in the 2020 CYPDRC Annual Report

No.	Recommendation / action	HCSD response
	○ cross-directorate agreement is established about safe sleeping guidelines ○ professionals and providers have access to evidence-based training and resources on safe sleeping. • the provision of safe infant sleeping promotion, co-sleeping and bed-sharing messages to all caregivers prior to and after the birth of the child by health and social welfare professionals • ensuring vulnerable families are provided with the necessary support to obtain appropriate bedding for the child prior to leaving hospital.	
Blind cords		
8	The Committee wrote to the Director-General of Community Services in 2014, following the deaths of 2 young children in NSW as a result of blind cord injuries. The Committee recommended that ACT Housing perform inspections of blind and curtain cords for safety and compliance with standards as part of the housing inspection process. The Committee also recommended that ACT Housing introduce methods to increase the safety of corded internal window coverings in public housing, such as the installation of safety devices.	HCSD notes this recommendation was closed in the 2020 CYPDRC Annual Report
Mental health		
9	**Involve young people with lived experiences** The Committee recommends that any future design and delivery of suicide prevention services include young people and their families who have a lived experience of suicide including within the analysis and co-design process in relation to the Office of Mental Health working group on the responses to the needs of children and young people with moderate to severe mental health support needs.	**Recommend as suitable for closure (actioned)** The Mental Health and Suicide Prevention division within HCSD has moved to embed lived experience in all aspects of its work. Genuine co-design and embedding lived experience, including that of young people, underlines all mental health and suicide prevention projects and programs. HCSD partnered with the Youth Coalition of the ACT and the Capital Health Network to establish the ACT Child and Youth Mental Health Sector Alliance (CYMHSA). The CYMHSA provides a structured, formal mechanism for government, community stakeholders, the private sector and people with lived experience to connect and collaborate to improve service system responses for children and young people. During 2024–25, the CYMHSA held 2 forums, ongoing working groups and online webinars

No.	Recommendation / action	HCSD response
		enabling sector-wide consultation, planning, prioritising and decision-making on projects to progress key reforms. HCSD continues to support the Youth Reference Group (YRG) of the ACT Child and Youth Mental Health Sector Alliance. The YRG, established in 2023, is a dedicated group of young people aged 16 to 25 with lived/living experience of mental illness across the spectrum of care. The YRG has supported initiatives across the sector through the key functions of consultation, building relationships and independent projects. It prioritises promoting and advocating for safe and accessible co-design practices across both government and community sectors. In 2024, the YRG released "Our Say": Youth lived experience frequently asked questions — a public resource to address consultation fatigue and promote meaningful engagement. The Youth at Risk of developing mental ill health project (the Youth at Risk Project) was established in 2022, as part of the Commonwealth-ACT Mental Health and Suicide Prevention Bilateral Agreement, to improve the ACT sector response to young people presenting with complex needs and trauma, with or at risk of developing moderate mental ill health. A range of co-design and consultation activities for the project took place across 2024-25. Approximately 450 individuals and more than 60 separate organisations, agencies, services participated in these activities. Consumer and youth representatives included the ACT Child and Youth Mental Health Sector Alliance Youth Reference Group, along with a group of young carers and members from the Carer Collective coordinated by Carers ACT. In 2025, HCSD commissioned the Youth Coalition to lead a co-design project for an aftercare service for young people aged 12 to 15 experiencing suicidal crisis or following suicidal distress. The co-design will inform future measures aimed at providing support for young people in this space. Similarly, a contract has commenced for a specialist consultancy to work with Community and Aboriginal Community Controlled Organisations (ACCOs) to co-design an Aboriginal and Torres Strait Islander Youth

No.	Recommendation / action	HCSD response
		Mental Health Service Model where self-determination and a true partnership approach is paramount. The provider will work in partnership with Community, ACCOs, non-Indigenous organisations, key reference groups and government to develop a youth mental health service model that is holistic and tailored towards the specific needs of our Aboriginal and Torres Strait Islander young people.
10	**Evaluate current youth mental health and suicide prevention programs** The Committee recommends that the ACT Government evaluate current youth mental health and suicide prevention programs, to determine their effectiveness including in meeting demand.	**Recommend as suitable for closure (actioned)** HCSD continues to implement the Youth Aware of Mental Health program (YAM), an evidence-based mental health and suicide prevention program for young people aged 14 to 16 years. Delivered by Mental Illness Education ACT (MIEACT), the program is provided to Year 9 students across public, independent and Catholic high schools in the ACT. It seeks to reduce depression and suicidal ideation and facilitate healthy lifestyle choices amongst young people. The positive impact of the YAM program is well documented internationally, and the Black Dog Institute's evaluation of the use of YAM in the NSW LifeSpan trial (published in 2023) has led the NSW Department of Education to adopt the program across public secondary schools. The ACT YAM program is currently funded until December 2029.

No.	Recommendation / action	HCSD response
11	**Implement information campaigns** The Committee recommends that targeted information campaigns be implemented that target young people at risk and their families. Specific information should be provided on risk factors, warning signs and available services so that those closest to young people in distress can provide support.	**Recommend as suitable for closure (BAU)** HCSD continues to support the implementation of the following youth-focused awareness initiatives. <u>The Youth Aware of Mental Health program (YAM)</u> This school-based program actively engages students with the topic of mental health through role-play and student-led discussions supported by a trained YAM Instructor. YAM is run over 3 weeks and the topics covered are: 1. What is mental health? 2. Stress and crisis 3. Self-help advice 4. Depression and suicidal thoughts 5. Helping a friend in need 6. Who can I ask for advice? <u>MindMap</u> MindMap is an online triage navigation portal for young people, parents and carers in the ACT seeking mental health support, services and information. It is operated by Marymead CatholicCare and provides support for young people online, links with existing services and provides holding support for people on a waitlist. Furthermore, the HCSD has continued to support information sharing, including for young people and their families, through participation in Mental Health Week in October 2024 and October 2025, and R U OK Day 2024 and 2025.

No.	Recommendation / action	HCSD response
12	**Implement and evaluate the Connecting with People program** The Committee supports the proposed implementation of the Connecting with People program within ACT clinical settings, as a model of person-centred assessment and safety planning that uses peer-reviewed clinical tools. Following the initial rollout, the Committee recommends that evaluation of the program's effectiveness be conducted, which includes consideration of establishing the program in education and non-government organisation settings.	**Recommend as suitable for closure (actioned/BAU)** Connecting with People (CwP) is an evidence-informed, compassion-based approach to suicide prevention and risk mitigation which aims to develop a shared language to improve understanding of suicidal distress. Following the initial roll out by Canberra Health Services (CHS) in March 2021, HCSD contracted the Mental Health Community Coalition in April 2024 to deliver CwP into the non-government mental health sector. Since June 2024, 20 CwP sessions have been delivered with 208 mental health care service workers participating across 3 different program modules. There have been 8 mental health care workers trained to continue to deliver the program into ACT workplaces through to April 2027. Preliminary quantitative and qualitative program evaluation shows good engagement and general satisfaction with the training.
13	**Implement a support plan process in clinical settings** The Committee recommends the implementation of a proactive support plan for all young people following a suicide attempt. Young people and caregivers should be supported to be involved in the development of a support plan before discharge from clinical settings. Continuity of care with clear timeframes and an identified key person who will follow up on service engagement should be identified. This plan should be shared with all individuals and organisations identified as a support to the young person.	**Recommend as suitable for closure (BAU)** The Child and Adolescent Mental Health Services (CAMHS) Hospital Liaison Team at Canberra Health Services (CHS) conduct safety planning and develop a safety plan with the young person and parent or guardian in the Emergency Department. Safety plans include contact details for police, Lifeline, Access Mental Health, Kids Helpline, Butterfly Foundation, National Helpline and the CAMHS North and South teams. Safety plans are documented in the young person's clinical file, and a copy is provided to the young person and their parent or guardian.
14	**Implement assertive outreach guidelines** The Committee recommends that assertive follow-up occur for young people after a suicide attempt, which should include contact within the first 24 hours, frequent contact, face-to-face visits and support that includes intense case management. Where possible, contact with young people and their families should be flexible, with the preference for professionals to meet with young people in their own environments.	**Recommend as suitable for closure (BAU)** The Child and Adolescent Mental Health Services (CAMHS) Hospital Liaison Team at Canberra Health Services (CHS) arrange follow-up for young people within 7 days of hospital discharge. CAMHS conduct 7-day post-hospital reviews to ensure continuity of care during a period of increased vulnerability, specifically aiming to maintain clinical stability and reduce the high risks of suicide and hospital readmission immediately following discharge. If a young person is already

No.	Recommendation / action	HCSD response
	The Committee recommends that the ACT Government monitor the effectiveness of the Suicide Prevention Outreach Teams in NSW to inform future planning of ACT suicide prevention outreach programs.	linked with a CAMHS community team, the community team will provide this follow-up. Alternatively, a young person will be referred to the Adolescent Intensive Home Treatment Team (AIHTT) to provide follow-up. The AIHTT provide in-home, post-hospital support for up to 4 weeks following a suicide attempt. AIHTT also conduct outreach support and provide intensive case management and therapeutic support in the young person's home or a public environment during business hours. Young people requiring earlier follow-up (within 24 hours) are referred for follow-up by the relevant CAMHS teams engaged in their care (CAMHS community or AIHTT). Alternatively, a referral may be made to Access Mental Health or the CAMHS weekend team if the 24-hour follow-up is required outside of business hours. HCSD continues to promote universal aftercare supports in the ACT. HCSD commissioned the Youth Coalition to lead a co-design for an aftercare service for young people aged 12 to 15 experiencing suicidal crisis or following suicidal distress. The co-design will inform future measures aimed at providing support for young people in this space.

No.	Recommendation / action	HCSD response
15	**Train staff on responsible information sharing** The Committee recommends that people from organisations who are likely to encounter suicidal young people be trained on responsible information sharing. This training should be followed with a communication strategy that provides clear guidance to professionals on information sharing guidelines	**Recommend as suitable for closure (BAU)** Canberra Health Services (CHS) has several policies, procedures and guidelines relating to information sharing that can be applied to young people. These include: • CHS Information Privacy Policy • Child Protection Policy • General Practitioners (GP) – Health Facility Access and Sharing of Clinical Information Procedure • Clinical Records Management Policy • Information Privacy Policy The following training is available to CHS staff on responsible information sharing in health care: • Confidentiality and Privacy Training • Champion Privacy Training. Additionally, all CAMHS clinicians will request the young person and their parent and carer or guardian complete a 'consent to share information' document. This document is completed in the clinical record and provides CAMHS with consent to share information with professionals and community-based support systems to better support shared care.

Acronyms

AACF	ACT Aboriginal and Torres Strait Islander Children's Forum
ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHTT	Adolescent Intensive Home Treatment Team
AIHW	Australian Institute of Health and Welfare
ASMR	Age-specific Mortality Rate
BRD/BDM	Registrar of Births, Relationships and Deaths- Formerly Births, Deaths and Marriages
CAMHS	Child and Adolescent Mental Health Services
CCR	Child Concern Report
CDR	Child Death Register
CED	City and Environment Directorate
CHS	Canberra Health Services
CPR	Child Protection Report
CwP	Connecting with People
CYF	Children, Youth and Families
CYMHSA	ACT Child and Youth Mental Health Sector Alliance
CYPDRC	Children and Young People Death Review Committee
CYPF	Children, Young People and Families Preferred Providers Panel
ERP	Estimated Resident Population
FRE	Family Response and Engagement
HCSD	Health and Community Services Directorate
ICD	International Classification of Diseases
ICD-10	International Classification of Diseases 10th Revision
IMR	Infant Mortality Rate
MIEACT	Mental Illness Education ACT
NCIS	National Coronial Information System
NICU	Neonatal Intensive Care Unit

NSW	New South Wales
SIDS	Sudden Infant Death Syndrome
SofS	Signs of Safety
SUDI	Sudden Unexpected Death in Infancy
WHO	World Health Organization
YAM	Youth Aware of Mental Health
YRG	Youth Reference Group

Glossary

Aboriginal and Torres Strait Islander

A person who –

a) is a descendant of an Aboriginal person or Torres Strait Islander person; and
b) identifies as an Aboriginal person or Torres Strait Islander person; and
c) is accepted as an Aboriginal person or Torres Strait Islander person by an Aboriginal community or Torres Strait Islander community.

From the *Children and Young People Act 2008* (ACT)

Certain conditions originating in the perinatal period

Deaths whose cause originates in that period, even though death may occur later. According to the World Health Organization, the perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500g) and ends 7 completed days after birth (WHO, 2011). The ACT definition differs in that the perinatal period begins from 20 weeks gestation and 400 grams in birthweight.

Child

A person who is under 12 years old.

The *Children and Young People Act 2008* (ACT) does not provide guidance on when an individual becomes a 'child'. In accordance with common law, a child is a person who has been born alive, which means the child must be living outside its mother's body by virtue of the functioning of its own organs and indicated by breathing, beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. The term 'a child born alive' does not include stillbirths or other fetal deaths.

Child concern report

Refers to a report made to Children, Youth and Families in accordance with s 359 of the *Children and Young People Act 2008* (ACT) and can be made by either a voluntary or a mandated reporter. A child concern report is a record of information regarding the needs of a child or young person or is about a child or young person's safety or wellbeing.

Child Protection Report/Report under s 360(5) of the Act

If the Director-General suspects, on reasonable grounds, that a child or young person subject to a child concern report may need care and protection, the Director-General must decide that the child concern report is a child protection report. Section 345 of the *Children and Young People Act 2008* (ACT) defines that a child or young person is in need of care and protection if the child or young person has been abused or neglected, is being abused or neglected, or is at risk of abuse and neglect AND no-one with parental responsibility for the child or young person is willing and able to protect the child or young person from the abuse or neglect or risk of abuse or neglect.

Congenital abnormalities

Includes deformities and chromosomal abnormalities and refer to physical and mental conditions present at birth that were either hereditary or caused by environmental factors and where there is no indication that they were acquired after birth.

Coroner

Refers to a coroner for the ACT appointed under the *Coroners Act 1997.*

Infant

In this report, refers to the period from 28 days to one year of age.

National Coronial Information System

The National Coronial Information System (NCIS) is a centralised data repository that contains information on deaths reported to coroners in Australia (from 2000 onwards) and New Zealand (2007–2024). Administrative support is provided by the Victorian Department of Justice and Community Safety. It is a critical resource for coroners and researchers, providing nationally standardised data to support analysis of preventable deaths and injuries.

The NCIS operates as a voluntary data-sharing collaboration between coroners' courts in each Australian state and territory. All information within the NCIS is prepared by, and remains the property of, the respective coroners' courts from each participating jurisdiction (NCIS, 2026)

Neonatal period

Refers to the period from birth to 28 days of age.

Neoplasm

An abnormal mass of tissue that results when cells divide more than they should or do not die when they should. Neoplasms may be benign (not cancer) or malignant (cancer). Also called tumours (definition from the National Cancer Institute).

Parent

Refers to a birth, step, de facto or adoptive parent of a child or young person as identified by the Committee from information obtained as part of its functions.

Perinatal

Refers to the period from 20 weeks gestation to 28 days of age.

Register

Refers to the ACT Children and Young People Deaths Register, the register of all deaths of children and young people in the ACT that is used by the Committee.

Review by the ACT

Refers to reviews undertaken in the ACT which may include: a coronial inquest into the manner and cause of death of a person who dies in circumstances set out in the *Coroners Act 1997;* a Clinical Health Review Committee; an internal review by the Office for Children, Youth and Family Support; or a joint ACT Health and Office for Children, Youth and Family Support review.

Sibling

Refers to all biological, half, step and adoptive siblings as identified by the Committee from information obtained as part of its functions.

Sudden infant death syndrome (SIDS)

SIDS is a category of SUDI (see below) that has 4 categories: 1a, 1b, 2 and unclassified.

SIDS 1a	• An infant aged over 21 days but under 9 months of age. • Gestational age equal to or over 37 weeks. • Normal clinical history, including during pregnancy. • Normal growth and development. • No similar deaths among siblings, close relatives or other infants in the custody of the carer. • The scene where the incident leading to the death occurred does not provide an explanation of the death. • Absence of potentially fatal pathological findings. • No evidence of unexplained trauma, abuse, neglect or unintentional injury. • No evidence of substantial thymic stress effect and • Negative result in other tests (e.g., toxicology).

SIDS 1b	As with SIDS 1a but:
	• an investigation of the scene where the incident leading to the death occurred was not performed, or
	• one of the following tests/screens was not performed:
	  ○ toxicology
	  ○ radiologic
	  ○ microbiologic
	  ○ vitreous chemistry, or
	  ○ metabolic screening studies.

SIDS 2	As with SIDS 1a or 1b except for at least one of the following:

	• age outside of range • similar deaths among siblings, close relatives or other children cared for by the carer not considered infanticide or a recognised genetic disorder • neonatal or perinatal conditions that have resolved at the time of death • mechanical asphyxia or suffocation caused by overlaying not determined with certainty • abnormal growth and development not thought to have contributed to the death and/or • marked inflammatory changes/abnormalities not sufficient to be unequivocal (certain) cause of death.
SIDS Unclassified	• Did not meet the criteria for SIDS 1 or 2, and • Alternative diagnosis or natural or unnatural conditions are equivocal (uncertain), including cases for which an autopsy was not performed.

SUDI

Refers to sudden unexpected death in infancy, meaning 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.

Young people

In the *Children and Young People Act 2008* (ACT), *young people* means persons over the age of 12 years who are not yet 18 years of age.

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The ACT Children and Young People Death Review Committee is established under the *Children and Young People ACT 2008*

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