ACT Children & Young People
Death Review Committee

Annual Report 2020

ACT Children and Young People Death Review Committee

Who are we?

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 to the Minister for Children, Youth and Families.

The legislation sets out the requirement for Committee members to have experience and expertise in a number of different areas, including paediatrics, education, epidemiology, social work, child safety products and working with Aboriginal and Torres Strait Islander children and young people.

What do we do?

The Committee aims to find out what can be learnt from a child's or young person's death to help prevent similar deaths from happening in the future. To assist with this aim, we keep a register of all the deaths of ACT children and young people who die before they turn 18. We use the information on the register to learn more about why children and young people die in the ACT.

We can make recommendations about changes to legislation, policies, practices and services to both government and non-government organisations.

The Committee does not investigate or determine the cause of death of a particular child or young person. We do not place blame or seek to identify underperformance of individuals.

What do we do with the information on the register?

The Committee provides its annual report on the deaths of children and young people in the ACT to the Minister for Children, Youth and Families and the ACT Legislative Assembly.

We also issue reports and fact sheets to government, public organisations and the community on different topics to help raise awareness of child safety or to spread child death prevention messages.

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

Enquiries about this publication should be directed to:
ACT Children and Young People Death Review Committee
GPO Box 158, Canberra ACT 2601
e childdeathcommittee@act.gov.au **t** 02 6207 7764
ISSN 2205-7250

Foreword

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

The Committee's report focuses on the deaths of children and young people as required by the Act, as well as two population groups: neonates and vulnerable children. As in previous reports, the detailed analysis of the data is based on the aggregation of five years of data (2016–20), thus ensuring individual privacy.

The Committee continues its work to review the circumstances and causes of child deaths in the ACT. In 2020, the Committee presented its thematic review into deaths of ACT children and young people by intentional self-harm. An increase in deaths in 2018 prompted the Committee to examine death by suicide in the ACT between 2017 and 2019, to explore significant systemic factors that may surround the suicide deaths of young people. The Committee provided seven recommendations to the ACT Government aimed at support services, schools, family and peers to reduce the future likelihood of young people dying by suicide.

The Committee would like to thank Dr Elizabeth Moore for her valuable contribution to the development of the report into deaths by intentional self-harm.

In this year's annual report, the Committee has, for the second time, reviewed progress on the recommendations made since its establishment. The Committee has made a total of 31 recommendations to government as well as expressed views in submissions to both national and local inquires. The Committee sought input from government in response to these recommendations, and we have been pleased with the actions taken. However, the Committee continues to be concerned that children remain vulnerable to a preventable death. Some areas of concern are how well information is shared between different government and non-government agencies to ensure the child at risk receives necessary support and the progress of improved regulation of back yard pools.

This year has also been the final year of appointment for Dr Sue Packer AM who has provided considerable expertise and support to the Committee since its establishment in 2012. I would like to extend our grateful thanks to Dr Packer for her valuable guidance and generous time given to the Committee's work.

The Committee will continue to work to improve systems intended to support children, young people and their families and to ensure they are effective at preventing harm.

Finally, I would like to thank the secretariat and members of the Committee, who have done an outstanding job throughout the year. I would also like to extend our sincere condolences to the families, friends and communities who knew and loved the children and young people whose deaths are reported here.

Ms Margaret Carmody PSM
Chair, ACT Children and Young People Death Review Committee

ACT Children & Young People Death Review Committee

Letter of transmission

Minister for Families and Community Services
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 2020 Annual 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 forthwith.

Yours sincerely

M Carmody

Ms Margaret Carmody, PSM
Chair
30 April 2021

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

GPO Box 158 Canberra City ACT 2601
t 02 6205 2949 | e childdeathcommittee@act.gov.au

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Executive summary

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

In accordance with s. 727S of the Act, this report provides information on the deaths of 153 children and young people up to the age of 18 years who were included on the Committee's Child and Young Person Deaths Register in the five-year period 2016–2020. Of the 153 deaths across the latest five-year period, 13 are awaiting the findings of the Coroner and are therefore not able to be included in this report. The remaining 140 deaths on the register include 23 deaths of children and young people who did not normally reside in the ACT.

Chapter 1 introduces the Children and Young People Death Review Committee. It lays out the legislative requirements of this report and the limitations of the data. It also explains how to use this report.

Chapter 2 provides an overview of all registered deaths of children and young people residing in or visiting the ACT.

Chapter 3 examines the deaths of children and young people who were ACT residents, excluding those children and young people who normally resided interstate or elsewhere. The chapter provides demographic and individual characteristic analysis.

Chapter 4 is the first of two chapters investigating a specific population group. This chapter focuses on neonates and infants.

Chapter 5 focuses on vulnerable children and young people.

Chapter 6 details the recommendations made by the Committee since its establishment and the progress of these towards implementation. Appendix D provides copies of advice provided by the relevant directorates in relation to recommendations. Appendix E provides a schedule of all submissions and recommendations made by the Committee and rationale for the Committees position.

Chapter 7 describes the Committee's activities during 2020 and its continuing work for the next calendar year.

The appendixes provide further information for reading, understanding and interpreting the findings in this report.

Chapter 1 Introduction to the Children and Young People Death Review Committee

This chapter describes the **role of the ACT Children and Young People Death Review Committee** and provides important information on how to read this report.

ACT Children and Young People Death Review Committee

The ACT Children and Young People Death Review Committee is an independent committee established under the *Children and Young People Act 2008* (ACT) (the Act) 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 that 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.

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

Who we are

Since 2012, the Committee has been responsible for reporting to the ACT Legislative Assembly on all deaths of children and young people under the age of 18 years in the ACT. 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 Torres Strait Islander children and young people
- social work
- investigations
- mental health
- child protection or
  -has other qualifications, experience or expertise, or membership of an organisation, relevant to exercising the functions of a committee member or
  -is a police officer with experience in working with children and young people and families.

The Director-General, Community Services Directorate (CSD) 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 eight and ten 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 2020

Chair

Ms Margaret Carmody PSM
Social policy and strategic human service delivery

Deputy Chair

Mr Eric Chalmers AM CF
Engineering and child safety products or systems

Ex-officio Committee members

Director General, Community Services Directorate	**Ms Jo Wood**
Children and Young People Commissioner	**Ms Jodie Griffiths-Cook**

Committee members

Dr Judith Bragg
Paediatrics

Ms Barbara Causon
Working with Aboriginal and Torres Strait Islander children and young people

Dr Amanda Dyson
Paediatrics and Neonatology

Dr Louise Freebairn
Epidemiology

Emeritus Professor Morag McArthur
Social Work and Child Protection

Dr Sue Packer AM (2012 – January 2021)
Paediatrics

Dr Catherine Sansum
Child forensic medicine

Ms Meg Brighton (November 2019 – May 2020)
Deputy Director General, Education

Mr David Matthews (May 2020 – Current)
Deputy Director General, Education

Station Sergeant Dennis Gellatly (2018 – August 2020)
ACT Policing – Officer in Charge, Judicial Operations

Station Sergeant Sue Smith (August 2020 – Current)
ACT Policing – Officer in Charge, Judicial Operations,
Police officer with experience in working with children and young people and families

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 of children and young people
c) to undertake research that aims to help prevent or reduce the likelihood of the death of children and young people
d) to identify areas requiring further research, by the Committee or another entity, that arise from the identified patterns and trends in relation to the deaths of children and young people
e) to make recommendations about legislation, policies, practices and services for implementation by the territory and non-government bodies to help prevent or reduce the likelihood of the death of children and young people
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.

Annual report

This annual report covers the period 2016 to 2020. It presents the 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.

Chapter 19A, Part 19A.4, s. 727S of the Act requires the Committee to report on the following information about the deaths of children and young people included on its register:

- total number of deaths
- age
- sex
- whether, within three years before his or her 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), was 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, 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.

As with previous years, the Committee has reported the incidence of death over the five-year period. This is largely as a result of the small number of deaths that occur in the jurisdiction each year. Conducting and reporting on analyses over a five-year period brings a level of stability to the data, allowing for generalisations to the broader population. It also minimises the risk of possible identification of any individual. Although greater rigour may be generated through the analysis of aggregate data, there are limitations noted and discussed across the report and, as such, caution must be exercised when interpreting results.

The annual report presents the Committee's activities during 2020 and outlines the continuing work for 2021. In 2018 for the first time the annual report presented a chapter reviewing the progress on the recommendations

made since its establishment. In discussion with Minister Stephen-Smith, the Committee decided to undertake this activity biennially. This report will provide a further update on the progress of recommendations.

Using this report

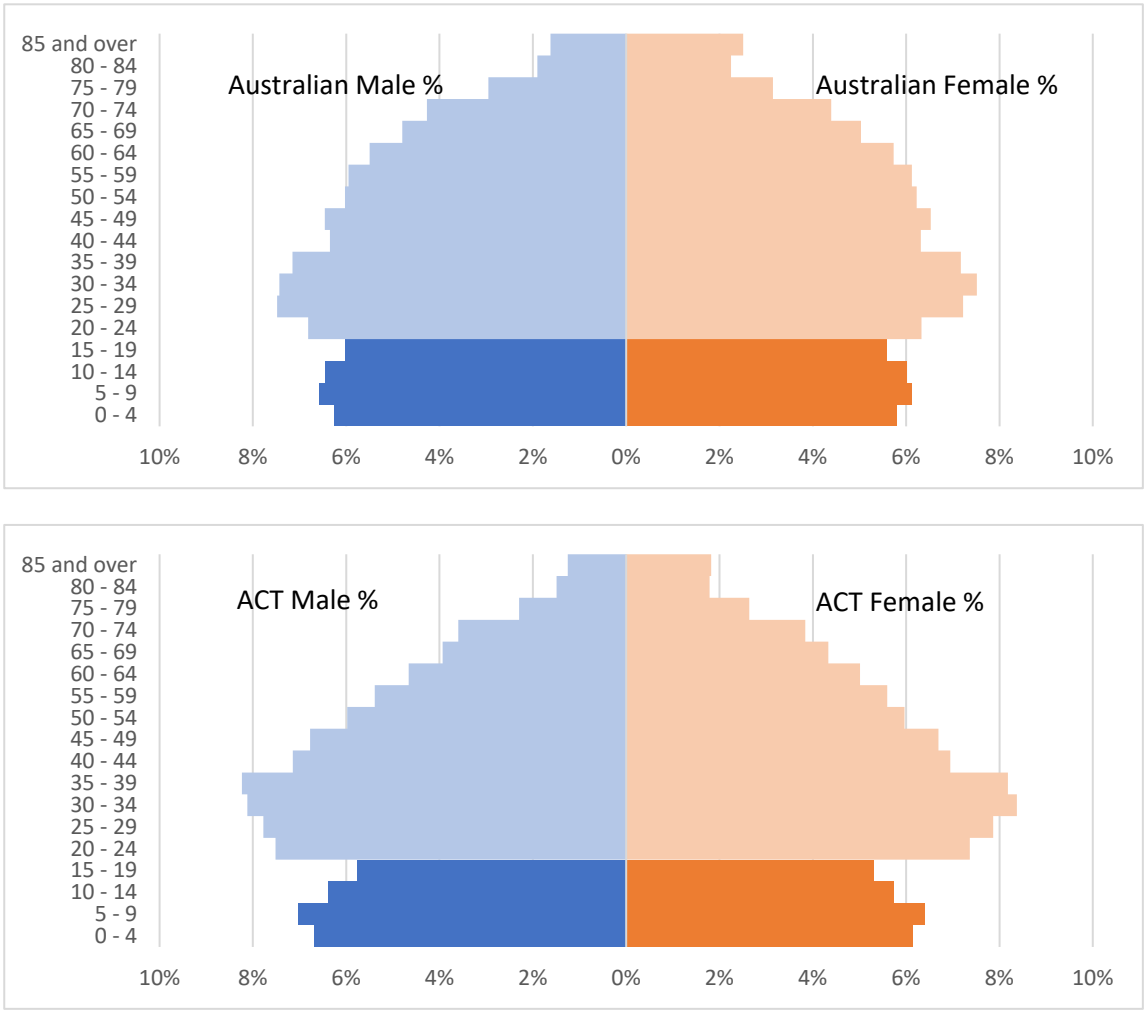
This annual report is a legislated requirement of the Committee and can be used as a catalyst or foundation for further investigations. To increase transparency and to enable greater use and reporting on the findings of this report, it is important to clarify the methods used.

ACT Population

The ACT population is currently projected to reach around 450,000 people by 2022. This increase is also seen in children and young people under 19 years of age. Canberra remains 'younger' than the national average, and the number of children and young people is projected to increase by 11% between 2017 and 2022. This age group accounts for around 25% of the total ACT population (ACT Treasury, 2019).

Figure 1.1 shows the differences between the age structures of both the ACT and Australia based on the Australian Bureau of Statistics' (ABS) quarterly population estimates data (ABS, 2021). The focus of this report is those children and young people under the age of 18 years. This group is highlighted in the bolder colours.

Figure 1.1 Population ratios comparing male and female total population between Australia and the ACT, 2020



Data source: (ABS, 2021)

The Australian figure shows a consistent rate through the early years of life for both males and females, with a slight drop around 10–14 years for both sexes. The ACT figure presents a sharper taper, indicating a greater change in the population during those years. If the age structures were the same, we would expect to see a relatively similar shape across the base of both pyramids.

Coronial counts

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

The legislation clearly stipulates that the Committee must not report on the causes of death of those cases that are being heard in the Coroner's Court at the time of publishing. However, this stipulation does not exclude the reporting of total numbers of deaths, including those currently being heard by the Coroner. As such, in the early chapters of this report, where total numbers are reported, these will include open coronial cases. The number of these will be indicated in brackets next to the total figure. These cases are excluded from subsequent analyses referring to cause of death or population in later chapters.

Delays in coronial cases continues to be a concern for the Committee. The ACT Coroner's Court Annual Report 2018/19 noted that the ACT is the worst jurisdiction in Australia in having cases older than 24 months not finalised. The report also described the ACT as having the lowest rate of judicial officers per 1000 finalisations (ACT Coroners Court, 2019). While there was an improvement in the rate of long-term pending finalisations in 2019/2020 financial year (ACT Coroners Court, 2020) the Committee continues to see cases not finalised within the five-year annual reporting window.

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

International Classification of Diseases

Since the inception of the Children and Young People Death Register, reporting on main cause of death or leading cause of death has centred largely on indicative causes with reference made to the International Classification of Diseases (ICD). The Committee has transitioned to reporting on the ICD framework, in line with World Health Organization standards (WHO, 2016). This report will continue the format adopted in the previous reports and include both the indicative causes of death and the ICD.

Reporting fewer than five cases

Given the small number of child or young person deaths in the ACT and the broad range of causes of those deaths, often there will be only one or two individuals who have died in a category. The same can be true when reporting on other factors, such as vulnerability, where the focus is 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 they number fewer than five incidents and the individual may be identified, the symbol • will be used to indicate that deaths have occurred but not how many. In some instances, further data have been suppressed to prevent calculation of figures. The suppression of further data will not occur when it will significantly impact on the Committee's ability to report population trends. In these instances, calculation of

figures may be possible. The identity of a child or young person who has died will not be disclosed or be able to be worked out. The supressed numbers will remain included in total figures and aggregated counts over five years.

Data quality

The Committee continues to work to improve data quality to more accurately identify the factors that contribute to the reported deaths. Anecdotal information reported by members would indicate that official causes of death do not always reflect the full story. Clearly, those cases that have been subject to a coronial inquiry provide excellent information to the Committee. It is only once timely, complete and more reliable information is available that improvements to systems and processes can be identified to prevent or reduce deaths. The Child Death Register database continues to be problematic in that it is complex and sometimes unreliable. The Committee have sought the assistance of CSD to undertake a review of this system and work continues to identify a suitable solution.

This report is presented by the Children and Young People Death Review Committee for the purpose of disseminating information for the benefit of the public. The Committee has taken great care to ensure the information in this report is as correct and accurate as possible. Whilst the information is considered to be true and correct at the date of publication, data updates after the time of publication may impact on the comparability of information over time. Differences in statistical methods and calculations, data updates and guidelines may result in the information contained in this report varying from previously published information.

Data sources

Unless otherwise stated, all figures reported in this document are sourced from the ACT Children and Young People Deaths Register. The information in this register is compiled from information sourced from 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 Child Death Review Team, and the National Coronial Information System. The Committee also has provisions to exchange data with Child Youth and Families, ACT Policing, Emergency Services Agency and the Family Court and Federal Circuit Court of Australia. Data comparisons with previous annual reports must take into account that coronial findings will have been released, thus enabling causes of death to be reported.

Chapter 2 All deaths of children and young people residing in or visiting the Australian Capital Territory

This chapter provides an overview of **all registered deaths** of children and young people that occurred in the ACT or involved ACT residents in the reporting period of 1 January 2016 to 31 December 2020. Subsequent chapters in this report will focus on ACT residents only; however, this chapter takes a broad overview of all deaths that have occurred in the ACT, including children and young people who typically lived interstate or elsewhere.

Overview

This section describes the overall incidence of mortality among children and young people in the ACT. Table 2.1 provides a summary of all deaths on the ACT Children and Young People Death Register for the five-year period 2016 to 2020.

Table 2.1: Deaths of children and young people in the ACT, 2016–2020

Deaths	Number[a]	Per cent
All deaths in the ACT	**153**	
Total ACT resident deaths	127	81.9
Interstate resident deaths	26	18.1
ACT residents who died elsewhere	19	8.8
Open coronial cases	13	5.0

[a] Figures do not sum; coronial cases appear in more than one category.

In total, 153 children and young people died in the five-year period 2016 to 2020. Of these, 127 were children and young people who normally resided in the ACT and 26 usually resided interstate. Of the 127 ACT residents who died, 19 of these deaths occurred elsewhere. There were also 13 cases before the Coroner in the ACT and other jurisdictions for the period 2016 to 2020, as at 1 February 2021.

ACT residents and non-residents

The Committee collects information relating to the deaths of all children and young people who die, and normally reside, in the ACT. 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 (Table 2.2).

Table 2.2: Annual deaths of children and young people including ACT residents who died elsewhere and interstate residents who died in the ACT, 2016–2020

Year	All deaths in the ACT[a]	ACT residents		non-ACT residents who died in the ACT	
Jan-Dec	Number	Number	Per cent	Number	Per cent
	153	**127**	**83.0**	**26**	**17.0**
2016	32 (1)	27	84.4	5	15.6
2017[b]	33 (1)	25	75.8	8	24.2
2018	41 (6)	36	87.8	5	12.2
2019	19	16	84.2	•	•
2020	28 (5)	23	82.1	5	17.9
Average	**31**	**25**		5	

[a] Figures provided in brackets are cases currently before a Coroner and are included in the total figure. These cases will not be included in subsequent analyses.

[b] Figures not directly comparable to previous reports.

In regard to all deaths (Table 2.2), the figures supplied in brackets are currently the subject of a coronial inquest. These cases are not included in chapters relating to cause of death or population focus, as it is not in the remit of the Committee to report on those cases that are subject to ongoing Coronial investigations.

Table 2.2 shows the year-on-year deaths of children and young people, of which the five-year average for 2016 to 2020 is 31. This is a slight decrease from the average in last year's report of 32. For ACT residents, the five-year average for the number of children and young people who died has also decreased from last year, with the mean moving from 26 in 2019 to 25 in 2020. While this is a positive trend in 2020, it should be noted that the number of child deaths each year in the ACT fluctuates due to our small population, and the decrease in 2020 should be interpreted with caution. The age-specific mortality rates of ACT residents aged 0–17 years are provided in Chapter 3.

Distribution across characteristics

The following discussion focuses on demographic and individual characteristics of the children and young people who died. Examination of these variables allows comparisons between groups and identification of trends within the total population, to better inform and advocate for system, service or programmatic change. Examined here are sex, age, and Aboriginal and Torres Strait Islander status.

Table 2.3 shows the total deaths of children and young people (not including open coronial cases) in the ACT over the five-year period 2016 to 2020, broken down by key demographic characteristics.

Age is a consistent predictor of mortality risk. Table 2.3 shows a higher number of deaths occurring in the early years followed by a reduction through primary years, with an increase again in adolescence and late teens. For the five-year aggregate period, deaths in the first year accounted for 65% (n=91) of all deaths.

Table 2.3: Key demographic characteristics of all deaths of children and young people in the ACT, 2016–2020

Characteristics	2016–2020 Deaths[a]	
	Number	Per cent
Total		
Persons 0–17 years of age	140	
Sex		
Female	63	45.0
Male	77	55.0
Age		
Less than 28 days	75	53.6
28-365 days	16	11.4
1–4 years	10	7.1
5–9 years	6	4.3
10–14 years	14	10.0
15–17 years	19	13.6
Aboriginal and Torres Strait Islander status		
Aboriginal and/or Torres Strait Islander	5	3.6
Neither Aboriginal nor Torres Strait Islander	129	92.1
Unknown	6	4.3

[a] Figures do not include open coronial cases.

Table 2.4 shows the total deaths of children and young people in 2020, broken down by key demographic characteristics. Due to small numbers, the age brackets in this table have been aggregated to show deaths of children aged 0–4 years and 5–17 years.

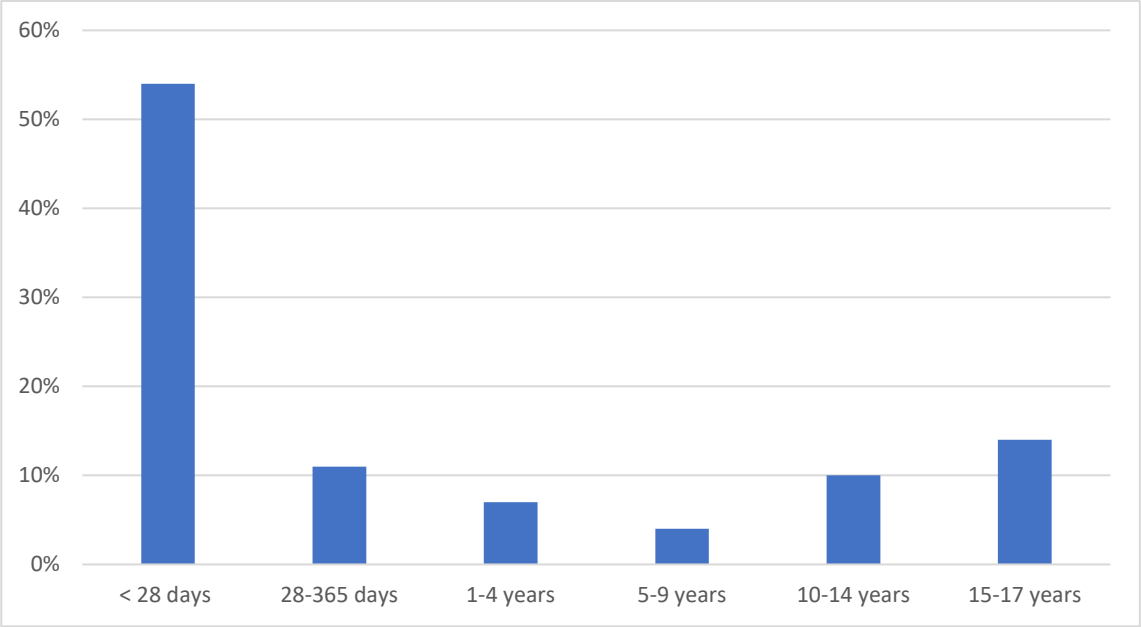
Table 2.4: Key demographic and individual characteristics of all deaths of children and young people in the ACT, 2020

Characteristics	2020 Deaths[a]	
	Number	Per cent
Total		
Persons 0–17 years of age	23	
Sex		
Female	11	47.8
Male	12	52.2
Age		
0–4 years	16	69.6
5–17 years	7	30.4
Aboriginal and Torres Strait Islander status		
Neither Aboriginal nor Torres Strait Islander	22	**95.7**
Aboriginal and/or Torres Strait Islander	•	•
Unknown	•	•

[a] Figures do not include open coronial cases.

Figure 2.1 shows that by far the greatest mortality risk is for infants aged less than 28 days. Many of the causes of death for these children are related to extreme prematurity and congenital anomalies.

Figure 2.1: Distribution of deaths by age, 2016–2020



Cause of death

Tables 2.5 and 2.6 present the causes of all deaths for the five-year period 2016 to 2020. As noted previously, the cause of death provided includes both indicative causes and those categories outlined in the International Classification of Diseases (ICD-10).

Table 2.5 shows that more than half (53.6%) of the deaths over the five-year period were due to medical reasons. The ICD-10 grouping in Table 2.6 provides some indication of types of medical disorders experienced by children and young people.

Table 2.5: Indicative cause of death, 2016–2020

Indicative cause of death	Number	Per cent
Total	**140**	
Medical causes	75	53.6
Extreme prematurity	38	27.1
Suicide	11	7.9
Unintentional injury/accident (including transport and drowning)	10	7.1
Unascertained	•	•
SIDS and or SUDI[a]	•	•

[a] SUDI=sudden unexpected death in infancy; SIDS=sudden infant death syndrome.

The ICD-10 is the tool adopted by the international community to analyse the health of population groups in terms of the incidence and prevalence of morbidity and mortality (WHO, 2011). As a classification system, it provides a common framework to report on rates of morbidity and mortality, 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.

Table 2.6: ICD-10 grouping cause of death, 2016–2020

ICD-10 grouping	Number	Per cent
Total	**140**	
Certain conditions originating in the perinatal period	70	50.0
Neoplasms	10	7.1
Congenital malformations, deformations and chromosomal abnormalities	10	7.1
Injury, poisoning and certain other consequences of external causes	9	6.4
Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified	8	5.7
Diseases of the circulatory system	8	5.7
External causes of morbidity and mortality	8	5.7
Diseases of the nervous system	5	3.6
Other medical disorders[b]	12	8.6

[a]Percentages do not total 100 due to rounding
[b] Other medical disorders include the following ICD-10 chapters: Other and unspecified effects of external causes; Disease of the blood and blood forming organs; Diseases of the Digestive System; Certain infectious and parasitic diseases; Diseases of the musculoskeletal system and connective tissue; Endocrine, nutritional and metabolic disease.

Chapter 3 Deaths of ACT resident children and young people: five-year review

This chapter provides an overview of the **registered deaths of ACT resident children and young people that occurred in the ACT or interstate in the last five years** (that is, excluding interstate residents who were included in Chapter 2). It will examine the incidence and causes, as well as other demographic and individual characteristics, of those deaths of ACT residents under the age of 18 years.

Overview

In the five-year period 2016 to 2020, a total of 127 children and young people who usually resided in the ACT died. Of these cases, 10 are currently before the Coroner and are therefore outside the scope of the Committee review at this stage.

Table 3.1: Breakdown of cases included in analysis, 2016–2020

Deaths	Number	Per cent
All ACT resident deaths[a]	**127**	
ACT residents who died in the ACT[b]	108	85
ACT residents who died elsewhere[b]	19	15
Cases before the Coroner	10	7.9

[a] Figures do not sum; interstate deaths are excluded, and coronial cases appear in more than one category.
[b] Included in further analyses.

In total, 108 ACT residents under the age of 18 years died in the ACT and 19 ACT residents died elsewhere. The following discussion relates to the **117 children and young people** normally resident in the ACT who died in the last five years and excludes deaths of interstate residents and cases before the Coroner.

Table 3.2 shows the age-specific mortality rate for the ACT across the reporting period. The annual mortality rate for children and young people varied from a low of 1.69 deaths per 10,000 population in 2019 to a high of 3.84 in 2018. The age-specific mortality rate for Australia in 2018 was 2.43 deaths per 10,000 population (ABS, 202a).

The annual figure should be interpreted with caution as statistical fluctuations are known to occur with small numbers. The Committee will continue to monitor this trend over time. The mean age-specific mortality rate for the five-year period 2016 to 2020 was 2.73 per 10,000 ACT children aged less than 18 years.

Table 3.2: Age specific mortality rates (per 10 000) of ACT residents aged 0–17 years 2016-2020

Year	Population	Deaths	ACT ASMR[a]
	0–17 years	Number	Per 10 000
2016	89 390	27	3.02
2017[b]	91 569	25	2.73
2018	93 681	36	3.84
2019	94 941	16	1.69
2020	96 509	23	2.38

[a] The rates in this table are not directly comparable to previous reports.
[b] Figures not directly comparable to previous reports.
ASMR = age-specific mortality rate.
Data Source - http://stat.data.abs.gov.au/ (Quarterly Population Estimates (ERP), by State/Territory, Sex and Age)

Distribution across characteristics

The following discussion focuses on demographic and individual characteristics for ACT resident children and young people who died between 2016 to 2020. Examination of these variables allows comparisons between groups and identification of trends within the total population, to better inform and advocate for system, service or programmatic change. Examined here are sex, age and cause of death of ACT residents in the five years 2016 to 2020.

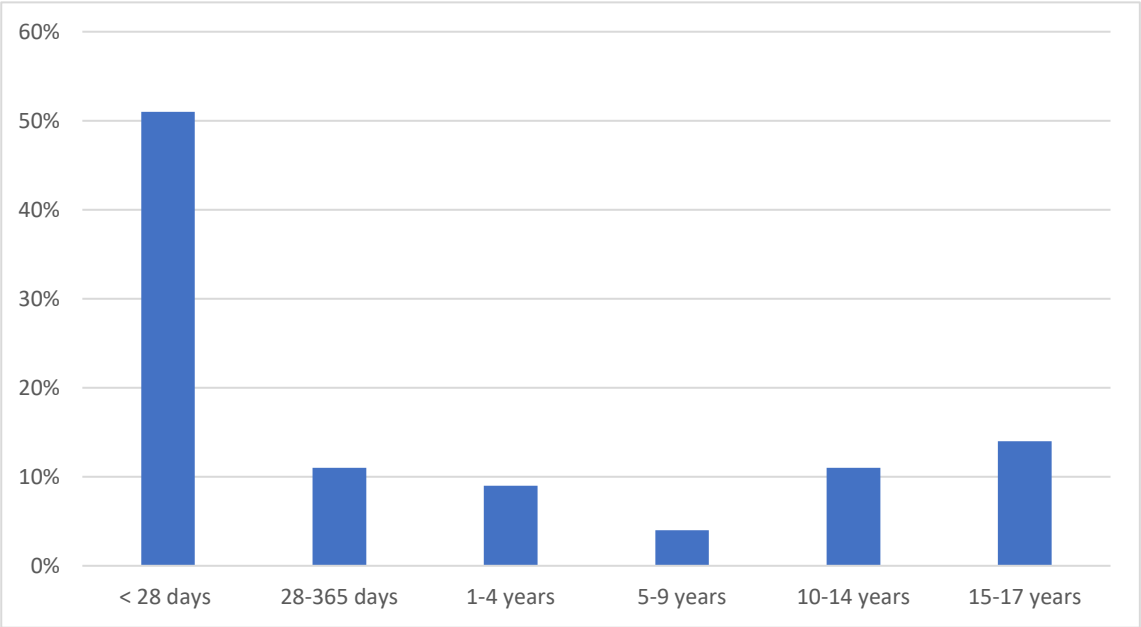
Table 3.3: Demographic characteristics of ACT resident children and young people who died, 2016–2020

Characteristic	Deaths	
	Number	Per cent
Total		
Persons 0–17 years of age	117	
Sex		
Female	59	50.4
Male	58	49.6
Age		
< 28 days	60	51.3
28-365 days	13	11.1
1–4 years	10	8.5
5–9 years	5	4.3
10–14 years	13	11.1
15–17 years	16	13.7

In the five years covered by this report, there were 59 deaths of ACT females aged less than 18 years and 58 deaths of ACT males aged less than 18 years.

Figure 3.2 shows the distribution of deaths by age for the five-year period. The graph shows that the proportion of deaths is highest in the first year of life and lowest between 5 and 9 years of age. In 2016 to 2020, the 5–9 age group accounted for 4.3% of all deaths. The proportion of deaths increases again during adolescence and is partially explained by an increase in death by suicide during 2018 in the 15–17 and 10–14 age groups. As previously mentioned, the Committee has recently completed a thematic review on this group.

Figure 3.2: ACT resident deaths by age, 2016–2020



Cause of death

As in Chapter 2, causes of death have been classified by indicative cause of death and those categories outlined in the International Classification of Diseases (ICD-10). While Chapter 2 considered all deaths recorded on the ACT Children and Young People Deaths Register, this section reports specifically on ACT resident children and young people.

Table 3.4 presents the indicative causes of death for ACT resident children and young people during the period 2016–2020, with medical causes accounting for more than half (55.6%) of all ACT deaths. Table 3.5 presents the ICD-10 grouping, with conditions originating in the perinatal period accounting for 45.3% of all deaths.

Table 3.4: Indicative cause of death, ACT resident children and young people, 2016–2020

Indicative cause of death	Number	Per cent
Total	**117**	
Medical causes	65	55.6
Extreme prematurity	30	25.6
Suicide	10	8.5
Unintentional injury/accident (including transport and drowning)	6	5.1
Unascertained	•	•
SIDS and or SUDI[a]	•	•

[a] SUDI=sudden unexpected death in infancy; SIDS=sudden infant death syndrome.

Table 3.5: ICD-10 grouping cause of death, ACT resident children and young people, 2016–2020

ICD-10 grouping	Number	Per cent
Total	**117**	
Certain conditions originating in the perinatal period	53	45.3
Neoplasms	10	8.6
Congenital malformations, deformations and chromosomal abnormalities	10	8.6
Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified	8	6.8
Diseases of the circulatory system	8	6.8
External causes of morbidity and mortality	6	5.1
Injury, poisoning and certain other consequences of external causes	6	5.1
Diseases of the nervous system	5	4.3
Other medical disorders[a]	11	9.4

[a] Other medical disorders include the following ICD-10 chapters: Diseases of the respiratory system; Other and unspecified effects of external causes; Disease of the blood and blood forming organs; Certain infectious and parasitic diseases; Endocrine, nutritional and metabolic disease.

Chapter 4 Population focus: neonates and infants

This chapter examines the incidence and causes, as well as other demographic and individual characteristics, of **neonatal deaths under 28 days and infant deaths 28–365 days** that occurred in the ACT during 2016–2020.

Overview

This section looks at mortality among neonates and infants in the ACT.

Table 4.1 provides a summary of the deaths of children under one year of age. In total, 93 children were included: 66 ACT infants died within the ACT and nine died elsewhere. Health services in the ACT provide care for high-risk pregnancies in the surrounding geographic regions, and 18 interstate infants died in the ACT. There were two cases before the Coroner as of 1 February 2021.

Table 4.1: Breakdown of infant deaths, 2016–2020

Deaths	Number	Per cent
Total [a]	**93**	
ACT residents who died in the ACT[b]	66	71.0
ACT residents who died elsewhere[b]	9	9.7
Interstate residents who died in the ACT	18	19.4
Cases before the Coroner	2[b]	2.2

[a] These figures do not sum due to coronial cases appearing in categories.
[b] Cases before coroner are in the public domain

Removing those children who usually reside elsewhere (n=18), children who died interstate (n=9) and coronial cases, the following analysis relates to the 64 neo-nates and infant children who were resident and died in the ACT during 2016 to 2020. In 2020, 10 children died under the age of one year. The Committee works closely with the ACT Maternal and Perinatal Mortality Committee to review the cause of deaths that occur in the perinatal period. While the analyses in this report examines 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 Health website: www.stats.health.act.gov.au.

The most recent data (2019) indicate that the infant mortality rate (deaths of children aged less than one year) for the ACT was 0.9 per 1,000 live births. This rate is below the Australian rate of 3.3 per 1,000 live births (ACT Government, 2020). The ACT has a small number of infant deaths each year, and this means that the infant mortality rate can fluctuate markedly year to year. Between 2015 and 2019 the ACT infant mortality rate ranged from 0.9 to 3.7 per 1,000 live births, whereas the national rate ranged between 3.1 and 3.3 over the same period.

Distribution across characteristics

The following discussion focuses on demographic and individual characteristics of infants who died. Examination of these variables allows comparisons between groups and identification of trends within the total population, to better inform and advocate for system, service or programmatic change. Examined here are sex and cause of death. Analysis of Aboriginal and Torres Strait Islander infants who died in the period 2016 to 2020 are not separately analysed in this report as the number is below five.

Table 4.2 provides the number of neonatal deaths under 28 days and deaths of infants (defined in the table as 28–365 days). Neonatal deaths account for the majority of deaths in children under one year in the five-year period 2016 to 2020 (n=55).

Sex

In the five years to December 2020, 64 children died in the first year of life, with a slightly higher incidence of female deaths. The distribution between male and female deaths in 2020 is not able to be reported due to the small number of deaths of children under the age of one year.

Table 4.2: ACT resident infant deaths by age group and sex, 2020 and 2016–2020

Characteristic	1 January 2020 – 31 December 2020 Deaths		January 2016 – December 2020 Deaths	
	Number	Per cent	Number	Per cent
Total	**8**	**100.0**	**64**	
Neonatal deaths under 28 days	•	•	55	86.4
Infant deaths 28-365 days	•	•	9	13.6
Sex				
Female	•	•	34	51.5
Male	•	•	30	48.5

Cause of death

Table 4.3 presents the main causes of death of ACT children under the age of one year during 2016 to 2020. As highlighted in Chapter 3, this cohort accounts for a large proportion of all deaths. Of ACT resident deaths in the five-year period, children under one year of age account for 62.4% of all ACT deaths.

Table 4.3: Indicative and ICD-10 cause of death of children less than one year of age, 2016–2020

Cause of death	Total
Medical causes and extreme prematurity	**57**
Certain conditions originating in the perinatal period	50
Congenital malformations, deformations and chromosomal abnormalities	7
SIDS & SUDI[b] and unascertained and other causes[a]	**7**
Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified	•
Total	**64**

[a] Other causes include the ICD-10 chapter; Injury, poisoning and certain other consequences of external causes.
[b] SUDI=sudden unexpected death in infancy; SIDS=sudden infant death syndrome.

The ICD-10 defines the category of 'certain conditions originating in the perinatal period' as deaths whose cause originates in that period, even though death may occur later. 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).

Most deaths of ACT children under the age of one occurred during the neonatal period. 'Certain conditions originating in the perinatal period' (n=57) is the major cause of death for both neonates and infants (aged 28–365 days), followed by 'chromosomal or congenital anomalies' (n=7). There were seven cases of deaths caused by sudden unexpected death in infancy (SUDI), sudden infant death syndrome (SIDS), injury, poising and certain other consequences of external causes or where the cause of death was unascertained.

Chapter 5 Population focus: vulnerable children and young people

This chapter provides an overview of the registered deaths of children that involved ACT residents in the **last five years and who had experienced factors of vulnerability** (defined below). It will examine the incidence and causes, as well as other demographic and individual characteristics, of those deaths.

Table 5.1: ACT children and young people who have died and were known to CYPS or ACT Policing, 2016–2020

Total[a]	Known to CYPS	Known to ACT Policing
117	**16**	**36**

[a] Figures include ACT residents only and do not include open coronial cases.

Overview

This section outlines the overall incidence of mortality among children and young people in the ACT who were experiencing identified vulnerability risk factors at the time of death. While the Committee acknowledges that all children and young people are vulnerable and in need of safe environments in which to grow and be nurtured, in this and previous reports the involvement of Children and Youth Protection Services (CYPS) and/or ACT Policing (the police) were the two proxy indicators of increased vulnerability.

There are two reasons why the Committee focuses on child protection services and the justice system in particular. First, it is a requirement of the legislation. But more importantly, these are the systems that are often involved when difficulties arise in a child's life and therefore are indicators of vulnerability.

Table 5.1 outlines the number of children and young people or their families who were known to CYPS or ACT Policing. In the five years 2016 to 2020, 117 residents of the ACT under the age of 18 years died in the ACT or elsewhere. Overall, 16 children and young people and/or their families were known to CYPS and 36 were known to police. These broad figures do not account for the extent to which the child or their family was involved with these systems; this will be discussed later.

Known to CYPS	When a report is initially made to CYPS, it is known as a 'child concern report', which is a record of information regarding the child or young person made by either a voluntary or mandatory reporter. CYPS 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' is recorded in accordance with s. 360(5) of the Act. It is under this same legislation that the Committee is required to provide this report to the Minister each calendar year about the deaths of children and young people with particular demographic and individual characteristics and trends relating to such (s. 727S).
Police involved	Not all deaths of children and young people require the involvement of police. Where a child or young person clearly dies as a result of medical causes in a setting where professionals are able to make a determination of death, such as a hospital, police are not necessarily informed or called. Police often become involved in a death where people aware of the death call emergency services, where the Coroner makes a determination that further inquiries are required or where the individual or persons associated with the individual have current or previous histories with police.

Distribution across characteristics

Table 5.2 shows the number of children and young people under the age of 18 years who normally reside in the ACT and who died in the five years 2016 to 2020. It also shows the number of those children and young people who were known to either—or both—CYPS and ACT Policing, by age.

Table 5.2: Number of deaths by system engagement and age, 2016–2020

System engagement	0-4 years	5-17 years	Total
Total	83	34	117
Not known to CYPS	**78**	**23**	**101**
Police involved	17	9	26
Known to CYPS	**5**	**11**	**16**
Police involved	•	8	•

Table 5.3 shows the number of ACT children and young people who were known to CYPS or ACT Policing broken down by the level of knowledge of the child or young person and their sibling by the relevant agency.

More females than males were known to the protection and justice systems. The only exception to this pattern is the police involvement in death incidents only, which is higher for males (n=14) than females (n=6). This is consistent with the pattern reported in previous reports.

Table 5.3: ACT children and young people deaths by child protection reports and police involvement and by sex, 2016–2020

	Child &Youth Protection Services		ACT Policing		
	Known to CYPS	Children with Siblings known to CYPS	Current or previous police involvement[a]	Death incident only	Not known to Police
Deaths					
Persons 0–17 years of age	16	12	16	20	81
Sex					
Female	•	•	11	6	42
Male	•	•	5	14	39

[a] Current or previous criminal history related to family member including grandparents, parents or child or young person.

Children known to CYPS may have experienced a range of risk factors within their life, including domestic and family violence, parental substance misuse, mental illness and involvement with the criminal justice system. As shown in Table 5.4, seven of the children had only child concern reports recorded (any report made to CYPS) and nine children had child protection reports recorded (a second stage of assessment conducted by CYPS to establish if there is a reasonable belief that a child is in need of care and protection).

In addition, fewer than five children had prenatal reports recorded. Fewer than five children who had died were not the subject of reports themselves; however, it was recorded that their siblings had received either child protection and/or child concern reports within three years of the child dying.

Table 5.4: Number of ACT notification reports of children who have died, 2016–2020

Child notification	Total[a]	Per cent
Child concern report only	7	6.0
Child protection report	9	7.7
Not known to CYPS	101	86.3

[a] Numbers do not add up as not all children known to CYPS received reports and fewer than five children received both child protection and concern reports.

Table 5.5 shows the number of ACT children and young people who were known to CYPS or ACT Policing broken down by indicative cause of death classification groupings. Most deaths of ACT children and young people occur due to medical causes; all other causes have been grouped together under 'other than medical causes.'

In the five-year period 2016 to 2020, a higher proportion of children and young people who died from classifications other than medical causes (19.2%) were known to CYPS than children who died of medical causes (9.2%).

Police involvement due only to death investigation was higher in classifications other than medical causes. As identified previously, Police may be less likely to become involved in a death of a child or young person as a result of medical causes in a setting where professionals are able to make a determination of death.

Table 5.5: Number of ACT children known to CYPS and ACT Policing, indicative cause of death, 2016–2020

	Total Deaths	Known to CYPS	Known to Police	Police Involvement Death Incident only
Other than medical causes[a]	52	10	7	14
Medical causes	65	6	9	6

[a] Other than medical causes include indicative cause of death classifications: Extreme prematurity; Suicide; Transport; Drowning; SIDS & SUDI and undetermined; Unascertained; Unintentional injury/accident.

Chapter 6 Recommendations

Introduction

Monitoring the implementation of recommendations is a legislated function of the Committee under s. 727B of the Children and Young People Act 2008 (the Act). In 2018, for the first time, the Committee undertook a project to formally report on the implementation of its previous recommendations in its annual report. This was done by seeking responses from the relevant ACT Government directorates on their progress to address recommendations made by the Committee. Original correspondence from the directorates is provided in Appendix D. The Committee acknowledges that in some circumstances recommendations generated by other reviews overlap with those of this Committee.

The Committee has undertaken three special reports since establishment.

1. *The Retrospective Report*, released in January 2017, looked at progress in the ACT between 2004 and 2013 to reflect on longer-term patterns and trends in the deaths of children and young people. The review used a social determinants of health approach to analysing data. The report highlighted areas for future work by the Committee and amongst other matters, recommended that the ACT Government improve information sharing between services.
2. In August 2018, the Committee released its *Changing the Narrative for Vulnerable Children: Strengthening ACT Systems Report* (Changing the Narrative Report). This report reviewed the deaths of 11 children from birth to three years who had died in the ACT prior to 2014 and who had been the subject of a closed coronial inquiry. This unusual qualitative review aimed 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. It identified improvements to policy, programs or practice that may prevent the future deaths of children. In doing so, the Committee made 19 recommendations. The ACT Government response fully accepted nine recommendations and agreed in principle to 10 recommendations.
3. In January 2021, the Committee released its *Review of Children and Young People Who Have Died as a Result of Intentional Self Harm* (Intentional Self Harm Report). This report reviewed the deaths of eight young people in the ACT who had committed suicide between 2017 and 2019. The review aimed to explore significant systemic factors that may surround the suicide deaths of young people and to offer key insights to support services, schools, family, and peers to reduce the likelihood of young people dying by suicide. The Committee made eight recommendations within the report.

Due to the recent completion of the *Intentional Self Harm report* and timing of this annual report the Committee is not in a position to comment on the ACT Government response to those recommendations. While these recommendations will be noted in this review it is acknowledged that at the time of writing, the formal response from Government has not been tabled in the Legislative Assembly.

In addition to these reports, the Committee contributed submissions to the following ACT and Federal Government inquiries:

- The ACT Government 2011 issues paper consulting on the introduction of regulation for swimming pools.
- The National Children's Commissioner 2014 inquiry into intentional self-harm and suicidal behaviour in children.
- The 2016 Review into the System Level Responses to Family Violence in the ACT (the Glanfield Inquiry).
- The 2016 issues paper by the Justice and Community Safety Directorate *Information Sharing to Improve the Response to Family Violence in the ACT*.
- The 2016 inquiry by the ACT Standing Committee on Health, Ageing, Community and Social Services into youth suicide and self-harm in the ACT.

- The Australian Competition and Consumer Commission's (ACCC) 2018 consultation on a draft regulation impact statement for the introduction of a quad bike safety standard under the Australian Consumer Law.
- The 2019 issues paper by the Justice and Community Services Directorate Review of Child Protection Decisions in the ACT.

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

Many of the recommendations reviewed in the 2018 annual report related to submissions made by the Committee to the above inquires. In total the Committee has provided 25 recommendations through submissions to six separate inquires. Eleven of these recommendations were made in the Committee's submission to the 2016 System Review into Family Violence Responses in the ACT. The Committee has decided that advice provided through submission will not be included in this review as they do not relate specifically to the Child and Young People Death Review dataset. The Committee considers these recommendations complete once the relevant inquiry is finalised. A detailed breakdown of these recommendations can be found at Appendix E.

Recommendations made by the Committee directly to government through reports under s.727T of the Act or by writing directly to directorates will be considered in this review. These 24 recommendations primarily come from the three special reports identified previously. For these recommendations the Committee has relied on the responses received from ACT Government and relevant directorates in both 2018 and 2020. The responses provided for the Committee's 2018 review of recommendations can be found at https://www.childdeathcommittee.act.gov.au/

Because of the limited scope of this review is not possible to establish if the strategies recommended to improve practice have been effectively implemented or whether there has been change in outcomes for children. The implementation of any policy or initiative can be best judged once a rigorous evaluation process has occurred. Rather, this review considers how government has addressed the recommendations through policy and program initiatives. This review classifies recommendations as 'achieved', 'ongoing' or 'not achieved'

Under s. 727B of the Act a function of the Committee is to make recommendations about legislation, policies, practices and services for implementation by government and non-government bodies to help prevent or reduce the likelihood of the death of children and young people. The intention of making recommendations is to provide expert advice that the Committee believes will positively impact service provision to children, young people and their families and ultimately reduce deaths. In doing this the Committee recognises that changes need to be implemented within the broader context of the relevant directorate's work and programs.

The Committee intends to use this progress review as a catalyst to proactively engage directorates and collaborate with them to better understand why some recommendations have not been addressed or the risk identified by the Committee was addressed through alternate methods. The Committee is eager to better understand what is occurring in key areas of human services delivery to ensure that recommendations are realistic and address the needs of Government and the community.

Indications 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 upon 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.

The Committee's recommendations

Improve messaging about Safe sleeping

Achieved

The Committee made the following recommendations about safe sleeping in the *Changing the Narrative Report*:

1. Safe sleeping guidelines be consistent across directorates and delivered consistently across the continuum of services by ensuring:
   I. cross-directorate agreement is established about safe sleeping guidelines.
   II. professionals and service providers have access to evidence-based training and resources concerning safe sleeping guidelines.
2. Safe infant sleeping promotion, co-sleeping and bed-sharing messages be provided to all caregivers prior to and after the birth of the child by health and social welfare professionals. Vulnerable families should be provided with the necessary support to obtain appropriate bedding for the child prior to leaving hospital.

Progress on recommendations

The ACT Government previously advised that they agreed in principle to these recommendations.

Canberra Health Services (CHS) has advised the Committee on current reforms and processes within the ACT. It is noted in the directorate response that MACH nurses provide safe sleeping practices to caregivers and that vulnerable families can access appropriate bedding for children through the Parent Enhancement Program. It is also identified that the Women, Youth and Child Division has safe sleep guidelines with consistent language and procedures which are delivered to families.

The Community Services Directorate (CSD) has advised that co-sleeping and safe sleeping practice guidelines have been implemented to support staff assessing sleep arrangements for infants. In addition, CSD notes that Children, Youth and Protective Services (CYPS) can purchase appropriate bedding for vulnerable families.

Our comments

The Committee is encouraged by the current activity across the directorates regarding the provision of safe sleeping messages. The Committee considers that recommendation 2 is completed. Although both CSD and CHS have developed safe sleeping guidelines for clients there is no evidence in the responses that they are consistent across the two directorates. Considering the ACT Government agreed in principle to this recommendation the Committee will now consider this recommendation closed.

While not seeking future status updates on these specific recommendations the Committee will continue to monitor deaths related to SIDS, SUDI and fatal sleep accidents and may in the future make additional recommendations to government.

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 and button battery ingestion.

The Committee wrote directly to the Chief Minister in April 2014 reiterating the Committee's submission to the ACT Government's 2011 issues paper on swimming pool regulation. The Committee noted that deaths from drowning would likely decrease if all pools were required to comply with fencing regulations and supported changes to regulation that would reduce the risk to children and young people in the ACT. As such, the Committee supported 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.

Reduce risks to children in and around the home

Swimming pool regulation

Not Achieved

Button batteries

Not Achieved

Regarding the final point, the Committee noted that these changes may not be practical and it may be appropriate to require fencing of older pools on a case-by-case basis, considering several factors, including extent of potential access to the pool by children.

Following a Queensland coronial inquest into the death of a young child as a result of button battery ingestion, the Committee wrote to ACT Health in November 2015 recommending it develop a protocol for managing the treatment of button battery ingestion. Button battery ingestion remains a serious risk for children with the Australian Competition and Consumer Commission (ACCC) recently reiterating concerns that there is a growing record of injuries and deaths from button batteries. Within Australia, one child a month is seriously injured after swallowing or inserting a button battery.

The Committee has also provided submissions to inquiries related to quad bike safety and blind cords. A description of these recommendations and outcomes is at Appendix E.

Progress on recommendations

Swimming pool regulation

The Environment, Planning and Sustainable Development Directorate (EPSDD) informed the Committee that the directorate has undertaken consultation on certain technical and industry capacity issues and has prepared for further consultation with the public. The directorate advised that the timing and scope of community engagement is a matter for Government.

Our comments

Consistent with the Committee's previous review of recommendations in 2018, the Committee remains concerned that young lives are still put at risk through the lack of reform to backyard swimming pool legislation. Given the importance of this issue, the Committee urges the ACT Government to take actions to address swimming pool regulation. The Committee will report on the progress of this recommendation in subsequent annual reports.

Button batteries

CHS recently advised the Committee that the draft guideline for the Emergency Management of Button Battery Ingestion, which they commenced consultation on in 2017, was ceased due to staffing and resource pressures. CHS explained that the redevelopment of the guideline recommenced in 2020 and that in the interim users are directed to The Royal Children's Hospital Melbourne – Paediatric Improvement Collaborative 'Foreign Body Ingestion' Guideline. It is unclear from the CHS response how this direction has been communicated with staff.

Our comments

The Committee is concerned that the development of these guidelines has been stalled for more than three years. In the absence of long-term resolution of the risk through improved product safety, these guidelines continue to play an important role in minimising the risk to young children, as does continuing community education. The Committee urges CHS to finalise these guidelines and will report on the progress of this recommendation in subsequent annual reports.

The Committee's recommendations

Within the *Intentional Self Harm Report* the Committee identified that access to appropriate services for young people, especially following a suicide attempt was a significant concern. The review also highlighted that youth suicide prevention requires a whole of community response and that it is crucial for parents, educators and peers to have information and training so that they are able to effectively respond to young people in distress.

The Committee made the following recommendations to address identified gaps in the youth suicide prevention system:

Implement and evaluate youth suicide prevention programs

Ongoing

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. The Committee supports the proposed implementation of the Youth Navigation Portal and considers this a critical piece of work to assist young people navigate the complex ACT support system.

5. Implement and evaluate the Connecting with People program. Consider implementation in education and non-government organisation settings.
6. Implement a support plan process in clinical settings that actively engages young people following a suicide attempt.
7. Implement evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.

ACT progress on recommendations

The ACT Government response to the *Intentional Self Harm Report* will be made available on the Committee's website once tabled in the Legislative Assembly.

Our comments

The Committee has now received the formal response by the ACT Government to the *Intentional Self-Harm Report* and will report on progress in its 2022 report.

The Committee's recommendations

The need for improvements to the systems and culture for sharing information in the interests of protecting vulnerable children was the primary finding in the Committee's 2017 *Retrospective Report*.

In the Committee's *Changing the Narrative Report*, it also made the following recommendations for additional changes that strengthen leadership and governance to improve the systems for recording and sharing information:

Improve recording and sharing of information

Achieved

1. For information-sharing arrangements to operate effectively, they must be supported by organisational and professional cultures with strong governance and practice leadership that observe and understand the guiding legislation. The ACT jurisdiction should consider providing training to relevant organisations concerning appropriate information sharing.
2. CSD should review quality assurance systems to ensure client documents are complete, information is recorded fully and accurately and assessments are documented in a manner that records the justification of decisions made by professionals in regard to the safety of the child.
3. The ACT continues to encourage the Commonwealth and other state jurisdictions to make nationally consistent legislation and administrative arrangements, including the development of a national database, to enable the sharing of information related to the safety and wellbeing of children.

The Committee recommended in the *Intentional Self Harm Report that* staff from relevant organisations be trained in responsible information sharing.

Progress on recommendations

The ACT Government previously responded to the recommendations made in the Changing the Narrative Report and agreed in principle to Recommendation 1 listed above, regarding training to relevant organisations concerning appropriate information sharing and agreed with Recommendations 2 and 3.

ACT Education cited in their recent response several projects addressing recording and sharing information including the passing of the Education Amendment Bill 2020 which changes information sharing provisions between the ACT Government and relevant interjurisdictional bodies. The Directorate also outlined a plan to commence an information sharing and record keeping project in 2021 with the aim of removing policy and legislative barriers to information sharing.

CSD recently provided a detailed response to the Committee citing numerous projects aimed at addressing issues with recording and information sharing:

- My Health Passports for children in Out of Home Care,
- the implementation of a new information management system in CYPS,
- co-location of key partner agencies within CYPS,
- work being undertaken by the Family Safety Hub,
- CYPS location within the Family Law Court.

CSD also noted work being done by Children, Youth and Families (CYF) for the ACT to be included in a national project to share information about children known to the child protection system in each Australian jurisdiction. The project, *Connect for Safety*, will allow for case managers to match basic demographic data which will improve assessments of children who have moved to the ACT and have no known local child protection history.

CHS provided a limited response to the Committee noting its support to CSD implementing the *Our Booris, Our Way* recommendations and the School Youth Health Nurse program which enables information sharing between Health staff, families and other agencies.

The Justice and Community Services Directorate (JACS) informed the Committee of the work currently being undertaken in response to the Royal Commission into Institutional Responses to Child Sexual Abuse which includes a focus on improved reporting and information sharing.

Our comments

The Committee acknowledges the significant work conducted across directorates to improve the recording, analysis and sharing of information. The Committee noted separate strategies in the 2018 review of recommendations which have now been addressed. This included the establishment of the single digital health record and legislative changes for information sharing between schools and CHS.

The Committee considers that the intent of the *Changing the Narrative* report recommendations has been achieved. The Committee notes the work across directorates and will continue to monitor the participation of the ACT jurisdiction in the *Connect for Safety* national project which when completed will address the intent of recommendation 3. The Committee continues to consider recording and sharing information as critical to effective service delivery. While directorate responses identified many policies and strategies that have been put in place this review is unable to comment on how practice changed. The training of staff concerning appropriate information sharing is seen as an ongoing gap in the current ACT system as cited again in the Committee's recent *Intentional Self Harm Report*.

The Committee's recommendations

In the *Changing the Narrative Report*, the Committee raised concerns that services focused on the needs of parents over their children and made the following recommendations:

Educate staff on child-focused practice

Achieved

1. 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 and ACT Housing, to be aware of and to act with the best interests of the child as a primary consideration.
2. Supporting organisations and professionals working with young children 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* (United Nations, 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.

Progress on recommendations

In 2019 the ACT Government agreed with the Committee's recommendations related to improving child-focused practice, advising that they are committed to the ongoing support of efforts to embed best practice and the promotion of a human rights culture in policy implementation.

Relevant directorates cited a range of policies, procedures and initiatives implemented with the aim to ensure staff keep the 'child in mind'. CSD noted in their response specific teams established in CYPS which can provide independent advice and assist case managers to focus on the child's experience. The CHS response highlighted family violence policies and procedures that require staff to be child focused and child protection training that provides information on the rights of the child.

Housing ACT has also recognised the importance of frontline staff being aware of the issues impacting children and young persons that may be impacted by trauma. Modules on 'Keeping Children and Young People Safe' and 'Reportable Conduct' have been included amongst the core competency training that Client Service Branch staff are required to complete.

Our comments

Directorate responses show a range of strategies which have been established to educate staff on the rights of children and to keep the child's needs at the forefront of service provision. The Committee welcomes the work across the directorates and considers the intent of the recommendations from the *Changing the Narrative Report* has been met. However, the recent *Intentional Harm Report* also identified issues related to child focused practice. The Committee intends to monitor the involvement of young people with lived experiences of suicide in suicide prevention service design and delivery as a strategy to keep children and young people at the forefront of service provision.

The Committee's recommendations

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

Not Achieved

Cumulative risk refers to the co-occurrence of multiple risk factors in a child's life that may indicate an increased probability of poor outcomes.

A particular finding of the Committee's *Changing the Narrative Report* was the identification of cumulative risk for those children who had died. The Committee made the following recommendations to enhance the capacity for risk factors to be addressed:

1. Review current practice models for prenatal reports to:
    a. Ensure that early intervention strategies across ACT Health and CSD are maximised before the birth of the child, including access to GPs and prenatal health checks – non-attendance should be followed up.
    b. Enhance engagement of culturally appropriate services for Aboriginal and Torres Strait Islander and culturally and linguistically diverse families.
2. Review current practice to identify and respond to cases of cumulative harm, including:
    a. A review of current legislation to test whether it is sufficient in protecting children where risks do not meet current thresholds for support but where cumulative harm is identified.
    b. The provision of enhanced training and mandatory refresher courses for workers to ensure that they are aware of the full extent of their powers under legislation. Training programs should be evaluated to assess their effectiveness.
3. Establish 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 – domestic and family violence, substance misuse, unstable housing and limited parental service engagement.

Progress on recommendations

In its response to the Changing the Narrative Report, the ACT Government agreed in principle to Recommendations 1 and 2 and agreed to Recommendation 3 made by the Committee.

Directorates have provided the Committee with a range of strategies to address the recommendations made. Primarily the recommendations from the *Changing the Narrative Report* relate to CSD and more specifically CYPS. In its response the Directorate drew the Committee's attention to the work done in the prenatal space, through the *A Step Up for Our Kids Out of Home Care Strategy 2015-2020* including the investment in intensive parenting and family preservation supports, the implementation of a new client management system, the development of a new training program and the launch of a guide for staff working with families affected by cumulative harm or neglect.

The CSD response also notes the final report of the *Our Booris, Our Way* Steering Committee review of all Aboriginal and Torres Strait Islander children and young people currently engaging with the child protection system, which provided 28 recommendations. The ACT Government agreed to all 28 recommendations. CSD notes in response to these recommendations several designated Aboriginal and Torres Strait Islander positions have been established by CYPS and that increased engagement with Aboriginal and Torres Strait Islander sector professionals has occurred through formal mechanisms.

CHS noted in its response to the Committee that Child Concern Reports are now made by CHS staff in a way that allows oversight by CYPS and that Child Protection Training is mandatory for all staff.

Our comments

The Committee acknowledges the significant work undertaken by CSD and other directorates to identify and respond to the cumulative risk experienced by children and young people. Many strategies appear to have been established to address recommendations 1 and 2 which were agreed in principle by the ACT Government. There is no evidence in the directorate response that a mechanism to review children after a threshold of reports in specific risk areas is identified (recommendation 3, which was agreed by government), has been addressed. The Committee will seek to raise this recommendation directly with CSD to understand the feasibility and suitability of the recommendation.

The Committee's recommendations

In the *Changing the Narrative Report*, the Committee made the following recommendations related to supporting families under pressure:

1. CYPS caseworkers making referrals for vulnerable families should provide follow-up support to families while they wait for services to commence.
2. Services across the ACT increase the awareness of professionals to recognise and respond to stress in families and to better understand the impact that stress has on children when other risk factors are evident.

Increase understanding and support for families under pressure

Achieved

Progress on recommendations

In response to the *Changing the Narrative Report* the ACT Government agreed in principle to the recommendations concerning the provision of enhanced supports for families under pressure

Relevant directorates provided the Committee with detailed summaries responding to recommendations to support families under pressure. CSD identified several programs run by community partners which support families under pressure.

ACT Education advised the Committee of a range of programs including the Network Student Engagement Team (NSET) and complex case management team's role in connecting families with services. CHS highlighted the implementation of the Our Booris, Our Way recommendations, child protection training to staff and the IMPACT coordination service as specific strategies the Directorate has in place to support families under pressure. Similarly, JACS noted Aboriginal and Torres Strait Islander specific programs to prevent contact with the criminal justice system and collaboration between the directorate and the Domestic Violence Crisis Service (DVCS) to support survivors of domestic violence offences whose partners are engaged in domestic violence programs within the Alexander Maconochie Centre.

Our comments

The Committee welcomes the range of services and programs implemented by directorates to enhance support for families under pressure in the ACT. The Committee's 2018 review of recommendations noted the reliance by ACT non-government services on CYPS to provide support to vulnerable families, although many of these families do not meet the threshold for CYPS engagement and advocated for mandatory reporting training that equips potential reporters with the skills and information about what else to do when they have concerns about children.

The Committee notes that there is no evidence in responses by directorates that mandatory reporting training has been provided. Despite this the Committee believes that the intent of the original recommendations from the *Changing the Narrative Report* has been met. While not seeking future status updates on these specific recommendations the Committee may in the future make additional recommendations to government.

The Committee's recommendations

In the *Changing the Narrative Report*, the Committee highlighted the need for an evidence-based, consistent approach to be undertaken across Health and CSD in the assessment of families, in order to enhance professional judgment and decision making about a parent's capacity to meet the needs of their child, rather than simply to keep them safe from harm. This type of assessment would also provide clear information for parents and workers to understand what their children need to thrive. The Committee recommended that the ACT jurisdiction consider:

Improve consistency in assessing parenting capacity

Not Achieved

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 four reports have been received which identify risk factors, including domestic and family violence, substance misuse, unstable housing and limited parental service engagement. These should include any prenatal reports about a child by CYPS.
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.

Progress on recommendations

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.

Within the 2018 review of recommendations the Committee noted that CYPS reported that risk assessments are undertaken based on the presenting risks and harms, regardless of the frequency of reports. It was also explained that the Child at Risk Health Unit (CARHU) is available to provide expert assessment and advice in complex child protection matters. CHS also provides programs to support vulnerable families from pre-birth until the child is 12 months old.

For this current review the responses from relevant directorates highlighted several programs that are currently in place to support families through intensive support, this includes functional family therapy and the Child and Family Centres (CFC) and Child Development Service (CDS). Training for staff was also noted which in the Health space included Family partnership training, *Strengthening Hospital Responses to Family Violence* training and *Circle of Security* training.

CSD note that the implementation of the CYPS client information management system which was established in October 2020 assists in the visibility of risk issues as it easily presents summary information of risk issues and case management information for staff.

When considering the specific recommendations made in the *Changing the Narrative Report* there was limited information in the responses to establish how directorates had addressed the three recommendations which was not identified in the Committee's 2018 review of recommendations.

Our comments

Recommendation 1 and 2 from the Changing the Narrative Report have not been addressed. There is no evidence in responses by *directorates* that standardised empirically validated assessment tools for use in the prenatal and postnatal periods have been introduced. Although directorate responses provide evidence of a range of services, training and programs in place to support families, the Committee believes that the use of consistent assessment tools across Health and CSD is a key contribution to an appropriate assessment process. There is also no evidence in responses that there has been consideration of a high-quality parenting capacity assessment service and support for parents with children where four reports with specific harm types have been received by CYPS. The Committee will seek to raise these recommendations directly with relevant directorates to better understand their feasibility and suitability.

The Committee's recommendations

In the *Changing the Narrative Report*, the Committee noted the absence of assessments relating to fathers in child protection matters and the focus on mothers as the 'protective parent'. The Committee recommended the following changes to address this:

1. The presumption of the mother as the 'protective parent' as observed in records and applied by workers needs to be critically reviewed. The participation of both 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.
2. 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.

Educate staff on assumptions about roles played by mothers and fathers

Achieved

Progress on recommendations

The ACT Government agreed to both recommendations relating to presumptions of the mother as the 'protective parent' and gendered service responses in the *Changing the Narrative Report*.

In the updated response for this review, CSD identified training within CYPS which attempts to address the issue of a gendered service response. The advice provided to the Committee notes intensive family violence training is delivered to staff which focuses on supporting the protective parent where family safety is identified as a significant risk. Noting also that a key component of this training includes engaging fathers. It is also planned for the Safe and Together Institute to undertake an organisational assessment and to deliver training to all CYPS staff in 2021.

In considering the need for professional development training it was highlighted that The CYPS Training and Workforce Development team provides specialist support to CYPS staff by delivering face-to-face and eLearning training. CSD note that this team has developed, implemented and maintained a significant number of training programs since its establishment. In addition to training programs, staff are supported by Senior and Principal Practitioners who are responsible for providing expert case practice advice and leadership to staff.

CHS provided the Committee with a list of training opportunities for staff and advised that clinical reflective practice remains a key support for nurses and midwives.

Our comments

The Committee welcomes the work across the directorates which aims to raise the importance of unconscious bias when engaging with families and more broadly gender-related matters in family support and health services. The Committee considers that the intent of the recommendations has been addressed through evidenced training opportunities that have been provided to staff.

The Committee's recommendations

In the *Changing the Narrative Report*, the Committee identified the impact on vulnerable families of intergenerational trauma related to child maltreatment and the need for service systems to recognise the impact this can have on parenting capacity and the willingness of parents to engage in services. The Committee recommended that the ACT jurisdiction does the following:

1. Offers vulnerable families with an intergenerational history of abuse, trauma-informed targeted parenting support prior to and following birth of their child in a non-stigmatising maternal health service.
2. Identifies innovative and evidence informed approaches to working with individuals who have experienced intergenerational trauma due to child maltreatment 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, and male and female perpetrators of family violence.

Increase support to families with a history of intergenerational trauma

Achieved

Progress on recommendations

The ACT Government previously advised the Committee that they agree in principle to the recommendations in the Changing the Narrative Report which related to supporting parents who have experienced intergenerational trauma.

For this review CSD informed the Committee of a range of parenting support programs that are offered to vulnerable families prior to and following birth. This included:

- The IMPACT program which is a multiagency coordination service for pregnant women, their partners and their young children (less than two years of age) who are clients of Mental Health ACT and/or are receiving opioid replacement therapy.
- The Newpin program which is primarily a group-focused centre-based program which provides parent therapeutic sessions, parenting education groups and therapeutic family play sessions.

CHS highlighted CARHU which provides specialist therapeutic interventions, counselling and support to children and young people who experience abuse or neglect.

When considering evidence based innovative approaches to working with individuals who have experienced intergenerational trauma, several examples of programs where highlighted in directorate submissions. The Functional Family Therapy – Child Welfare program, Australian Childhood Foundation Intensive Support and Family Group Conferencing were highlighted as new approaches incorporated within CYPS.

ACT Education informed the Committee that all ACT public schools are resourced to meet the needs of children with a history of developmental trauma. This support includes access to a range of supports and flexible education arrangements.

Our comments

The Committee notes the programs currently available to children, young people and families who have experienced intergenerational trauma. The Committee believes that the intent of the recommendations of the *Changing the Narrative Report* have been addressed through the programs and services identified within directorate responses.

Conclusion

The Committee acknowledges the range of initiatives by the ACT Government and across directorates that seek to enhance the supports for families and improve the outcomes for children. The Committee welcomes the changes that have been made at the policy and practice level and to organisational and cross-directorate processes to improve systems supporting families.

The implementation of any policy or initiative is only truly understood once a rigorous evaluation process has occurred. It is the view of the Committee that evaluation of programs, policies and services is a gap across the ACT service system. Within the responses from directorates there was limited evidence that the programs implemented to address identified issues had been evaluated to determine effectiveness. An ongoing focus for the Committee will be to advocate the need for evaluation of services.

Chapter 7 Children and Young People Death Review Committee activities

This chapter provides an overview of the activities of the Children and Young People Death Review Committee throughout 2020.

Committee Matters 2020

The Committee reports to the Minister for Families and Community Services who has responsibility for the administration of the *Children and Young People Act 2008*.

The Committee's administrative, financial and human resource management is overseen by the Community Services Directorate. The Committee is supported by one Senior Research and Review Officer.

The Committee met four times in 2020 with a number of sub-committees supporting specific aspects of its work.

The focus of the Committee's work in 2020 was the *Review of Children and Young People who have died as a result of intentional self-harm 2017 - 2019*. This review sought to explore significant systemic factors that may surround the suicide deaths of young people and to offer key insights to support services, schools, family and peers to reduce the future likelihood of young people dying by suicide. The findings of this report were made available to Government in January 2021 and can be found at www.childdeathcommittee.act.gov.au

The Committee continued to work across the following areas:

- The timely and accurate collection of information about the circumstances and causes of death for children and young people in the ACT.
- Contributing through its Annual Report, to Government and community, knowledge, 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 to offer informed views aimed at preventing or reducing deaths.
- Maintaining links with interstate and national bodies undertaking similar work.

Committee Membership

This year was the final year of membership for Dr Sue Packer AM and the Committee acknowledges her significant contribution since inception.

The Committee congratulates Deputy Chair Mr Eric Chalmers who received an Order of Australia (AM) for significant service to the community through child accident prevention and road safety organisations.

Most Committee member appointments were due to end in January 2021. Subsequently, in the latter part of 2020, expressions of interest were sought for membership to the Committee. Due to the ACT having only a small pool of experts with the required legislated qualifications and experience, current members were encouraged to submit an expression of interest through this process.

All expiring members who applied were re-appointed to the Committee. These appointments provide expertise as required under the Act on a range of range of specialties including paediatrics, epidemiology, child forensic medicine, engineering and child safety products, social work and police officer with experience or expertise working with children, young people and families. Returning Committee members include Mr Eric Chalmers, Dr Catherine Sansum, Ms Louise Freebairn and the Ms Sue Smith, Officer in Charge of Judicial Operations, ACT

Policing, Professor Morag McArthur and Dr Judith Bragg. Ms Barbara Causon was a continuing member with her term due expire in April 2021.

Continuing work

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

The Committee continues to develop its capacity in monitoring the safety and wellbeing of children and young people through the following activities:

Improving data quality

Monitoring of data quality issues in relation to cause of death and death certificates, with particular regard to suicide and domestic violence.

Identifying and investigating opportunities for data sharing to enhance the quality of data held on the Register.

Monitoring the implementation of recommendations

The Committee continues to monitor the implementation of recommendations including those about strengthening supports systems for children under the care of the child protection system; information sharing to enhance supports for children and young people at risk; and safety around the home. The Committee plans to engage with relevant directorates in 2021 to address outstanding recommendations.

Promote understanding of the cause and impact of child deaths in the ACT

The Committee will continue to increase public awareness and advocate for the issues that affect the health and safety of children and young people in the ACT by disseminating information through its Annual Report, the Committee's website and through 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. In 2020 the Committee provided information to entities in Queensland and NSW:

- Queensland provides high-level data from all state and territory child death review committees to provide a basic national data set. In August 2020, we provided information to the Queensland Family and Child Commission on the number of deaths of children in ACT by age, sex, Aboriginal status and broad cause of death. This was reported in the *Annual Report: Deaths of Children and Young People, Queensland, 2019–2020*.
- The NSW child death register includes children who normally live in NSW, but whose death occurred the ACT. In August 2020 we provided the NSW Child Death Review team with information about the deaths of NSW resident children who died in the ACT. In June 2018 the ACT signed an information exchange agreement with the NSW Child Death Review Team under s. 34D(3) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

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Appendix A Population tables

ACT Quarterly population estimates (ERP)[a]

Time	Jun-16			Jun-17			Jun-18			Jun-19			Jun-20		
	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females
Age															
0 - 4	**28054**	**14556**	**13498**	**28411**	**14702**	**13709**	**28178**	**14585**	**13593**	**28008**	**14383**	**13625**	**27861**	**14297**	**13564**
0	5696	2954	2742	5600	2904	2696	5335	2738	2597	5332	2719	2613	5559	2862	2697
1	5694	2945	2749	5733	2967	2766	5612	2918	2694	5325	2727	2598	5353	2736	2617
2	5556	2913	2643	5790	2993	2797	5775	2974	2801	5626	2914	2712	5392	2748	2644
3	5603	2857	2746	5613	2930	2683	5842	3025	2817	5834	2977	2857	5686	2953	2733
4	5505	2887	2618	5675	2908	2767	5614	2930	2684	5891	3046	2845	5871	2998	2873
5 - 9	**25767**	**13404**	**12363**	**26810**	**13948**	**12862**	**27766**	**14418**	**13348**	**28312**	**14688**	**13624**	**28871**	**14956**	**13915**
5	5391	2819	2572	5606	2931	2675	5781	2972	2809	5695	2949	2746	5951	3068	2883
6	5432	2823	2609	5461	2850	2611	5680	2973	2707	5837	3005	2832	5761	2975	2786
7	5139	2677	2462	5492	2830	2662	5507	2861	2646	5661	2960	2701	5862	3027	2835
8	4981	2585	2396	5206	2702	2504	5548	2878	2670	5548	2885	2663	5710	2981	2729
9	4824	2500	2324	5045	2635	2410	5250	2734	2516	5571	2889	2682	5587	2905	2682
10 - 14	**22170**	**11384**	**10786**	**23012**	**11891**	**11121**	**23942**	**12374**	**11568**	**24875**	**12920**	**11955**	**26015**	**13548**	**12467**
10	4842	2503	2339	4883	2531	2352	5083	2650	2433	5281	2757	2524	5611	2913	2698
11	4472	2276	2196	4872	2511	2361	4951	2565	2386	5131	2688	2443	5307	2761	2546
12	4355	2250	2105	4530	2315	2215	4887	2524	2363	4979	2603	2376	5163	2697	2466
13	4295	2238	2057	4389	2275	2114	4580	2327	2253	4909	2540	2369	4997	2622	2375
14	4206	2117	2089	4338	2259	2079	4441	2308	2133	4575	2332	2243	4937	2555	2382
15 - 17	**13399**	**6814**	**6585**	**13336**	**6757**	**6579**	**13466**	**6926**	**6540**	**13535**	**6983**	**6552**	**13733**	**7100**	**6633**
15	4306	2208	2098	4291	2156	2135	4410	2295	2115	4487	2337	2150	4596	2337	2259
16	4384	2220	2164	4421	2260	2161	4400	2225	2175	4496	2348	2148	4522	2351	2171
17	4709	2386	2323	4624	2341	2283	4656	2406	2250	4537	2292	2245	4615	2412	2203
Total	**89390**	**46158**	**43232**	**91569**	**47298**	**44271**	**93681**	**48501**	**45108**	**94914**	**49102**	**45812**	**96480**	**49901**	**46579**

[a] (ABS. Stat, 2021) By state/territory, sex and age: ACT

Australia Quarterly Population Estimates (ERP)[a]

Time	Jun-16			Jun-17			Jun-18			Jun-19			Jun-20		
	Total	Males	Females	Total	Males	Female	Total	Males	Females	Total	Males	Females	Total	Males	Females
Age															
0 - 4	**1573626**	**807893**	**765733**	**1578994**	**811093**	**767901**	**1572293**	**807995**	**764298**	**1568205**	**806625**	**761580**	**1556711**	**801169**	**755542**
0	318860	164034	154826	306802	157886	148916	303407	156125	147282	303693	156573	147120	302836	155929	146907
1	312044	160005	152039	321129	165223	155906	308459	158682	149777	305005	156924	148081	304444	156912	147532
2	311507	159736	151771	315373	161762	153611	323809	166552	157257	311132	160022	151110	306771	157848	148923
3	316679	162613	154066	315183	161549	153634	318292	163366	154926	326803	168037	158766	313199	161091	152108
4	314536	161505	153031	320507	164673	155834	318326	163270	155056	321572	165069	156503	329461	169389	160072
5 - 9	**1567281**	**804219**	**763062**	**1586851**	**814019**	**772832**	**1604540**	**823433**	**781107**	**1618582**	**830275**	**788307**	**1628593**	**835815**	**792778**
5	314636	161432	153204	318322	163475	154847	324001	166389	157612	321625	164961	156664	324602	166669	157933
6	316919	162362	154557	317926	163075	154851	321028	164791	156237	326725	167759	158966	324369	166400	157969
7	312612	160540	152072	319654	163743	155911	320255	164301	155954	323567	166023	157544	328989	168951	160038
8	313041	160537	152504	315298	161885	153413	321787	164888	156899	322596	165501	157095	325873	167174	158699
9	310073	159348	150725	315651	161841	153810	317469	163064	154405	324069	166031	158038	324760	166621	158139
10 - 14	**1431690**	**735448**	**696242**	**1473263**	**757231**	**716032**	**1515917**	**779271**	**736646**	**1555840**	**799164**	**756676**	**1595815**	**819062**	**776753**
10	299311	153699	145612	312546	160619	151927	317746	162883	154863	319695	164240	155455	326250	167139	159111
11	287662	148006	139656	301572	154859	146713	314444	161611	152833	319973	163997	155976	321795	165376	156419
12	283993	146382	137611	290029	149268	140761	303530	155889	147641	316579	162687	153892	321937	164999	156938
13	280529	143766	136763	286183	147532	138651	292012	150341	141671	305454	156881	148573	318372	163642	154730
14	280195	143595	136600	282933	144953	137980	288185	148547	139638	294139	151359	142780	307461	157906	149555
15 - 17	**866346**	**444110**	**422236**	**868020**	**444755**	**423265**	**866825**	**444498**	**422327**	**869383**	**446196**	**423187**	**880134**	**452168**	**427966**
15	286211	147017	139194	283296	145231	138065	285577	146286	139291	290690	149774	140916	296220	152370	143850
16	289244	147904	141340	290389	149167	141222	286559	146922	139637	288637	147794	140843	293076	150925	142151
17	290891	149189	141702	294335	150357	143978	294689	151290	143399	290056	148628	141428	290838	148873	141965
Total	**5438943**	**2791670**	**2647273**	**5507128**	**2827098**	**2680030**	**5559575**	**2855197**	**2704378**	**5611075**	**2881469**	**2729606**	**5661253**	**2908214**	**2753039**

[a] (ABS. Stat, 2021) By state/territory, sex and age: Australia

Estimated and projected Aboriginal and Torres Strait Islander population[a]

Age	ACT					Australia				
	2016	**2017**	**2018**	**2019**	**2020**	**2016**	**2017**	**2018**	**2019**	**2020**
0	166	172	178	185	195	17,654	18,161	18,671	19,172	19,662
1	160	169	175	181	189	17,149	17,635	18,142	18,652	19,153
2	154	159	169	175	180	16,676	17,143	17,629	18,136	18,646
3	159	152	158	168	174	16,176	16,670	17,137	17,623	18,130
4	145	155	148	154	164	16,714	16,172	16,666	17,133	17,619
5	135	141	150	144	149	16,773	16,710	16,168	16,662	17,129
6	116	131	136	145	139	16,543	16,769	16,706	16,164	16,658
7	115	114	128	132	141	16,556	16,540	16,766	16,702	16,162
8	127	114	114	127	131	16,735	16,554	16,538	16,764	16,700
9	118	128	115	116	127	16,131	16,733	16,552	16,536	16,762
10	141	120	129	117	117	15,505	16,129	16,731	16,550	16,534
11	127	141	120	130	119	15,516	15,503	16,127	16,729	16,548
12	121	126	141	120	131	15,620	15,514	15,501	16,125	16,727
13	115	118	123	136	118	15,874	15,617	15,510	15,497	16,121
14	134	112	115	120	132	15,599	15,870	15,613	15,506	15,493
15	115	132	111	114	118	15,525	15,593	15,864	15,607	15,500
16	138	117	134	114	117	15,584	15,517	15,586	15,857	15,601
17	138	146	126	142	123	15,576	15,576	15,509	15,578	15,849

[a] (ABS, 2016) Single year of age, Australian Capital Territory and Australia

Appendix B Methodology

Date-of-death reporting for the register

For the purpose of 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 five-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 significant 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 Births, Deaths and Marriages and other Australian jurisdictions.

Fewer than five total deaths

When a particular cohort of children and young people has fewer than five total deaths, the exact number of deaths will not be reported. 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 •, which means the number of children and young people who died is fewer than five but greater than zero.

When a cause of death has fewer than five deaths, this report will not provide more detailed information about this 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. The suppression of further data will not occur when it will significantly 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 worked out.

Population estimates and rates

ACT and Aboriginal and Torres Strait Islander children and young people populations are taken from the latest Australian Bureau of Statistics' estimated resident populations as at 30 June.

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 Glossary

Aboriginal and Torres Strait Islander

In the *Children and Young People Act 2008* (ACT):

> *Aboriginal or Torres Strait Islander person* means 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.

Certain conditions originating in the perinatal period

Refers to deaths whose cause originates in that period, even though death may occur later. The perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500g) and ends seven 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

In the *Children and Young People Act 2008* (ACT):

> *child* means 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 foetal deaths.

Child Concern Report

Refers to a report made to Care and Protection Services 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 be in need of 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 anomalies

Includes deformities and chromosomal abnormalities and refers to physical and mental conditions present at birth that are 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

Refers to the initiative of the Australasian Coroners Society that is managed by the Victorian Department of Justice on behalf of the Australian Government and the states and territories. Information about every death subject to a coronial inquiry in Australia is stored in the system, providing a valuable hazard identification and death prevention tool for researchers, including state and territory death review committees (definition from the National Cancer Institute).

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 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.

SIDS

Refers to Sudden Infant Death Syndrome. Category of SUDI (see below) that has four categories: 1a, 1b, 2 and unclassified.

SIDS 1a	• An infant aged over 21 days but under 9 months of age. • Gestational age of 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 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 1 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 recognised genetic disorder • neonatal or peri-natal 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, which is 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 young persons over the age of 12 years who are not yet 18 years.

Progress against recommendations of the ACT Children and Young People Death Review Committee

Information Sharing and Recording	
Recommendations 1	**Response**

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 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.
	Child and Youth Protection Services (CYPS) policies, processes and systems that support information sharing, and the recording of practices to prevent the death of a child or young person include:
	
	<u>Health Passports</u>
	• My Health Passports are provided to children and young people 0-14 years in Out of Home Care. My Health Passport is a small booklet specifically designed to allow health information to be stored in one location. My Health Passport can be easily inserted into the ACT Personal Health Record, also known as the Blue Book. The intent of the My Health Passport is that carers take it to appointments in order to capture a contemporary and detailed summary of a child or young person's health records. The My Health Passport and Blue Book are used to document all health appointments and therapies for a child.
	• Information relating to a child or young person's health can be entered into their Health Passport by their carer, CYPS, ACT Together and practitioners from ACT Health and Women, Youth and Children Community Health services. Information about a child or young person's health can be reviewed or updated by Child at Risk Health Unit (CARHU), Child Health Checks, Maternal and Child Health Nursing Service (MACH) and Kindergarten Health Checks. My Health Passports are issued prior to the first CARHU out of home care health and wellbeing screening, which generally occurs within a week of a child or young person entering care.
	• In addition to the above carers are also encouraged to ask other health personnel (e.g. doctors, dentists and therapists) to record information in the Health Passport.
	
	<u>Implementation of the Child and Youth Record Information System (CYRIS)</u>
	• The Child and Youth Record Information System (CYRIS) for CYPS went live for case management services on 1 October 2019, and replaced the 20-year-old legacy system CHYPS. CYRIS will be extended to Bimberi Youth Justice Centre in November 2020 delivering one record keeping system for all children and young people involved with CYPS.
	• The ACT Government has committed to expanding the scope of the development of the new system to the Child and Family Centres (CFCs) and the Child Development Service (CDS), and to build capability to integrate with key stakeholders. This work is underway. An important aspect to consider for CFCs is the requirement of consent from families to exchange information with other agencies.
	• The CYRIS system reduces duplication of data entry, provides a genogram view of family relationships, has a powerful reporting capability, is designed to integrate with other systems relatively simply and has removed the need for paper files.
	• When extended to all of Children, Youth and Families it will provide those working with families in the CFCs and CDS, with improved access to effectively manage information to case manage children and young people and help keep them safe.
	
	<u>Connect for Safety (C4S)</u>
	• Children, Youth and Families have been working on a national project to share information about children known to the child protection system in each Australian jurisdiction. Connect for Safety (known as C4S) is a secure business system that allows each jurisdiction to check if a child or their family members are known to another child protection jurisdiction. Every jurisdiction has agreed to participate, and the Commonwealth has funded the initial set up. Only basic demographic information is matched, but this is sufficient to identify risk and direct case managers to jurisdictions to find out more information.
	• The C4S system went live at the end of September 2020 with NSW, Queensland, Victoria and Western Australian data available. The remaining jurisdictions, including the ACT will be providing data over the coming months.
	• This is an innovative project which will significantly improve risk assessment for children who have recently moved to the ACT and have no known history.
	
	<u>Co-locating staff from key partner agencies</u>
	• Key partner agencies have entered into information sharing agreements to best support child, young people and their families. These agreements and/or contracts include services delivered by Onelink, DVCS and Functional Family Therapy – Child Welfare. These agencies have staff who are co-located within CYPS to provided assistance to staff, to support referrals to services.
	•

	Interstate Transfers • When a child or young person moves in or out of the ACT, an 'Interstate Alert' or 'Interstate Notification' is sent from their originating State/Territory to their destination State/Territory (if known). This prompts CYPS, or its interstate counterparts, to request a child protection history under Part 10 of the Interstate Child Protection Protocol. Information sharing occurs throughout these processes and procedures. • There are current projects being trialled between the ACT and NSW in respect of information sharing. These projects are aimed at creating a database accessible by either the ACT or NSW that will provide information as to whether a child or young person is known by that jurisdiction. These potential databases contain functions such as creating matches on the identification of a child or young person, and allow for an alert system to be set up so the alert-creator is notified when a child or young person becomes known to another jurisdiction, amongst other functions. The trial of this database has already proved beneficial in the early stages. Family Safety Hub The Family Safety Hub takes an innovative approach to creating and testing new solutions for those affected by domestic and family violence. The Hub bring together community, government, the private sector and people who have experienced domestic and family violence, to co-design and test new ideas that can improve services and support in the ACT. • In April 2018 the Domestic Violence Prevention Council held an extraordinary meeting focussed on the needs of children and young people affected by domestic and family violence. The council made recommendations in six priority areas including consulting with children and young people so the ACT Government "puts the voices of children and young people at the heart of service design and delivery so that they directly influence the development of child-centred service responses to family and domestic violence." The ACT Government committed funding to address this recommendation through a partnership between the Family Safety Hub and the ACT Children and Young People Commissioner, bringing together the Commissioner's expertise in consultation with young people and the Hub's co-design and innovation processes. • Consultations sessions were held from September 2019 to February 2020. The sessions focussed on the experiences young people had when trying find the supports or services they need. The outcome of the consultation were 13 insights that speak to the unique and complex experience young people have of domestic and family violence. They are a powerful reflection of just how difficult it is for young people to be heard, to be respected and to find a pathway to safety that suits their individual needs. • The Family Safety Hub is sharing the insights across government and the service sector so the ACT Government, the service sector and the community hear what is needed to improve support and services for children and young people affected by domestic and family violence. • The Family Safety Hub will now lead a process to co-design solutions to the problems young people have told us about. This will begin before the end of 2020. This co-design process will bring together people in government and the community and will also involve young people themselves. During the consultations young people shared their own ideas about what could help them, and others like them. These ideas will be incorporated into the co-design process. The result of co-design could be a new service, a change to how we work, updated legislation or a completely new idea. A common dataset has been developed within the Community Services Directorate (CSD) to enable better analysis of client demographics and use of services. The dataset provides a guide for the collection of relevant service user data, including personal details, key characteristics, presenting needs and circumstances, service journey and service experience and outcomes. COVID-19 High Risk Coordinated Response to Children and Young People at Risk of Abuse and Neglect • The High Risk Coordinated Response meeting is a forum that provides across agency collaboration in response to children and young people at risk of abuse and neglect during the COVID-19 Public Health Emergency. • The Public Health Emergency is unprecedented for service delivery agencies in the ACT, including for those that work to keep children and young people safe from abuse and neglect. The focus of this meeting is to assist with: ○ the identification of systemic and thematic issues arising, or those which have the potential to arise during COVID-19; and ○ the escalation of individual matters that cannot be addressed through a standard case management response. CYPS located at ACT Family Law Court • As part of an Australian Government pilot program, CYPS has commenced a liaison role with the Federal Circuit Court's Family Court. The intent of the pilot program is for CYPS to be co-located at the Court, but with COVID-19 restrictions this aspect is largely happening remotely for the time being. The aim of the pilot is to enhance and streamline information sharing between CYPS, the AFP and the Court to ensure the Court has all the necessary information to make timely and safe decisions for children. CYPS provide:

	○ the Court timely information in response to notice of risk information requests and 69ZW orders ○ the Court timely information to inform independent child and parenting assessments ○ work in collaboration with AFP and Court on the identification and management of family safety risks ○ assist with urgent applications to be heard by the Court on an *ex parte* basis (principally applications for recovery orders) and indicate if CYPS holds relevant information ○ support referrals by CYPS to the Court ○ support the development, evaluation and analysis of policies and procedures related to information sharing between CYPS, the AFP and the Court. • By providing a dedicated liaison role, CYPS are providing a practical way for CYPS, the AFP and the Court to work smarter together, minimising barriers and enabling relevant information to be shared early in proceedings to help keep children and young people safe. It also provides the opportunity to increase the knowledge and understanding of the Court and AFP of our CYPS risk assessments and processes. • The Children, Youth and Families Community Engagement and Client Services (CECS) Team, consider level two complaints, including those about Child and Youth Protection Services. CECS is about to enter a period of change to pivot the complaints process to one that takes a conciliation and restorative practice approach. One aspect of change will be to ensure boarder accessibility for all people to be able to contact CECS and make a complaint about services provided by Children, Youth and Families. • The governance structure of the ACT Government's Out of Home Care Strategy *A Step up for Our Kids 2015-2020 (Strategy)* provides various fora to raise policy, systems and operational issues that relate to the provision of services funded under the Strategy. It is governed by one Joint Governance Group, and four sub-committees that address issues under the auspices of Accountability, Performance and Evaluation; Carer Wellbeing; Policy and Operations; and Workforce Capability. • ACT Togethers internal complaints policy and procedures is an ongoing piece of work, the review is well progressed, but not yet complete.
Addressing the risk factors in children's lives	
Recommendations 2	**Response**
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. ○ 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 ○ domestic and family violence ○ substance misuse ○ unstable housing ○ limited parental service engagement. • Reviewing the capacity for current practices to identify and respond to cumulative harm through: ○ 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. ○ Training and mandatory refresher courses for workers raise awareness of the full extent of their powers under legislation.	The following activities, resources and roles continue to support improvements to responding to risk factors. <u>CYPS Liaison Officers</u> • CYPS Liaison Officers role is focussed on coordination and collaboration between CYPS and ACT Health. The position of CYPS Health Liaison Officer works in tandem with the Canberra Health Service Child Protection Liaison Officer, ACT Health Liaison Officer and provides support to agencies to improve processes between the two organisations. This CYPS Health Liaison Officer sits at Canberra hospital once a week and the Child Protection Liaison Officer sits within CYPS twice a week. This has allowed an informal system for timely sharing of information facilitated by the CYPS Health Liaison Officer and Canberra Health Services Child Protection Liaison Officer. This supports projects and provision of information and assists ACT Health staff regarding CYPS policy, procedure, decision making and relevant legislation. Opportunities have been created for ACT Health practitioners to provide education to CYPS staff. • The IMPACT Program and Prenatal Liaison Officer is focussed on improving coordination and delivery of services to clients of the ACT Health IMPACT (Integrated Multi-agencies, Parents and Children Together) Program. This is a program for vulnerable families who have a family member receiving opioid replacement services and/or are a client of Mental Health ACT that are pregnant or have children less than 2 years of age. They also coordinate prenatal reporting responses within CYPS and support the range of early intervention and differential response for CYPS. The IMPACT Program is currently undergoing a restructure where criteria for referral is under review and will possibly extend to vulnerable high-risk families who require additional support to parent their child safely. • The Prenatal Liaison Officer role supports CYPS caseworkers in the interventions they undertake with vulnerable pregnant women and their families in the ACT who may be involved with multiple service providers and have a multitude of risk factors present that may impact on their unborn child and post birth of the child. The use of Pre-birth Alerts is widely practiced across the Canberra Hospital and Calvary Hospital facilitating a timely notification to CYPS of a baby's birth where risk is identified prior to birth. • The IMPACT Program and Prenatal Liaison Officer attends a variety of liaison meetings with Canberra Health Services and Calvary Hospital including maternity, social work, Aboriginal Liaison Officers, Pregnancy Enhancement Program (PEP) midwives, Blue Star Clinic, Maternal And Child Health (MACH) PEP, Karinya House, Alcohol and Drug Service and Perinatal Infant Mental Health to identify high risk pregnant or parenting women. • Liaison Officers meet with NSW DCJ managers covering Yass, Queanbeyan, Bega, Goulburn, Cooma and South Coast quarterly to identify high risk families

Training programs should be evaluated to assess their effectiveness.	who cross both jurisdictions, often to give birth. *A Step Up for Our Kids Out* of Home Care *Strategy 2015-2020* • Under the ACT Government's *A Step Up for Our Kids: Out of Home Care Strategy 2015-2020*, new services have been established to assist families with vulnerabilities that may place children at risk. A key focus of the Strategy has been the investment in intensive parenting and family preservation supports to prevent children and young people from entering out of home care. Services funded under the Strategy include: • Karinya House o Karinya House Mother and Baby Service provides supervision and support in a community-based setting, for mothers whose babies are at risk of entering the out of home care system. It includes accommodation, transitional housing and outreach support. o Karinya also provides an intervention program that allows mothers to remain with their babies while risk is closely monitored, and they are supported to learn parenting skills. • Uniting Children and Families ACT o Uniting provides placement prevention and reunification services under the Strengthening High-Risk Families domain. These include a family response program delivering outreach and in-home services across the ACT. Uniting can work with families in their own homes, or at an alternative home-like environment, for up to 12–18 months. Uniting will tailor support to each family's specific needs, and supports parents to connect with education, mental health services or drug and alcohol programs. o ACT Newpin (New Parent and Infant Network) is a centre-based, intensive therapeutic approach to break the cycle of abuse and neglect. The program has a restorative focus where parents are supported to develop parenting skills in order for their child to be returned back to them in a positive parenting environment. o Other services that support the intent of the Strategy and early intervention are Family Group Conferencing (FGC) and Functional Family Therapy. Further information on these programs is available at recommendations 3 and 5. Our Booris, Our Way Final Report (December 2019) On 17 December 2019, the Our Booris, Our Way Steering Committee released its final report into the circumstances of each Aboriginal and Torres Strait Islander child and young person involved in the child protection system, including those in out of home care. The Final Report outlined a total of 28 recommendations. Of the 28 recommendations made, the Government agreed to all 28 recommendations. In response to several recommendations, the following positions were established during the 2019-20 financial year: • The appointments of designated Aboriginal and Torres Strait Islander: o Practice Leader; o Senior Policy Officer; o Training and Workforce Development Officer; and o Principal Practitioner. • The engagement of SNAICC to undertake training for CYPS staff on the implementation of the *Aboriginal and Torres Strait Islander Child Placement Principle*. o Increase the cultural proficiency of CYPS staff to ensure a greater understanding of Aboriginal and Torres Strait Islander culture, with a focus on collaboration and the establishment of positive working relationships. o The development and implementation of several practice guides, procedures for staff and information sheets for families, and advocacy groups o Working with the Ngura Naraganabang (Safety in the Pouch) Advisory Group, an independent body of sector professionals who provide advice and feedback to CYPS on operational policy and resource development to support practice when working the Aboriginal and Torres Strait Islander children, young people, families and communities. Child and Youth Record Information System (CYRIS) • The new Child and Youth Record Information System (CYRIS), went live for CYPS case management on 1 October 2020. CYRIS has powerful reporting and dashboard capability that easily presents summary information of risk and case management information for case managers. This will assist in visibility of risk issues. • When all stages are completed the system will also allow automated real time exchange of risk, safety and wellbeing information about children and young people between relevant government agencies.

	CYPS Training • CYPS staff receive training in cumulative harm through e-learning as well as during induction and risk assessment training. • The CYPS training program will be reconsidered in 2021, with due consideration given to the training needs of staff from induction through to the needs of team leaders and operations managers. Refresher courses will be developed to ensure continuous learning, and learning will be scaffolded based on the skills and experience of caseworkers. Working with Families Affected by Cumulative Harm or Neglect • On 20 June 2019, CYPS launched and made available to all staff, a guide titled *Working with Families Affected by Cumulative Harm or Neglect.* This guide outlines the approach in understanding and managing cumulative harm, and neglect, in the context of child protection and youth justice work in the ACT. It is intended for use by CYPS staff and its partners working with ACT children and young people. • The guide informs the link between cumulative harm and neglect, a theoretical understanding of the impacts of cumulative harm on children and young people, a practice approach to the identification and assessment of cumulative harm, how to take action when cumulative harm is suspected. • The guide provides clarity on when cumulative harm meets the legal threshold for a Child Protection Report due to 'significant risk of abuse or neglect' and when a matter should be appraised.

Enhanced supports for families under pressure	
Recommendations 3	**Response**
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. o Voluntary family support services should be provided by someone other than CYPS to avoid duality of roles. • 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: o children who are identified as experiencing cumulative harm o young parents who were engaged in statutory child protection services and/or corrective services o 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	Integrated Services and Programs • In July 2015, Child Protection Services and Youth Justice Services integrated to establish CYPS. A key feature of the integration of child protection and youth justice is a single case management model across both functions. This model focuses on the appointment of a single case manager across both custody and community, responding to both care and protection and youth justice matters, to provide consistency and seamless service delivery to young people throughout their involvement. • Another key component is the establishment of a single case plan to ensure improved planning, service coordination and delivery on all professional support provided through CYPS. The single case management model is young person-centred practice in which young people are actively involved in decision making, ensuring their views and wishes are considered, alongside the impact that decisions and actions will have on them, their development, wellbeing and safety. *OneLink* • OneLink is a free phone and outreach-based service that provides information and referral for children, young people and their families seeking accommodation and family support. OneLink brings together families, support services and community resources to help promote the safety and wellbeing of children, young people and families. OneLink can help all members of the community including people who are already or might become involved with statutory agencies like CYPS. • CYPS funds two part-time CYPS OneLink Liaison Officers. These OneLink staff co-locate two days a week with CYPS to facilitate improved referral pathways for families known to CYPS. The OneLink workers provide information about and referrals to services including child, youth and family services; tenancy support; support for people who are homeless including emergency accommodation; legal services; financial counselling; mental health services. *Safer Families Collaboration Pilot* • The Domestic Violence Crisis Service are working with CYPS under a *Safer Families Collaboration Pilot,* to provide expert family and domestic violence advice and support to CYPS in delivering child protection and youth justice services to the ACT community. This pilot program increases the capability of CYPS to respond to families impacted by Family and Domestic Violence. *Functional Family Therapy – Child Welfare* • Gugan Gulwan Youth Aboriginal Corporation, in partnership with OzChild, deliver Functional Family Therapy for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with the child protection system. The aim of the program is to reduce the number of Aboriginal and Torres Strait Islander children and young people entering, or remaining in out of home care, through interventions that strengthen families and communities. OzChild are co-located with CYPS staff one day each fortnight to support referrals to the program and to answer any questions CYPS staff may have about eligibility.

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.	*Uniting* • *Newpin* is primarily a group-focused centre-based program, with families and children attending 2 days per week for up to 18 months. Newpin provides parent therapeutic sessions, parenting education groups and therapeutic family play sessions. Parent education programs focus on attachment, safety and meeting the emotional needs of children. Occasional home visits are made to assess progress with transference of new skills to the home environment, and preparedness for restoration. *Australian Childhood Foundation* – intensive support • The Australian Childhood Foundation (ACF), as part of the ACT Together consortia, provide therapeutic specialist support and advice specific to children and young people through the child or young person's individual care team and professional meetings to collective work through the best approach to meeting the child or young person's needs. • As part of this process, a therapeutic assessor will undertake an evaluation of all information on the child or young person including health screening, observation and analyses the information gathered. The therapeutic assessor presents the information and their assessment to the child or young person's therapeutic care team. • Some strategies to reduce serious behaviours and mental health concerns can include 24-hour professional support, individually tailored behavioural support plans, mental health assessments and treatment and increased supervision. *Family Group Conference* – divert families away from court process • During 2017-18, CYPS developed a Family Group Conferencing model for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with the child protection service. The aim of Family Group Conferencing is to provide families with the opportunity to develop effective family plans that will keep their children safe. The priority is working with the family to keep children at home or planning for the successful restoration of children back to their families following some time in out of home care. Where children are not able to stay safely at home, the team works with and supports the families to identify the most appropriate kinship options to ensure the children remain connected to family and community. Family Group Conferencing ensures all members of a child's extended family are contacted and encouraged to be involved in the decision-making process about their child's situation. This process is considered in line with Aboriginal and Torres Strait Islander cultural values of family and community responsibility. *Child and Family Centres* (CFCs) • The CFCs are co located with Maternal and Child Health (MACH) services. MACH nurses refer clients identified as vulnerable to the CFC service on a regular basis. The CFC staff and MACH staff share clients on occasion, the "warm referral" process on site is a very successful model of supporting these vulnerable clients. MACH nurses are able to complete "warm referrals" with identified vulnerable families by walking the clients to the CFC intake office and making introductions. With consent, the needs of the clients are then discussed, and the CFC will complete an assessment to link the family with supports and service either on site or in the wider community. • Evidence of the strong working relationships being of benefit to the community is seen in the flexibility of the MACH nurses on site weekly who will immunise CFC clients at TCFC without appointments. This ensures that this barrier is removed for the families and the children receive this essential free service. <u>Evidence based approaches</u> *Case Analysis Team* • The Case Analysis team has developed a specific methodology which was informed by the recommendations of both the Glanfield and Muir reviews, and has been endorsed by its oversight Committee comprising expert 'critical friends' from other jurisdictions. This methodology applies a consistent approach to reviewing each case but allows for individualised terms of reference in order to deliver to CYPS staff, appropriate and specific recommendations which relate to each child in the family, as well as the family as a whole. • The team is staffed by three FTE senior and experienced case analysis staff, all of whom have professional qualifications as well as review expertise and firsthand child protection experience. This has allowed the ACT to provide a professional and individualised response to each referred case, rather than relying on use of an empirical tool which is typically relied upon by larger jurisdictions with fewer professional staff and less capacity to provide a tailored response. *IMPACT Program* • The IMPACT Program is a voluntary program based on client consent for full information sharing across agencies. The IMPACT team consists of two coordinators based at The Canberra Hospital (TCH) and three Liaison Officers who are located in their operational areas, consisting of the Alcohol and Drug Liaison at TCH, the Mental Health Liaison at Perinatal Infant Mental Health, Woden and the CYPS Liaison located within CYPS.

	• A major function of the program is a multiagency membership which consists of representatives from TCH Social Work, MACH nurses, Alcohol and Drug Service, Perinatal Infant Mental Health, CYPS IMPACT Liaison The Blue Star Clinic TCH, TCH and Calvary Maternity and Co-ordinators represent feedback from General Practitioners, NGO's and any other service providing support to families.

Child-focussed practice	
Recommendations 4	**Response**
Changes to services to make them more focussed on children by: • 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.	<u>Melaleuca Place</u> • Melaleuca Place is a specialised therapeutic service in the ACT focused on helping young children recover from the impacts of child abuse and neglect. The CYPS staff work with children aged 0 to 12 years old involved with child protection, and their carers. The specialised services help children to understand and work through the trauma that has happened, their emotions and to learn to trust again. • The CYPS staff at Melaleuca Place are a highly skilled team of clinical psychologists, social workers, a speech pathologist, an occupational therapist, and an operational support officer. • The team at Melaleuca Place provide multidisciplinary psychosocial assessments that outline the child's multiple and complex needs. These assessments guide treatment planning to meet the specific therapeutic needs of the child in a sequential, phase-based approach. • Melaleuca Place works from a child-centred, strengths-based framework, respecting the child's wishes and best interests. The staff at Melaleuca Place are trained in various evidence-based treatment modalities to match the child's changing needs. • Melaleuca Place will also work with the child's declared care team to establish a therapeutic care environment, prioritising safety and stability, and helping the care team respond to the child in a trauma-informed manner. <u>Establishment of the Case Analysis Team</u> • The Case Analysis team undertakes case analysis of identified cases of children and young people with extensive involvement with the child protection service, or those considered at high risk. The team provides independent advice and quality assurance to caseworkers and team leaders. The team assists CYPS to further develop consolidated histories which identify historic and current risks, impact, and risk of cumulative harm, identified vulnerabilities to children's safety and protective factors which mitigate the vulnerabilities. <u>Embedding the Human Rights of Children and Young People</u> • The ACT was the first jurisdiction to enact the *Human Rights Act 2008* in which the rights of children are included. The *Human Rights Act 2004* provides the statutory basis for respecting, protecting and promoting civil and political rights in the ACT. This means that every Directorate embeds the principles and rights of the *Human Rights Act 2004* in the development and implementation of all strategic and organisational policies and documents including contracts with the NGO sector. • To support ongoing efforts to embed best practice and promote a human rights culture in policy implementation, CYPS ensure staff are appropriately trained in policy and legislation, including the *Children and Young People Act 2008* and the *Human Rights Act 2004* to fulfil obligations in supporting children and young people and their families who are involved in the child protection system. • Decision making in the ACT is subject to unique and complex oversight obligations to six separate statutory office holders (across several legislations) including; the Public Advocate of the ACT, the ACT Children's Commissioner, the Senior Practitioner (HRC), the ACT Ombudsman, the Official Visitors (including an Aboriginal and/or Torres Strait Islander Official Visitor) and the Human Services Registrar. Amongst other things, these agencies receive copies of all abuse in care reports which proceed to an investigation, as well as copies of all applications for new or amendments to Care Orders, Emergency Action, Youth Justice Orders, copies of Annual Reports pertaining to all children in care and Case Plans (including Cultural Plans, Transition Plans, Care Plans and YJ Case Plans). • CYPS welcomes the introduction of an external review of decisions process to streamline these obligations and eliminate the current duplication in reporting, as well as current lack of legal harmony between these legislations. The internal review process, which will commence in 2021 will create a suitable platform for consistent recording of all key child protection and youth justice decisions.

Assessment of parenting capacity	
Recommendations 5	**Response**
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 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.	<u>*A Step Up for Our Kids* Out of Home Care Strategy 2015-2020</u> • Since 2015 under *A Step Up for Our Kids*, Uniting Children and Families ACT has been commissioned to provide intensive, tailored family support for vulnerable children at risk in the child protection system. The support provided by Uniting aims to keep vulnerable children together by providing parents with the tools and knowledge to sustain a safe home environment for their children. This service provides intensive support for extended periods of time with capacity to support 84 families per year (annualised). <u>Functional Family Therapy – Child Welfare</u> • Gugan Gulwan Youth Aboriginal Corporation, in partnership with OzChild, continue to deliver *Functional Family Therapy – Child Welfare* in the ACT. Functional Family Therapy – Child Welfare works specifically with Aboriginal and Torres Strait Islander families with children and young people aged from birth to 17 years who are facing vulnerable times in their lives and are at risk of entering the out of home care system. • Functional Family Therapy aims to support families to keep child and young people at home safely, reducing or eliminating the need for ongoing involvement of the child protection system and creating positive family experiences. • Since implementation of the Pilot Program in November 2018 to 30 June 2020, Oz Child and Gugan Gulwan Youth Aboriginal Corporation, have engaged with a total of 40 families involving 116 children and young people. Of this, 25 families, made up of 82 children and young people, have successfully completed the Functional Family Therapy (FFT-CW program) with no subsequent entries of children and young people in the out of home care system. • For Aboriginal and Torres Strait Islander families at risk of involvement with the child protection system, the ACT Government is currently supporting a trial of Functional Family Therapy being delivered by Gugan Gulwan Youth Aboriginal Corporation in partnership with OzChild. <u>Child and Family Centres and Child Development Service (CDS)</u> • Parents who require less intensive parenting support can access to a range of programs and services through the CFCs in Gungahlin, Tuggeranong and West Belconnen, and through community organisations funded under the Child, Youth and Family Support Program. These programs may include family support or counselling services. CFC's also partner with other community organisations to offer parenting programs. • The new *Child and Young People Record Information System* (CYPS) is in the process of implementing a new client management system (CYRIS), which will allow for improved information sharing and data matching between agencies and mandatory reporters. The Government has committed to expanding the scope of the new system to include CFCs and the CDS, and to build capacity to integrate with key stakeholders. • The project will build connections with key government partners, commencing with ACT Policing and the Education Directorate, and will allow automated real time information exchange of risk, safety and wellbeing information about children and young people. The system will provide CYPS staff, and those working with families in the CFCs and CDS, with improved access to effectively manage information to case manage children and young people and help keep them safe.
Staff training and development of decision making capacity	
Recommendations 6	**Response**
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	<u>CYPS Training and Development</u> • The CYPS Training and Workforce Development team provides specialist support to CYPS staff by delivering face-to-face and eLearning training; and assisting to increase the knowledge capacity and skills of staff within the child protection system. The team has developed, implemented and maintained a significant number of training programs since its establishment. • An e-Learning package on cumulative harm has been developed for CYPS staff. Key learnings from the training include understanding the impacts of cumulative harm; identifying the indicators of cumulative harm; being able to take appropriate action when you believe you have identified when cumulative harm is present; and knowing where to find more information and support to assist in developing your knowledge of cumulative harm. • CYPS provides intensive training to staff in relation to family and domestic violence, which focuses on supporting the protective parent where family safety is identified as a significant risk. A key component of this training also includes engaging fathers, through a whole family approach to safety. • In early 2021, CYPS will engage the Safe and Together Institute to undertake an organisational assessment and to deliver training to CYPS staff, including CYPS executive, the CYPS Leadership team and case managers. This will ensure the Safe and Together principles are imbedded in both

trauma, domestic violence and service utilisation. • 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.	practice and policy development across the organisation. • Housing ACT has also recognised the importance of frontline staff being aware of the issues impacting children and young persons that may be impacted by trauma. Modules on 'Keeping Children and Young People Safe' and the 'Reportable Conduct' have been included amongst the core competency training that Client Service Branch staff are required to complete. As at 2 October 2020, 75% of CSB staff have completed the Keeping Children Safe module and 78% of staff have completed the Reportable Conduct training. Housing ACT is seeking to have all frontline staff complete these modules by the end of 2020. <u>Restoration Panel</u> • In late 2018, CYPS developed and implemented a Restoration Panel to increase the number of children on interim or short-term orders successfully restored to their birth parents. The Restoration Panel facilitates effective and efficient communication, collaboration and alignment with the Step Up for Our Kids strategy in regard to restoration and permanency. The goal is to ensure there is effective planning for restoration and to provide the optimum conditions for parents to succeed in achieving positive change and having children restored home to a safe and nurturing environment. • The Panel meets on a fortnightly basis and is membership includes managers from Uniting, ACT Together, and CYPS. Advisor roles to the panel are held by the Cultural Services Team, the Assessment and Support Team, and the Principle Therapist from Melaleuca Place. <u>Role of CYPS Principle and Senior Practitioners</u> • The Senior Practitioners are responsible for providing expert case practice advice and leadership, supporting and developing case managers in the integration of theory and practice while demonstrating expertise through case management. The Principal Practitioner's roles are focussed on driving excellence in service delivery through a range of interventions including co-working on case management, strategically working to improve practice and through direct case management of complex and/or sensitive cases, as well as: ○ Develop and share professional knowledge to facilitate and promote best practice service delivery. Including developing knowledge, understanding and ability to articulate a cohesive practice framework regarding child development, attachment, and trauma theories. ○ Build a positive culture of feedback, reflective practice and learning by fostering a collaborative learning environment. ○ Build knowledge across CYPS of the legislative and policy drivers for trauma informed case management practices. ○ Actively participate in reflection sessions and other review opportunities to improve delivery of child, young people and family focussed outcomes. ○ Coach and mentor other staff (including team leaders) in case management to continuously improve engagement and service delivery. • Work with and support the Practice Leaders, other Principal and Senior Practitioners, Team Leaders and Operations Managers in their roles as coaches and mentors. <u>*Children and Young People Act 2008* – Best Interests Principle</u> • Decisions about the long-term placement of children are complex ones and are guided by the Children and Young People Act 2008 (the Act) and often in the context of the ACT Children's Court through a Case Management Conference negotiation. The Act requires that when decisions are made in relation to a particular child, the decision maker must regard the best interests of the child as the paramount consideration. These decisions are typically discussed in the context of declared care teams and recorded in a transparent and easily reviewable format. <u>Application Review Committee</u> • The Application Review Committee (ARC) reviews proposed applications for orders and reviews the practice and legal issues that form the basis of a proposed application. The aim of the ARC is to ensure that all applications for orders are child centred and consistent with the best interests principles, demonstrate collaboration with key partners, demonstrate good decision making, are timely, provide stability for children and young people, are robust, transparent and accountable. • The ARC panel consists of three Senior Managers originating from the two areas of operations and the CYPS Legal Services unit Advisor roles to the panel are held by the Cultural Services Team and the Assessment and Support Team. <u>CYPS Risk Assessment Framework</u> • The CYPS Risk Assessment Framework is used by CYPS staff in reaching professional decisions about a child's exposure to risk. It is intended to assist staff to both identify and articulate a professional analysis of the level and consequences of risk to a child based on the probability and consequences of abuse and/or neglect, as well as the impact of cumulative harm. The Framework provides CYPS with a structured and systematic process for making decisions consistent with compliance with legal thresholds for government intervention into the family; the level of concern held by CYPS about the safety and wellbeing of children; and the scope of an intervention by CYPS to these reported concerns.

	Internal and External Merits Review of Child Protection Decisions • The ACT Government is currently developing a unified model of internal and external merits review for child protection decision-making. The unified model of internal and external merits review will integrate restorative child protection practice, policy and process into CYPS decision-making. • The ACT Human Rights Commission and Community Services Directorate jointly facilitated two online roundtable discussions about child protection decision-making with interjurisdictional and ACT stakeholders, to inform the development of an external merits review model for the ACT. • Over the course of 2020 CYPS has been consulting with key stakeholders about how to improve internal decision review processes. The next stage of work is to consolidate feedback and develop policies, guidance, and training for staff.
Safe sleeping	
Recommendations 7	**Response**

Provide families with information on safe sleeping through:
• Consistent guidelines agreed across the directorates and delivered through the continuum of services.
  ○ 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.
	Co-Sleeping and Safe Sleeping Practice Guideline
	The Practice Guideline: *Co-sleeping* provides information to CYPS staff about the risks associated with co-sleeping. The Practice Guideline: *Safe Sleeping* provides further information to support staff in assessing sleep arrangements for infants.
	Both Practice Guidelines include tips for CYPS staff in working with parents of infants such as sighting the child's bedding, pet arrangements and cultural elements.
	CYPS may also provide assistance to families to purchase a bassinet or cot for their infant to support child/infant safety or seek the assistance from MACH for the provision of a Pepi pod.
	CYPS has also developed a Breastfeeding and substance use care procedure.

Blind Cords	
Recommendation 8	**Response**
The Committee wrote to the Director-General of Community Services in 2014, following the deaths of two 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.	• Housing ACT did not generally install window furnishings in 2014, however there was a program where, upon becoming vacant, three-bedroom properties were fitted with pelmets and rod and ring fixtures. This program concluded in the 2016-17 financial year. • Housing ACT undertook an education campaign to raise tenant awareness of the dangers associated with unsecured window covering cords. This occurred through face-to-face engagement with tenants at client service visits and information in the Spring 2014 edition of the Housing ACT newsletter, *Home Front*. Housing ACT now allocates properties with blinds and/or window furnishings and follows the necessary safety requirements that all cords are attached securely to the wall to comply with the Australian Consumer Product Safety Standard. These requirements are checked as part of property inspections and they have also been included in training provided to Housing Managers about the conduct of Client Service Visits and property inspections.

ACT Government | ACT Health

Office of the Director-General

Ms Margaret Carmody, PSM
Chair
ACT Children and Young People Death Review Committee
c/o will.constantine@act.gov.au

Dear Ms Carmody

Changing the Narrative for Vulnerable Children: Strengthening ACT Systems Report

Thank you for your letter of 22 September 2020 seeking an update to the work undertaken in response to the recommendations made by the ACT Children and Young People Death Review Committee. I apologise for the late response.

I am pleased to provide an update on activity Canberra Health Services and the ACT Health Directorate have undertaken to address the recommendations made by the committee. This information is attached for your consideration.

If you have any further questions related to this response, please contact Rebecca Williams, Director, Social Policy, at rebecca.williams@act.gov.au.

Yours sincerely

Kylie Jonasson
Director-General

13 November 2020

GPO Box 825 Canberra ACT 2601 | Ph: (02) 5124 9400 | Email: DGACTHealth@act.gov.au | www.act.gov.au

ACT Children and Young People Death Review Committee Report 'Changing the narrative for vulnerable children: Strengthening ACT systems'
Response by ACT Health Directorate and Canberra Health Services (CHS) – October 2020

Recommendation	Response	Current activity addressing the recommendation	Opportunities to consider	2020 input
Recommendation 1 That current practice models with parents following prenatal reports be reviewed to: • Ensure that early intervention strategies across ACT Health and Community Services Directorates are maximised before the birth of the child, including access to GPs and prenatal health checks - non-attendance should be followed up.	Agree	• Child protection education and training (CHS) has updated the fact sheet '*Prenatal reporting, prenatal information sharing, pre-birth alerts'.* • As a CHS employee, it is voluntary to make a prenatal report to Children and Youth Protection Services (CYPS). • Pregnancy Enhancement Program (PEP) midwife identifies risk factors and refers to either to Parenting Enhancement Program (PEPs) or Integrated Multi-agencies for Parents and Children Together (IMPACT) program (community based). IMPACT aligns with engaging with vulnerable families linking with Alcohol and Drug and Perinatal Mental Health services.	• Support and encourage voluntary prenatal reporting by all health professionals. • Streamlining (for example, screening) in the acute Women Youth and Children (WYC) setting and PEPs in WYC community health. • Collaborating with the Family Safety Hub to progress a concept to dedicate an antenatal visit and one postnatal visit to address psychosocial issues for the families. The aim is to target vulnerability concerns in visit. • Align Maternal and Child Health (MACH) services with the proposed Maternity Access Strategy to enhance holistic service and support for families identified as vulnerable.	*ACT Government Response to the Inquiry into Maternity Services in the ACT*: **Recommendation 36** The ACT Government acknowledges the importance of an integrated, holistic and culturally appropriate model of care for Aboriginal and Torres Strait Islander families. Currently at CHS and Calvary Public Hospital Bruce, Aboriginal and Torres Strait Islander people have access to an Aboriginal Liaison Officer during their perinatal journey. CHS and Calvary Public Hospital Bruce also work in conjunction with Winnunga Nimmityjah Aboriginal Health and Community Services to provide maternity care for Aboriginal and Torres Strait Islander people through the Australian Nurse-Family Partnership Program (ANFPP) and Midwifery programs. Through CHS a number of early intervention activities have taken place since the previous update:

			• The implementation in 2019 of a Health Justice Partnership with Legal Aid ACT at The Canberra Hospital provided an additional early response to families where prenatal concerns have been identified. • Child Protection Training continues to encourage CHS staff to submit a voluntary prenatal report. • Current pre-birth alerts are sent weekly via CPLO to both TCH and Calvary. • Canberra Maternity Options Service (CMOS), formerly Maternity Access Strategy, commenced in September 2019 and coordinates early pregnancy care across the ACT. • CMOS identify vulnerable clients and link them into supportive services including the Antenatal Pregnancy Enhancement Program at both Canberra and Calvary public hospitals. These programs provide vulnerable pregnant women with individual antenatal advice and support and ensure seamless transition to postnatal service support including the Parent

				Enhancement Program and MACH services.
Recommendation 2 That ACT services review current practice to identify and respond to cases of cumulative harm. This includes: • A review of the current 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. • Providing enhanced training and mandatory refresher courses for workers to ensure that they are aware of the full extent of their powers under legislation. Training programs should be evaluated to assess their effectiveness.	Agree	• CHS has mandatory child protection training for all staff including contracted and volunteer staff. • Training is conducted face to face and via E Learning platforms • Education is targeted to different levels depending on clinical responsibility and clinical interaction with vulnerable children / families. This includes mandatory refresher training for level 3 clinical staff every 3 years • The child protection training programs are regularly evaluated to assess currency and effectiveness. • Child Protection Liaison Officers facilitate cross-Directorate communications between CHS and CYPS. Liaison Officers are available for support and expert advice to CHS staff. • The Child at Risk Health Unit (CARHU) provides an intake service that provides information, consultation and referrals to assist professionals including CHS staff and the public seeking health information, guidance,	• ACT Health Directorate in consultation with CHS finalised and strengthened Child Risk Concern Reports to an online secure system via RISKMAN portal to CYPS. This improves accountability for CYPS and the reporter. Notification will be received by both parties. Strengthen governance and collaboration. • CYPS to strengthen feedback processes following child concern report regarding what action was taken or not.	The *Children and Young People Act 2008* is the law that governs child protection in the ACT. It provides the legal framework and responsibilities in regard to ensuring the care, safety and wellbeing of children. ACTHD and CHS continue to support CSD with implementing *Our Booris, Our Way* recommendations. SNAICC (Secretariat of National Aboriginal and Islander Child Care) have been engaged to undertake training for CYPS staff on the implementation of the *Aboriginal and Torres Strait Islander Child Placement Principle* in practice. CHS has made improvements to identify and respond to cases of cumulative harm: • Child Risk Concern Reports are now submitted via Riskman for CHS staff which allows oversight and accountability with CYPS. • Child Protection Training is evaluated by participants and trainers also link in with

		treatment and referral on issues relating to child abuse and neglect.		trainers across jurisdictions to discuss content and delivery of training. • CPLO continues to coordinate cross directorate meetings with CYPS and DJCS. • Child Protection Training remains mandatory for all CHS staff and has been maintained over the COVID period to ensure compliance and understanding.
Recommendation 4 For the ACT jurisdiction to ensure that safe-sleeping guidelines are consistent across Directorates and delivered consistently across the continuum of services by: • Ensuring cross directorate agreement is established about safe sleeping guidelines. • Professionals/providers have access to evidence-based training and resources concerning safe sleeping guidelines.	Agree	• WYC Division have safe sleep guidelines with consistent language and procedures • It is recommended that nurses and midwives view the sleep environment for all clients at the initial home visit with permission from the parent • Liaison with non-governance agencies for consistent information eg Queen Elizabeth II • Engage Red Nose, Saving Little Lives (formerly Sids and Kids) to provide education sessions for MACH staff	• Provide free Pepi-pod bed as a safe co-sleeping environment for all vulnerable families with particular attention on smoking and parents with large body mass.	To build on safe-sleeping guidelines a MACH nurse provides information on safe sleep practices and instruction for the safe use of Pepi-pods, which are offered (free) to eligible clients on the Parent Enhancement Program; eligibility includes: • smoke exposure-especially in pregnancy as well as smoking in households • prematurity • low birth weight • teen/young parents • obesity in pregnancy • babies who sleep in unsafe situations

				• parents with previous or current drug use.
Recommendation 5 Safe infant sleeping promotion, co-sleeping and bed-sharing messages need to be provided to all caregivers prior to and after the birth of the child by health and social welfare professionals. • Vulnerable families should be provided with the necessary support to obtain appropriate bedding for the child prior to leaving hospital.	Agree	• As outlined above in Recommendation 4	• Liaison between CHS and CYPS prenatal liaison worker to conduct joint prenatal home visit to identify issues with the individual infant sleeping environment and opportunities for support and education. Addressing issue of safe sleep in the home before introducing a baby into the home is best practice for early intervention • Strengthen education to all parents and carers on child's safe sleeping needs	CMOS identify vulnerable clients and link them into supportive services that provide individual antenatal and postnatal advice and support including safe sleep practices.
Recommendation 6 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 the necessary training for practitioners.	Agree	• CHS Implemented Perinatal Psychosocial Screening Assessment (PPSA) tool in 2014 as part of the National Perinatal Depression Initiative (NPDI). Screening is conducted antenatally and postnatally at the initial contact with a midwife or nurse. • Guidelines on Perinatal Emotional Wellbeing have been developed • E-learning is available to staff to complete on perinatal emotional wellbeing	• Funding for all staff to complete Family Partnership training • Highly recommend relevant clinical staff attend Circle of Security (CoS) training • Extend Strengthening Hospital Response to Family Violence (SHRFV) to all the WYC division staff • All maternity services in the ACT to undertake Strengthening Hospital Response to Family	*ACT Government Response to the Inquiry into Maternity Services in the ACT*: **Recommendation 37** The *Territory-wide Health Services Plan*, currently under development, will identify priorities for health service development and redesign across the ACT. Through this work, the ACT Government will review maternal, child and family community-based services currently provided to Aboriginal and Torres Strait Islander people to determine

		• Referral pathways established for appropriate support services • WYC community health staff undertake Family Partnership training • Strengthening Hospital Response to Family Violence (SHRFV) program is being piloted in CHS antenatal and MACH services • Implemented Purple Crying program. Dose 1 conducted in maternity services, and dose 2 conducted in the community setting.	Violence (SHRFV) training program • Strengthen Purple Crying program across all ACT maternity services (potential alignment with proposed Maternity Access Strategy).	current demand and future needs. Family Partnership training is a requirement by CHS for all MACH nurses and midwives. CoS training is regularly offered to relevant staff. SHRFV training is essential education for CHS managers and from 2021 will be rolled out to clinicians in WYC Division which includes midwives.
Recommendation 10 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.	Agree	• All WYC community health staff have undertaken targeted trauma informed care education in 2018. • WYCCHP staff completed Family Partnership training • Access to Early Parenting Counselling service for all parents regardless of gender • Collaborate with Family Safety Hub and contributing to idea concepts that will be piloted in different directorates across ACT • All nurses/ midwives in the WYCCHP access clinical reflective practice	*Opportunities to consider* • Other relevant staff attend Circle of Security training as appropriate • Extend Strengthening Hospital Response to Family Violence (SHRFV) training program to all WYC Division staff • All maternity services in the ACT to undertake Strengthening Hospital Response to Family Violence (SHRFV) training program • Clinical reflective practice to be implemented and available for all nursing and midwifery staff to access	ACTHD continues to implement the *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023*. Through the Strengthening Health Response to Family Violence (SHRFV) training modules, CHS is raising awareness of the gendered nature of family violence and the serious lifelong impacts on children. The training informs new CHS processes which have been developed to improve the identification and response to disclosures of family violence. WYCCHP is currently updating the allied health clinical supervision

		• Staff have access to professional development opportunities • All WYCCHP health professionals engage in a range of clinical supervision supports. Health professionals delivering services to vulnerable families have a focus on trauma and the impact of violence on families in clinical supervision.		policy to ensure it meets the needs of clinical staff. Clinical Reflective Practice remains a key professional support for registered nurses and midwives in WYC CHP. Trauma informed care refresher training commences in 2021.
Recommendation 11 That vulnerable families with an intergenerational history of abuse should be offered trauma-informed targeted parenting support prior to and following birth of their child in a non-stigmatising maternal health service.	Agree	• Early Parenting Counselling Service provide service through a trauma informed framework • Parenting Enhancement Program (PEPs) targets parenting support service for vulnerable families • IMPACT program is currently under-going review of model of care to propose the focus is more on the child at the centre and incorporating parenting support in the program • CARHU assists children and young people affected by abuse and neglect by providing specialist therapeutic interventions, counselling and support to assist them to heal from the traumatic consequences of these experiences.	• Parenting Enhancement Program eligibility criteria timeframe to be expand for 3 years instead of 1 year. • IMPACT Program to expand the current eligibility for clients to stay on the program until preschool age instead of 2 years. • Strengthen the ability for families to engage in formal child care.	Refer response at Recommendation 6 above. *ACT Government Response to the Inquiry into Maternity Services in the ACT*: **Recommendation 40** The ACT Government will work to strengthen the relationship between community-based and hospital care providers to enhance the continuity of care across health services for Aboriginal and Torres Strait Islander people. A trauma informed approach underpins the SHRFV training model which acknowledges the impact of intergenerational trauma and seeks to foster a health environment where it is safe to disclose and seek help. A review of the Sustained Home Visiting model of care in WYCCHP

				is being considered with the aim of increasing the age of children on the program to two years and a framework for parenting education and outcomes developed. Improving the interface with the Education Directorate Early Childhood Education and Care access for vulnerable children at age three years is in discussion.
Recommendation 12 • That the ACT jurisdiction identifies innovative and evidence informed approaches to working with individuals who have experienced intergenerational trauma particularly in relation to the following groups: • • 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. •	Agree	• Parenting Enhancement Program attends Canberra College Cares (a college program that supports young mothers) to support young parents • The Community Paediatric and Child Health Service (CPCHS) is a service for children and adolescents requiring medical assessment, treatment or review relating to suspected or established developmental delay or disability and behavioural or emotional disturbance. These children have developmental differences which may be attributed to and/or exacerbated by domestic violence, mental illness, substance abuse and other psycho-social adversities. • CARHU assists children and young people affected by abuse		ACTHD and CHS continue to support CSD with implementing *Our Booris, Our Way* recommendations. The Functional Family Therapy-Child Welfare Program is a service partnership between OzChild and Gugan Gulwan Aboriginal Youth Corporation which aims to reduce the number of Aboriginal and Torres Strait Islander children and young people entering or remaining in out of home care through culturally specific interventions that strengthen families and communities. The SHRFV project is focused on strengthening and building new internal and external partnerships to establish effective referral

		and neglect by providing specialist therapeutic interventions, counselling and support to assist them to heal from the traumatic consequences of these experiences.		pathways for victim survivors and perpetrators of family violence. CPCHS is currently piloting a nurse led clinic for children younger than school age who have been referred to a community paediatrician. The intent being to provide a responsive and timely service which provides assessment and treatment pathways for vulnerable families. Further support for the health needs of children in out of home care is being explored.
Recommendation 13 There is a need to build 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 and ACT Housing, to be aware of and to act with the best interests of the child as a primary consideration.	Agree	• IMPACT program is currently undergoing a review of the model of care with the aim for aligning the focus on the child and parenting support for the families. • Advocate for child friendly areas in community health centres • Draft clinical guidelines to assist clinicians balance the concerns for adults attending psychotherapeutic assessments and treatments when infants, with their different needs, are present at the adult's appointment • CHS factsheet is available that informs and educates staff	• Implement Child-safe, Child-friendly, Child-aware practices within all health services	ACTHD and CHS continue to support CSD with implementing *Our Booris, Our Way* recommendations. CHS Family Violence policies and procedures embed processes that require our staff be child focused when assessing risk and responding to disclosures of family violence. CARHU will be relocating in 2021 and the new build has involved consultation with consumers and carers to ensure a child friendly space within the CHS campus.

		about Child-safe, Child-friendly, Child-aware practices		
Recommendation 14 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.	Agree	• Embedded into everyday professional practice for MACH staff with infant mental health as a primary focus of care. • CHS Child Protection training provides information on the United Nations Convention on the Rights of the Child.		ACTHD and CHS continue to support CSD with implementing *Our Booris, Our Way* recommendations. CHS Child Protection Training continues to provide information on the Rights of the Child.
Recommendation 15 Caseworkers making referrals for vulnerable families should provide follow up support to families while they wait for services to commence.	Agree	• The MACH model of care framework incorporates a MACH Plus service where additional support is offered via a home or clinic visit or access to early days group session • Identified pathways provide referrals to ongoing support services eg, PEPs • MACH escalation policy prioritises home visiting for more vulnerable client referrals • Ability to identify vulnerable families following birth is enhanced through e-referral system from maternity service in the ACT to MACH service. • Child and Family Centres and MACH have strong relationship	• Enhance communication improvement with CYPS • Early intervention service currently with CSD. An opportunity exists for improved alignment to increase clinical governance and referral process.	ACTHD and CHS continue to support CSD with implementing *Our Booris, Our Way* recommendations. CHS CMOS offers flexible appointments to women identified as vulnerable including follow up care and prioritised continuity of care at their hospital of care. A pathway between CMOS, the antenatal Pregnancy Enhancement Program and the postnatal Parenting Enhancement program has been strengthened and streamlined. The IMPACT coordinators liaise closely with designated officers in

		and the ability of 'warm referral' for families. • CARHU provides 'Concerns Interviews' to parents/carers, providing an opportunity to discuss concerns about children in their care who may have been exposed to abuse and neglect.		drug and alcohol, mental health and CYPS to coordinate care for vulnerable families.
Recommendation 16 That services across the ACT increase 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.	Agree	• Referral to Perinatal Mental Health Consultation service (PMHCS) • Education of staff at WYCCH program days • Clearer level of vulnerability of client outlined in the MACH model of care • CARHU provides an intake service that provides information, consultation and referrals to assist professionals including ACT Health staff and the public seeking health information, guidance, treatment and referral on issues relating to child abuse and neglect. • CPCHS service supports families of children with development and behavioural issues to understand the implications and trajectory of their child's developmental differences.		ACTHD and CHS continue to support CSD with implementing *Our Booris, Our Way* recommendations. CPCHS is working to formalise a triage category model which identifies vulnerabilities and risk factors as a decision making tool.
Recommendation 17	Agree		• Consideration needs to be given to the concept of the	ACTHD and CHS continue to support CSD with implementing

For information sharing arrangements to operate effectively, they must be supported by 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.			'treating team' in health systems and legislative constraints regarding the Health Record Act. • As CHS increases its interface with ACT schools, consideration of information sharing in this context should also be a consideration, ie education and health professionals. • Health's experience in information sharing is that it is much clearer when CYPS are involved and a 'declared care team' under the legislation is activated. • CHS and ACT Health Directorate agree and are supportive of training across government and to relevant organisations concerning appropriate information sharing. Such training should include information sharing in both child protection and domestic and family violence sectors.	*Our Booris, Our Way* recommendations. WYCCHP ensure all information is treated in line with the *Health Records (Privacy and Access) Act 1997*. The School Youth Health Nurse Program is delivered in participating ACT Government High Schools. Where the RN believes that it is in the best interest of the adolescent, and also where mandated, information will be shared; for example, with school staff, parents, health professionals and/or CYPS. The RN discusses the need to share information with the adolescent with a focus on keeping them safe and supporting them to receive the care they need.

ACT Government | ACT Health

Office of the Director-General

Margaret Carmody, PSM
Chair
ACT Children and Young People Death Review Committee
c/o will.constantine@act.gov.au

Dear Ms Carmody

Update of recommendations – Changing the Narrative for Vulnerable Children: Strengthening ACT Systems Report

I am writing in relation to the request received from your office on 11 February 2021, seeking an update on work undertaken in response to the recommendations made by the ACT Children and Young People Death Review Committee relating to youth suicide and button batteries.

I am pleased to provide the following additional information on these recommendations:

Youth Suicide
The ACT Government implementation of the LifeSpan Integrated Suicide Prevention Framework has a major focus on reducing youth suicide. In partnership with ACT Education Directorate, ACT Health is implementing Question Persuade Refer (QPR) Training, and the

Black Dog Institute (BDI) Youth Aware of Mental Health (YAM) Program through LifeSpan.

QPR Training is free, online training for adults in the ACT community, to build community knowledge of suicide warning signs, and skills and confidence in communicating with people at risk, to recognize and respond when help is needed. ACT Education Directorate is promoting QPR training to school communities including parents, carer's and teachers.

YAM is a flagship program of ACT LifeSpan which commenced in ACT high schools in February 2020 and is being delivered to year 9 students. YAM is an evidence-based peer support program developed to promote mental health and reduce suicidal behavior in young people aged 14 to 16 years. To date 14 schools and over 2000 Year 9 students have completed the program, which is being extensively evaluated by BDI.

Button Batteries
In 2016, Canberra Health Services (CHS) undertook the development of a draft Guideline for the Emergency Management of Button Battery Ingestion, with planned implementation in 2017.

GPO Box 825 Canberra ACT 2601 | Ph: (02) 5124 9400 | Email: DGACTHealth@act.gov.au | www.act.gov.au

The Guideline commenced consultation phase in 2017 and was circulated to core response areas of CHS, including Emergency Department, Medical Imaging, Paediatric Surgery and Gastroenterology. Unfortunately, due to the lead clinician leaving and resource pressures the progression of the Guideline ceased.

During 2020, redevelopment of the Guideline commenced with a dedicated policy officer allocated to the project.

A draft placeholder has been developed, directing users to The Royal Children's Hospital Melbourne – Paediatric Improvement Collaborative 'Foreign Body Ingestion' Guideline. This approach aims to support clinicians to recognise that a child has inhaled or ingested a foreign body, alerts them to the risks of button battery ingestion, and outlines the response and management of such.

The draft placeholder underwent General Paediatrics and Paediatric Surgery consultation, with broader CHS consultation to occur at the end of March 2021.

If you have any further questions related to this response, please contact George Vallance, Senior Director, Policy, Partnership and Programs, at ACTHealthPolicyPartnerships-Programs@act.gov.au.

Yours sincerely

Kylie Jonasson
Director-General

18 March 2021

ACT Government
Education

Ms Margaret Carmody PSM
Chair
ACT Children and Young People Death Review Committee
GPO Box 158
Canberra ACT 2602

Dear Ms Carmody,

Thank you for your letter of 22 September 2020 about ACT Education Directorate's progress with the recommendations from the ACT Children and Young People Death Review Committee (see attached table).

The Directorate continues to recognise the importance of inter-Directorate collaboration and partnerships with non-Government organisations to support and protect vulnerable children and their families.

If you require any additional information about the Directorate's programs, policies, and services supporting the wellbeing and inclusion of children and young people in our education system, please contact Kristen Laurent in the first instance via DGEDUoffice@act.gov.au or (02) 6207 9264.

I look forward to hearing about the continued progress of the recommendations across broader Government initiatives. The Directorate remains committed to supporting the work of the Committee to prevent and reduce the deaths of vulnerable children and young people in the ACT.

Yours sincerely,

David Matthews
A/g Director-General
ACT Education Directorate
22 December 2020

Recommendations of the Children and Young People Death Review Committee relating to the Education Directorate

Recommendations relating to EDU work	Updates for 2020
Information sharing Improvements to information sharing aimed at enabling: • The assessment of risks when families move between jurisdictions. • Better decision making and better outcomes for individuals to reduce avoidable deaths of children and young people. • Service providers to use informal system for sharing of information, moving away from a penalty framework.	**Improvements to Information Sharing** In 2020, the *Education Amendment Bill 2020* was passed in the ACT Legislative Assembly and will come into effect on 1 January 2021. The Bill presented amendments to the information sharing provisions between the ACT Government and relevant interjurisdictional bodies with authoritative responsibility, such as NSW Education or NSW Department of Communities and Justice, in relation to participation and attendance where required in the best interests of the child. There is currently no mechanism to enforce attendance for students who are enrolled in ACT schools but reside in NSW. These amendments enable the ACT Government to strengthen the mechanism to also follow up on student attendance of non-ACT residents, in the same way that we do for students who live in the ACT. In addition, the Education Directorate's Royal Commission Response Team have undertaken extensive project planning to commence an *information sharing and record keeping project* in 2021. This project will respond directly to the Royal Commission recommendations relating to information sharing and has a particular focus on information sharing between schools and other agencies, including interstate agencies. The key objective of the project is to remove policy and legislative barriers to information sharing, where it is in the best interests of student safety and wellbeing, and enable information sharing between authorised school staff members and other prescribed bodies/agencies regarding students impacted by child sexual abuse or harmful sexual behaviours. **Update on the Improving Educational Outcomes Committee** The Improving Educational Outcomes Committee has not met in 2020 due to COVID-19 disruptions. Student Wellbeing, as measured through school attendance, remains an area that the Directorate actively monitors. The Directorate's approach to attendance is guided by several recent reports and legislative amendments, including: • Report of the Inquiry: Review into the System Level Responses to Family Violence in the ACT • amendments to the *Education Act (2004)* made in 2019 • The Final Report - Making Institutions Child Safe • Those Who Disappear: The Australian education problem nobody wants to talk about Recommendations from the current Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability may also inform future responses. All ACT Public Schools are required to implement the Attendance and Enrolment Policy and associated procedures.

Recommendations of the Children and Young People Death Review Committee relating to the Education Directorate

	This includes ensuring accurate records of daily attendance, follow up of unexplained absences and referral to the Network Student Engagement Team (NSET) as required. If a school has been unable to reengage the child and their family with the support of NSET, the School Attendance Team is tasked with identifying and working children and young people, and their families, to support reengagement with education. The School Attendance Team includes social workers, teachers and the Education/Child and Youth Protection Services (CYPS) Liaison Officer. Embedding the CYPS Liaison Officer within the School Attendance Team offers an opportunity to strengthen the working relationship between CYPS and enhance the authority of the team in tracing missing students. While the current attendance policy and procedures provide sufficient capacity for schools and the Education Support Office to support disengaged students, the School Attendance Team is revising and developing standardised operating procedures that complement: a) increased data availability through the delivery of SAS b) legislative changes that support the sharing of data across jurisdictions c) system level data opportunities Attendance data has been incorporated into a business intelligence dashboard that enables the Directorate to examine attendance at a system, network, school, and student level. The Directorate uses this data to identify students of concern whose attendance and engagement may have been less visible through previous attendance reporting practices. This data provides opportunities for early intervention at a school level rather than postvention. The aim of this work is to ensure the Directorate has real time visibility of all students and their attendance at school or approved educational program.
Enhanced supports for families under pressure • 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. • The need for services to be proactive in engaging parents to benefit from services,	**<u>NSET and Complex Case-management (CCM) team's role in connecting families with services</u>** NSET and the CCM team work closely together to respond to the needs of schools and to support students and their families. NSET is a multidisciplinary team comprised of executive teachers, social workers, senior psychologists, occupational therapists, physiotherapists, and speech language pathologists. Schools refer directly to NSET to request support to engage, consult and work with staff and families with students who have complex needs. The CCM team works alongside NSET to request support for identified students and their families. NSET collaborates with and connects families to external community and other government services. This includes connecting and supporting families to connect with the NDIS, CYPS and ACT health services. NSET has also developed and provided a comprehensive list and description of services available to students and their families within the ACT. This resource is provided to schools who can then directly contact services to support families. The School Attendance Team, as part of the CCM team, proactively seek out students and families who may have become disconnected from their education and work in a wholistic way to help them re-engage with education. The team supports families to link in with key community

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.	organisations, work with schools on problems that may have led to long term absenteeism and support families in getting their children back into the education system. This has been very effective in helping our most vulnerable families in crisis. **Flexible education including changes to support for Distance Education** During 2020, Flexible Education assumed ownership of the Distance Education program. The purpose of this restructure was to have greater oversight of students accessing the program. As part of this enhanced service response, a Teacher and Youth and Family Engagement Officer have been engaged to work in partnership with Finigan School of Distance Education (NSW), students and their families. This additional support has allowed for: • an enhanced intake process to ensure all educational options have been explored and that families have a clear understanding of their obligations • improved communication and information sharing with Finigan School of Distance Education • identification of students who are not meeting requirements for the program to provide early intervention support • supporting students and families to engage with appropriate community and support services where needed • supporting students to transition back to mainstream schooling, vocational or other learning opportunities as appropriate. **School Psychology Service - expanded service provision (Assessment and Intervention Team)** All ACT public schools, students, parents/carers and teachers have access to a school psychologist. They work with students and their families to address barriers to educational success and wellbeing and assess risk and safety. The school psychologist can identify specific learning disorders or mental health concerns and provide families and schools with recommendations and strategies to support students. Early identification and timely intervention is the key to success in the classroom and improves future educational and wellbeing outcomes for students. The school psychology service includes two centrally based teams: • The **Assessment Team** supports school-based psychologists by undertaking cognitive and learning assessments for early childhood and primary school students following a referral by the school psychologist. In 2020 the team commenced developmental assessments for preschool aged children presenting with significant delays in their development. • The **Early Intervention Team** runs small group interventions for high school and college students with a focus on developing skills to help manage stress, enhance resilience, and regulate emotions. Group education sessions for parents targeting student anxiety and school refusal commenced in term 3, 2020. This team works alongside school psychologist and Student Wellbeing & Support teams to identify students who would benefit from participation in the evidence-based groups. The work of these teams helps share the workload for school psychologists, allowing psychologists to attend to learning and wellbeing needs for a greater number of students for their respective school community at both universal and targeted levels. **Expansion of Allied Health, including Social Work and their relationship with NGOs e.g. YWCA to connect families to support** The student engagement branch currently employs a range of allied health professionals including social workers, psychologists, occupational therapists, physiotherapists, and speech language pathologists with allied health presence increasing. Expansion of the social work service, in

ACT Government
Justice and Community Safety

Ms Margaret Carmody PSM
Chair
ACT Children and Young People Death Review Committee
GPO Box 158
CANBERRA ACT 2601
By email: childdeathcommittee@act.gov.au

Dear Ms Carmody

Thank you for your letter dated 22 September 2020 about the ACT Children and Young People Death Review Committee's (the Committee) monitoring project. I apologise for the delay in responding and thank you for providing us with further time to prepare our response.

I welcome this opportunity to provide the Committee with an overview of the work of the Justice and Community Safety Directorate relating to the Committee's recommendations, to help prevent or reduce the likelihood of the death of children and young people in the ACT.

The Directorate's response for 2018-2020 is attached. As discussed with your Secretariat, the response reflects the broad themes of the recommendations made by the Committee over a range of reviews and enquiries. It also includes information about related initiatives to provide greater support vulnerable cohorts of children and young people such as LGBTIQ+ young people.

I would like to thank the Committee for the challenging but vital work that you do in helping to make our ACT community a safer place for children and young people.

Please do not hesitate to contact me if any further information is required.

Yours sincerely

Richard Glenn
Director-General
Justice and Community Safety Directorate

24 December 2020

GPO Box 158 Canberra ACT 2601 | phone: 132281 | www.act.gov.au

Justice and Community Safety Directorate (JACS) input to recommendation monitoring project – 2018 to 2020

Information Sharing
JACS has undertaken a range of work that aims to facilitate appropriate information sharing to better protect children and respond to risks of harm.

The Government response to the Royal Commission into Institutional Responses to Child Sexual Abuse includes a focus on improved reporting and information sharing.

On 15 June 2018, the ACT Government announced its response to all the recommendations made by the Royal Commission, including its Criminal Justice Report which made 85 criminal justice recommendations. Those recommendations propose legislative and non-legislative reforms across the criminal justice system to better prevent and protect children from child sexual abuse, as well to improve access to justice for victims

In the 2018-19 Financial Year, the Government allocated specific funding for a policy and legislation team to implement legislative reforms associated with the Royal Commission recommendations. Since that time, the Government passed further amendments contained in the *Royal Commission Criminal Justice Legislation Amendment Act 2018*, the *Royal Commission Criminal Justice Legislation Amendment Act 2019* and the *Royal Commission Criminal Justice Legislation Amendment Bill 2020*.

These reforms included the introduction of amendments that remove protections for information provided under the confessional seal, and require information to be reported to better protect children and young people.

In 2018-19, JACS continued to lead the ACT's implementation of the National Redress Scheme for Institutional Child Sexual Abuse. The Scheme provides survivors of institutional child sexual abuse with counselling and psychological services and a direct personal response as well as an opportunity for compensation. The scheme requires the ACT Government to provide the Scheme Operator with a range of sensitive information to assist in the assessment of an application to the scheme.

JACS chairs the Redress Implementation Group (RIG) which consists of representatives from all ACT Government Directorates involved in meeting the ACT's obligations as a participant in the Scheme. The RIG met regularly throughout the period, continuing to put in place processes which will ensure that ACT Directorates respond effectively to applications which involve abuse which occurred in organisations for which they are, or were, responsible. JACS continues to work closely with the Scheme Operator to ensure the Scheme is accessible and responsive to survivors in the ACT.

Enhanced support for families under pressure
The Directorate works in various ways to support families under pressure and raise awareness with professionals to recognise and respond to stress in families.

Support for families involved in domestic and family violence

ACT Corrective Services (ACTCS) continues to work collaboratively with the Domestic Violence Crisis Service (DVCS) to support victims of domestic violence offences whose current partners are engaged in the Domestic Abuse Program (DAP). ACTCS delivers this program to male perpetrators of domestic violence who are assessed as being of medium risk of reoffending or higher. Regular meetings with DVCS ensures collaboration in supporting the victims whilst the perpetrator is engaged in offence specific treatment. ACTCS also participates in a Reference Group linked to the Family Violence Intervention Program Coordinating Committee which continues to provide collaboration in the management of family and domestic violence offenders.

During the 2020 calendar year, two DAP programs commenced in the Alexander Maconochie Centre (AMC) and one in the community. Two of the programs are ongoing and one completed. Domestic and family violence offenders who are assessed as being at lower risk of reoffending continue to be referred to community agencies for interventions in addition to case management by ACTCS.

Royal Commission into Institutional Responses to Child Sexual Abuse

As noted above, the response to the Royal Commission included a commitment to a range of reforms for the protection of children from abuse, changes to sentencing processes and evidence laws, and the improvement of measures designed to mitigate trauma in child sexual abuse proceedings – including the introduction of an intermediaries scheme to protect vulnerable witnesses. The Directorate has been progressing the implementation of these recommendations in line with the ACT Government response.

Support for Aboriginal and Torres Strait Islander families

JACS is continuing to work across government and with the community sector on progressing the Yarrabi Bamirr Trial. Yarrabi Bamirr (meaning 'Walk Tall' in the Ngunnawal language) was launched in April 2017. It involves using a family-centric model of service support with Aboriginal and Torres Strait Islander families to improve life outcomes and reduce or prevent contact with the criminal justice system. Yarrabi Bamirr is designed to address complex needs using a comprehensive approach that is co-designed with the client and their family. A range of agencies work collaboratively to support the clients to address issues they are facing. This involves intensive support that, over time, builds the clients capacity to navigate the issues they face and self-manage their affairs.

During the trial period there were three local Aboriginal services delivering Yarrabi Bamirr - Winnunga Nimmityjah Aboriginal Health Service, Aboriginal Legal Service NSW/ACT, and Mulleun Mura (meaning 'Eagle' in Ngunnawal and based at the Women's Legal Service). The Australian National University conducted an initial independent evaluation of the Winnunga element of the trial. In 2020, JACS provided funding to local Aboriginal services Winnunga Nimmityjah Aboriginal Health Service, Tjillari Justice and Yeddung Mura (Good Pathways) to extend the Yarrabi Bamirr program to 20 families.

The Women's Legal Centre ACT and Region receives ongoing funding from the Directorate to deliver the Mulleun Mura Aboriginal and Torres Strait Islander Women's Access to Justice Program. The program provides Aboriginal and Torres Strait Islander women with access to culturally appropriate case management support for a range of law and justice matters including domestic and family violence, care and protection, family law and employment discrimination.

Child-focused practice
The Directorate is involved in ongoing work to ensure that services are appropriately focussed on children, in both a practical and cultural sense.

Following amendments to the *Magistrates Court Act 1930* in 2017-18, work continued on establishing the Warrumbul Court Children's Circle Sentencing Court (Warrumbul Court). The Warrumbul Court is an alternative model of sentencing for Aboriginal and Torres Strait Islander young people attending the ACT Children's Court. It is a type of restorative practice that aims to provide culturally relevant and effective sentencing options for young Aboriginal and Torres Strait Islander people (10-17 years) by incorporating Elders and cultural aspects into the Children's Court and similarly addressing over representation issues and offending behaviour. A referral to Warrumbul Court involves a young person participating in a Family Conference with a panel of community Elders that will determine their suitability for circle sentencing, as well as assessing any underlying issues in the family or young person's life that may be contributing to their offending. After the conference, the young person will either go forward to sentencing or begin a rehabilitation pathway.

Other work to prevent or reduce the death of children and young people
The Directorate has also been involved in a number of initiatives that focus on reducing the risk of mental health issues and of self-harm and suicide in young people.

In 2020 JACS developed the *Births, Deaths and Marriages Registration Amendment Act 2020*, to remove barriers for LGBTIQ young people in relation to the recognition of their gender identity in official documents where they do not have the support of both parents.

It is recognised that transgender young people face particularly high risks of discrimination and mental health concerns, including risks of self-harm and suicide. The amendments seek to support LGBTIQ+ young people by creating independent pathways to changing registered sex and given names in official documentation. For young people over 16 changes will be able to be made without parental approval. A separate pathway is created for young people under 16 which requires an assessment by the ACAT regarding the level of understanding and maturity of the young person to make their own decisions regarding these issues.

In this period JACS also worked with the Chief Minister Treasury and Economic Development Directorate to develop the *Sexuality and Gender Identity Conversion Practices Act 2020*. Evidence from survivors of conversion practices in the ACT and across Australia reveal the extent and long-term impact of the harm caused by conversion practices, including increased risks of self-harm and suicide. These practices have been condemned by peak national medical bodies. The *Sexuality and Gender Identity Conversion Practices Act 2020* protects children and young people through criminalising these harmful practices when conducted on a child under 18. The Act also amends the *Human Rights Commission Act 2005* to allow for a person to make a conversion practice complaint to the Human Rights Commission and ACAT.

ACT Government
Environment, Planning and Sustainable Development

Ms Margaret Carmody, PSM
Chair
ACT Children and Young People Death Review Committee

By email: childdeathcommittee@act.gov.au

Dear Ms Carmody

Thank you for your letter of 22 September 2018 about the ACT Children and Young People Death Review Committee (the Committee) reporting on the implementation of recommendations of the Committee on swimming pool regulation. I apologise for the delay in responding.

The Environment, Planning and Sustainable Development Directorate (EPSDD) has policy responsibility for building legislation and standards for pool barriers in residential swimming pools and spas. EPSDD previously undertook consultation on certain technical and industry capacity issues and has prepared for further consultation with the public and pool owners. The timing and scope of community engagement is a matter for Government, but it is expected that it will give people an opportunity to provide feedback on what they believe is an appropriate transition period for upgrading pools to meet current pool safety compliance and maintenance standards, and any concessions and other matters that should be taken into consideration in the development of a pool barrier scheme.

EPSDD officers would like to discuss the implementation of the recommendations of the Committee on swimming pool regulation and will contact the Committee's Senior Research and Review Officer directly to make arrangements.

Yours sincerely

Ben Ponton
Director-General
18 November 2020

GPO Box 158 Canberra ACT 2601 | phone: 132281 | www.environment.act.gov.au

Appendix E Schedule of Recommendations

Date	Source of Recommendation	Relevant Inquiry or Context	Committee Recommendation	Inquiry Finding	Outcome	Rational
2014	Letter to the Chief Minister	ACT Swimming Pool Fencing Discussion Paper 2011	Support for pool compliance, registration, inspections at change of ownership or tenancy, CPR training for pool owners, fencing for all pools.	No recommendation or finding was made by the inquiry, although feedback was received from a range of stakeholders.	NOT ACHIEVED	EPSDD informed the Committee that the directorate has previously undertaken consultation on certain technical and industry capacity issues and has prepared for further consultation with the public and pool owners. The directorate advised that the timing of public consultation is a matter for government.
2014	Letter to Director-General of CSD	Deaths of two children in NSW from blind cord injuries.	ACT Housing to perform inspection of blind and curtain cords for safety and compliance with standards as part of housing inspection process. Introducing methods to increase the safety of corded internal window coverings in public housing, such as the installation of safety devices.	N/A	ACHIEVED	The ACCC introduced a mandatory standard for the installation of internal blinds, curtains and corded internal window coverings supplied after 30 December 2010. Housing ACT now allocate properties with blinds and / or window furnishings and follow the necessary safety requirements that all cords are attached securely to the wall to comply with the Australian Consumer Product Safety Standard. When a property becomes vacant the blinds/cords would be checked as part of the overall final inspection of the property.
2014	Submission to National Children's Commissioner	National Children's Commissioner inquiry into intentional self-harm and suicidal behaviour in children	Need for accuracy in the reporting of suicide and intentional self-harm. Suggestions are: better training for medical students to ensure understanding about the importance of accurate death certificates; more detailed information in completing death certificates; removing stigma for doctors.	Strengthen data collection through development of national database under the Australian and New Zealand Child Death Review and Prevention Group. Use of standardised National Police Form in all jurisdictions by 2015. Standing Council on Law, Crime and Community Safety should put the standardisation of coronial legislation and systems on its agenda.	ACHIEVED	Inquiry finalised. The Committee continues to be concerned with the quality of death certificates. The Committee has completed a literature review into national and international strategies to address the issue. Work is planned for 2021 to advise government on potential solutions.

2014	Submission to National Children's Commissioner	National Children's Commissioner inquiry into intentional self-harm and suicidal behaviour in children	Highlights barriers to support: stigma attached to suicide and self-harm; changes to the level of therapeutic support when a young person turns 18 possibly leading to disengagement from services; need for input from young people to better understand barriers.	Continued implementation of universal suicide prevention strategies aimed at raising public awareness, encouraging help-seeking behaviour and challenging stigma. Encouraging young people to access supports, building awareness of early warning signs.	ACHIEVED	Inquiry finalised. This recommendation has been superseded by recommendations from the Committee's Deaths by Intentional Self-Harm Review.
2014	Submission to National Children's Commissioner	National Children's Commissioner inquiry into intentional self-harm and suicidal behaviour in children	Need for more work in relation to data collection in the area of intentional self-harm and suicidal behaviour in children. Need for more data sources to fully understand intentional self-harm and suicide in children with the aim of identifying potential points of intervention and postvention.	Establish national research agenda through the National Strategic Framework for Child and Youth Health.	ACHIEVED	Inquiry finalised. The National Suicide and Self-harm monitoring project has been established which includes the implementation of a national suicide and self-harm monitoring system. Australian Institute of Health and Welfare (AIHW) is working with ACT Government and key stakeholders to develop local suicide register.
2014	Submission to Australian College of Midwives	Australian College of Midwives' Position Statement on Bed-sharing and Co-sleeping	Need for unbiased position statement that clearly applies a risk elimination approach. Suggested that the key principles include more information from the SIDS and KIDS Sleep Safe, My Baby public health recommendations and its promotion of room-sharing. More information should be given about the specific risks associated with co-sleeping. Prominence should be given to the statement about babies at risk of SUDI with a focus on the vulnerability of the child.	N/A	ACHIEVED	This recommendation has been superseded by recommendations from the Committee's Deaths by Intentional Self-Harm Review.
2015	Letter to ACT Health and ACT Hospital Network	Queensland coronial inquest	That a protocol is developed for the management of button battery ingestion.	N/A	NOT ACHIEVED	CHS advised the Committee that the drafting of the protocol commenced in 2017. It was placed on hold due to staffing and resource issues. CHS currently uses a draft guideline

						developed in Victoria. It is anticipated work on an ACT specific guideline will re-commence in 2021.
2016	Submission	System Review into Family Violence Response in the ACT	Need for 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.	CYPS should use case conferencing more frequently to ensure decision making is more fully informed and is done on a transparent and collaborative basis with government, non-government agencies and families.	ACHIEVED	Inquiry finalised - CSD provided advice on the use of family group conferencing for Aboriginal and Torres Strait Islander families and single case management to ensure continuity of service provision to children, young people, and families.
2016	Submission	System Review into Family Violence Response in the ACT	Information sharing between jurisdictions to enable assessment of risks when families move between jurisdictions.	When a child is unenrolled from school and the school has had significant concerns about the particular child, the Education Directorate should advise CYPS. Subsequently the Education Directorate should confirm the move with the family and confirm enrolment in the new jurisdiction. CYPS should inform their counterparts in the new jurisdictions that a family of concern has moved to their state or territory.	ACHIEVED	Inquiry finalised - ACT Education and CSD provided advice on significant reforms in this area including the Education Amendment Bill and CSD working on the national Connect for Safety project.

2016	Submission	System Review into Family Violence Response in the ACT	Information sharing between service providers including health referrals, decisions and recommendations. Access by doctors to health notes during pre-court assessment period.	Legislative provision should be made in the ACT similar to Chapter 16A of the NSW children and Young Persons (Care and Protection) Act 1998 in relation to family violence more broadly (not just in relation to children) to authorise information sharing and to foster a culture of appropriate information sharing and collaboration. Any legislative amendments should also be accompanied by an awareness campaign and guideline material about how information can be shared.	ACHIEVED	Inquiry finalised - Reportable Conduct and Information Sharing Legislation Amendment Bill 2017 introduced changes to the Children and Young People Act 2008 to enable improved information sharing among organisations in the ACT in relation to reportable conduct. Changes are now operational.
2016	Submission	System Review into Family Violence Response in the ACT	Supervision of staff to assist in critical reflection of casework decisions/practice and professional development.	A review should be undertaken of what decisions made by CYPS should be subject to either internal or external merits review. CSD should continue to review its recruitment practices and cultural awareness training programs and ensure appropriate quality control in decision making to reduce unintended bias.	ACHIEVED	Inquiry finalised - ACT Government is currently developing a unified model of internal and external merits review for Child Protection decision-making. The Human Rights Commission (HRC) and CSD facilitated round table to develop external merit review process.

2016	Submission	System Review into Family Violence Response in the ACT	Improve interpretation of drug screen results through training for staff and practice directions to assess the impact of the drug use on the capacity to provide safety and care.	Not specifically addressed by the recommendations.	ACHIEVED	Inquiry finalised - Original submission from Committee was not specifically addressed in the inquiry's final recommendations.
2016	Submission	System Review into Family Violence Response in the ACT	Weighting decisions when considering the capacity of the parents as opposed to the vulnerabilities of the child. Need for good data to support judgements made.	Not specifically addressed by the recommendations.	ACHIEVED	Inquiry finalised - Original submission from Committee was not specifically addressed in the inquiry's final recommendations.
2016	Submission	System Review into Family Violence Response in the ACT	Need for access to and connection with services that can assist families to avert crisis. Voluntary family support services should be provided by someone other than CYPS to avoid duality of roles as responsible for statutory intervention and voluntary work with families, noting inherent relationship tensions and power imbalances. Clear and trusted access point for families at points of crisis.	CYPS should refer matters involving family violence to appropriate service providers and when undertaking appraisals should collaborate with those providers to ensure support for the family as a whole. Sufficient services should be made available to which individual members of a family can be referred. This includes specific services for children who have witnesses or experience family violence and services for perpetrators.	ACHIEVED	Inquiry finalised - A Coordinator-General for Family Safety has been appointed and the Family Safety Hub has been established. Uniting has been commissioned to deliver services to families focused on managing risks and providing supports within families to prevent children from coming into care or returning them home as soon as it is safe to do so.
2016	Submission	System Review into Family Violence Response in the ACT	Service systems should be proactive in engaging parents to benefit from services and ensuring that the child or young person is at the centre of decision making. Role of NDIS in this engagement.	Not specifically addressed by the recommendations.	ACHIEVED	Inquiry finalised - Original submission from Committee was not specifically addressed in the inquiry's final recommendations.

2016	Submission	System Review into Family Violence Response in the ACT	Decision making in relation to the restoration of children to their parents must be supported with evidence based decision making. Need for clarification around when restoration is no longer considered in the best interests of the child.	Not specifically addressed by the recommendations.	ACHIEVED	Inquiry finalised - Original submission from Committee was not specifically addressed in the inquiry's final recommendations.
2016	Submission	System Review into Family Violence Response in the ACT	Need for 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.	CYPS must adopt a culture of transparency and engagement with clients, agencies and service providers to inform improved decision making and to engage more effectively with those who provide services to families who come to the notice of CYPS.	ACHIEVED	Inquiry finalised - The ACT Government invested in enhancing quality assurance practices and improved decision making in CYPS. This has included the establishment of the CYPQAI committee (now Strengthening Practice Committee) to provide arms-length quality assurance and ensure compliance by statutory services, and a case analysis team to undertake case analysis work on identified cases of children and young people with extensive involvement with statutory services.
2016	Submission	System Review into Family Violence Response in the ACT	Need for comprehensive medico-psychosocial assessment for families with multiple and complex needs, with services prioritised to child's assessed needs. Need to assess whether the child's needs are being adequately met.	Not specifically addressed by the recommendations, but the report noted the importance of addressing complex needs within a family and CYPS considering the views of the child or young person.	NA	Inquiry finalised - Original recommendation in submission from Committee was not specifically addressed in the inquiry's final recommendations.
2016	Submission to Standing Committee on Health, Ageing, Community and Social Services	Inquiry into youth suicide and self-harm in the ACT by the Standing Committee on Health, Ageing, Community and Social Services	Build community knowledge of warning signs and skills to communicate with and support young people at risk. Inform, educate and empower family and friends to recognise when help is needed and how to help. Committee recommends the Care after a suicide attempt report commissioned by the NHMRC Centre of Research Excellence	The inquiry made three recommendations to the ACT Government on reporting progress with the development of a national database, funding agreement between the ACT and Commonwealth and that the government review approaches to early intervention, education and access to services following	ACHIEVED	Inquiry finalised. This recommendation has been superseded by recommendations stemming from the Committee's Deaths by Intentional Self-Harm Review.

			in Suicide Prevention, Black Dog Institute, UNSW, University of Melbourne, Lifeline and ANU.	the funding arrangements being finalised.		
2016	Submission to JACs Discussion Paper	Information Sharing to Improve the Response to Family Violence in the ACT	Improved information sharing to enable better decision-making, produce better outcomes for individuals and reduce avoidable deaths of children and young people. Improved integration of information sharing practice into community to enhance service delivery practice, rather than reliance on legislative requirements. More use of informal systems for sharing of information, suggested move away from negative or penalty framework as first port of call. Greater funding to agencies to improve education around rights and responsibilities to improve information sharing.	The inquiry had no final report.	ACHIEVED	Inquiry finalised - The inquiry had no final report.
2016	Submission to JACs Discussion Paper	Information Sharing to Improve the Response to Family Violence in the ACT	Moving the focus for support by designated agencies to the best interests of the child and, in particular, on decision making to ensure the child's safety.	The inquiry had no final report.	ACHIEVED	Inquiry finalised - The inquiry had no final report.
2016	Submission to JACs Discussion Paper	Information Sharing to Improve the Response to Family Violence in the ACT	Cumulative risk should be a main focus, rather than episodic risk, so that the family or child's needs can be addressed holistically rather than in an ad-hoc piecemeal way, where the scale of the problem only becomes apparent after an 'event'.	The inquiry had no final report.	ACHIEVED	Inquiry finalised - The inquiry had no final report.

2016	Submission to JACs Discussion Paper	Information Sharing to Improve the Response to Family Violence in the ACT	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.	The inquiry had no final report.	ACHIEVED	Inquiry finalised - The inquiry had no final report.
2017	Retrospective: Progress in the ACT between 2004 and 2013	Other report under section 727T of Children and Young People Act 2008	Government and related services to improve the systems and culture for sharing information in the interests of protecting vulnerable children.	N/A	ACHIEVED	Reportable Conduct and Information Sharing Legislation Amendment Bill 2017 introduced changes to the Children and Young People Act 2008 to enable improved information sharing among organisations in the ACT in relation to reportable conduct. This is now operational.
2018	Submission to ACCC Regulation Impact Statement	ACCC inquiry into quad bike safety	Supports the recommendations by the QLD Family and Child Commission (QLD Deputy State Coroner) - Children under 16 should be prohibited from using adult sized or side-by-side vehicles not specified for use by young people, prohibit children under 16 as passengers on adult sized sit astride and under 7 years as passengers on adult sized bikes, design features to address specific issues of child use/rollover or asphyxia, warnings at purchase point and labelling on bikes and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (Vic) - Children under 14 should not be allowed to ride a quad bike, those aged 14-16 only allowed to ride a quad bike with an engine of 90CC or less.	The ACCC has proposed the introduction of a safety rating system, crush protection devices and mandatory minimum performance standards. It has been consulting on these proposals through a Consultation Regulation Impact Statement and will make a final recommendation to the Assistant Minister to the Treasurer in the second half of 2018.	ACHIEVED	Review finalised - All quad bikes sold in Australia must meet first standard of Australian Government mandatory safety standard. Additional standards to be implemented in 2021.

2018	Letter to the National Children's Commissioner, Australian Human Rights Commission	Report to UN committee on rights of the child	Highlighting issues associated with inaccuracy of death certificates, limitations of ICD-10 classifications, need for national framework to ensure consistency in reporting of data.	The NCC is preparing a report to the UN Committee. The Australian Child Rights Taskforce is also preparing a 'shadow report', including information from NGOs and community groups about Australia's performance on children's rights. The UN Committee will then consider these and make recommendations to government (Concluding Observations) to improve the implementation of the Convention of the Rights of the Child.	ACHIEVED	This is subsumed into the report made to the UN Committee which is not publicly available. There is no evidence that the recommendation was addressed in the UN Committee Concluding Observations.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	Ensure that early intervention strategies across ACT Health and CSD are maximised before the birth of the child, including access to GPs and prenatal health checks - non-attendance should be followed up. Enhance engagement of culturally appropriate services for Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse families.	N/A	ACHIEVED	ACT government agreed in principal. Under the ACT Government's 'A Step Up for Our Kids: Out of Home Care Strategy 2015-2020', new services have been established. Uniting provides services and supports to assist families to address vulnerabilities that may place children at risk and is considering extension of the service to provide antenatal supports. CYPS has implemented a Family Group Conferencing model for Aboriginal and Torres Strait Islander families at risk on ongoing involvement with CYPS.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	A review of current 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.	N/A	NOT ACHIEVED	ACT Government agreed in principle. No evidence from directorate responses that a review of legislation has occurred.

2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	Providing enhanced training and mandatory refresher courses for workers to ensure that they are aware of the full extent of their powers under legislation. Training programs should be evaluated to assess their effectiveness.	N/A	ONGOING	ACT Government agreed to recommendation. CSD advised the Committee that the CYPS Training and Workforce Development team delivers training to CYPS staff. It is unclear form the directorate response if training programs have been evaluated to assess their effectiveness.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	CSD establish 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 - domestic and family violence, substance misuse, unstable housing and limited parental service engagement.	N/A	NOT ACHIEVED	ACT Government agreed to recommendation. There is no evidence in the directorates response that a mechanism has been implemented to review children who have received four reports with identified risk factors.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	Safe sleeping guidelines are consistent across Directorates and delivered consistently across the continuum of services by ensuring cross directorate agreement is established about safe sleeping guidelines and professionals and service providers have access to evidence-based training and resources concerning safe sleeping guidelines.	N/A	ONGOING	ACT Government agreed in principal. There is no evidence in responses from CHS or CSD that safe sleeping guidelines are consistent across directorates.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	Safe infant sleeping promotion, co-sleeping and bed-sharing messages need to be provided to all caregivers prior to and after the birth of the child by health and social welfare professionals. Vulnerable families should be provided	N/A	ACHIEVED	ACT Government agreed to recommendation. CSD informed the Committee that CYPS had developed co-sleeping and safe sleeping practice guidelines. CHS advised that MACH nurses provide safe sleeping to all clients and vulnerable families have access to pepi pods.

			with the necessary support to obtain appropriate bedding for the child prior to leaving hospital.			
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	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.	N/A	NOT ACHIEVED	ACT Government agreed in principle to this recommendation. There was no evidence in directorate responses that this recommendation had been addressed. Recommendation closed due to government initially agreeing in principal and no evidenced development of strategies to address identified issues.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	The ACT jurisdiction should consider establishing a high-quality parenting capacity assessment service and support for parents with children where four reports have been received about a child by CYPS, including any prenatal reports.	N/A	NOT ACHIEVED	ACT Government agreed in principle to this recommendation. There was no evidence in directorate responses that this recommendation had been addressed. Recommendation closed due to government initially agreeing in principal and no evidenced strategies to address identified issues.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	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.	N/A	NOT ACHIEVED	ACT Government agreed in principle to this recommendation. There was no evidence in directorate responses that this recommendation had been addressed. Recommendation closed due to government initially agreeing in principal and limited evidenced strategies to address identified issue.

2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	The presumption of the mother as the 'protective parent' as observed in records and applied by workers needs to be critically reviewed. The participation of both 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.	N/A	ACHIEVED	The ACT Government agreed to this recommendation. CSD advised the Committee that staff are supported by Senior and Principal Practitioners who are responsible for providing expert case practice advice and leadership to staff and specific family violence training to staff.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	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.	N/A	ACHIEVED	ACT Government agreed in principle to this recommendation. CSD advised the Committee CYPS has a supervision framework in place and provide training to all staff on this framework. CYPS Training and Workforce Development team provides specialist support to CYPS staff by delivering face-to-face and eLearning training the Safe and Together Institute to undertake an organisational assessment and to deliver training to all CYPS staff in 2021.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	Vulnerable families with an intergenerational history of abuse should be offered trauma-informed targeted parenting support prior to and following birth of their child in a non-stigmatising maternal health service.	N/A	ACHIEVED	ACT Government agreed in principle to this recommendation. CSD provided immolation on United Newpin, Karinya House, Child and Family Centre warm referrals from MACH nurses, IMPACT program. ACT Health review of sustained home visiting model. ACT Education informed the Committee that all ACT public schools are resourced to meet the needs of children with a history of developmental trauma.

2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	There is a need to build 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 and ACT Housing, to be aware of and to act with the best interests of the child as a primary consideration.	N/A	ACHIEVED	ACT Government agreed to this recommendation. Establishment of case analysis team and Melaleuca place to provide expert advice to case managers. CHS implementation of family violence policies and procedures. Housing ACT providing keeping children safe and reportable conduct training in place.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	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.	N/A	ACHIEVED	ACT Government agreed to this recommendation. CHS Child Protection Training provides information on the United Nations Convention on the Rights of the Child. CSD advised that CYPS ensure staff are appropriately trained in policy and legislation, including the Children and Young People Act 2008 and the Human Rights Act 2004 to fulfil obligations in supporting children and young people and their families who are involved in the child protection system.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	Caseworkers making referrals for vulnerable families should provide follow up support to families while they wait for services to commence.	N/A	ACHIEVED	ACT Government agreed in principle to this recommendation. CSD advised that information sharing arrangements are established with Onelink, DVCS and Functional Family Therapy – Child Welfare. These agencies also have staff who are co-located within CYPS to provided assistance to staff, to support referrals to services.
2018	Changing the narrative for vulnerable children:	Other report under section 727T of Children	That the ACT jurisdiction identifies innovative and evidence informed approaches to working with	N/A	ACHIEVED	ACT Government agreed in principal to this recommendation. Several examples of programs where highlighted in directorate submissions. The Functional Family Therapy –

	Strengthening ACT systems 0-3 Group Review	and Young People Act 2008	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.			Child Welfare program, Australian Childhood Foundation Intensive Support and Family Group Conferencing were highlighted as new approaches incorporated within CYPS.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	That services across the ACT increase 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.	N/A	ACHIEVED	ACT Government agreed in principle to this recommendation. ACT Education advised the Committee of a range of programs including the NSET and complex case management team's role in connecting families with services. CHS identified the implementation of the Our Booris, Our Way recommendations, child protection training and the work of IMPACT coordinators as strategies to support families under pressure. JACS noted Aboriginal and Torres Strait Islander specific programs to prevent contact with the criminal justice system and collaboration between the directorate and the Domestic Violence Crisis Service (DVCS) to support survivors of domestic violence offences whose partners are engaged in domestic violence programs within the Alexander Maconochie Centre.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	For information sharing arrangements to operate effectively, they must be supported by 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	N/A	NOT ACHIEVED	ACT Government agreed in principle to this recommendation. It is unclear from the directorate responses that training has been provided to relevant organisations.

			appropriate information sharing.			
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	That the Community Services Directorate review quality assurance systems 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.	N/A	ACHIEVED	ACT Government agreed to this recommendation. CYPS has implemented a new client management system which enables staff to make more informed decisions, share information more easily, improve chronologies of information and activities undertaken by staff and the availability of client history, while also decreasing administrative burden on staff.
2018	Changing the narrative for vulnerable children: Strengthening ACT systems 0-3 Group Review	Other report under section 727T of Children and Young People Act 2008	That the ACT continue to encourage the Commonwealth and other states jurisdictions to make nationally consistent legislation and administrative arrangements, including the development of a national database, to enable the sharing of information related to the safety and wellbeing of children.	N/A	ONGOING	ACT Government agreed to this recommendation. CSD has engaged in a national project to share child protection information with other jurisdictions. ACT Education Amendment Bill 2020 which changes information sharing provisions between the ACT Government and relevant interjurisdictional bodies.
2019	Submission to JACs Discussion Paper	Submission into ACT CYPS Decision Making	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.	N/A	ONGOING	CSD advised the Committee that CYPS is developing an internal and external merit review process.

2019	Submission to JACs Discussion Paper	Submission into ACT CYPS Decision Making	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.		ONGOING	CSD advised the Committee that CYPS is developing an internal and external merit review process.
2019	Submission to JACs Discussion Paper	Submission into ACT CYPS Decision Making	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.		ONGOING	CSD advised the Committee that CYPS is developing an internal and external merit review process.
2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	Involve young people with lived experiences of suicide in suicide prevention service design and delivery.	N/A	ONGOING	ACT Government response has not been made public.
2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	Evaluate current youth mental health and suicide prevention programs to determine effectiveness including in meeting demand.	N/A	ONGOING	ACT Government response has not been made public.
2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	Implement information campaigns that target young people at risk and include practical intervention skills for peers and family.	N/A	ONGOING	ACT Government response has not been made public.

2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	The Committee supports the proposed implementation of the Youth Navigation Portal and considers this a critical piece of work to assist young people navigate the complex ACT support system.	N/A	ONGOING	ACT Government response has not been made public.
2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	Implement and evaluate the Connecting with People program. Consider implementation in education and non-government organisation settings.	N/A	ONGOING	ACT Government response has not been made public.
2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	Implement a support plan process in clinical settings that actively engages young people following a suicide attempt.	N/A	ONGOING	ACT Government response has not been made public.
2021	Review of Children and Young People who have died as a result of intentional self-harm	Other report under section 727T of Children and Young People Act 2008	Implement evidence-based, assertive outreach guidelines into ACT Government policy that include face-to-face contact with young people who have attempted suicide.	N/A	ONGOING	ACT Government response has not been made public.

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

GPO Box 158 Canberra City ACT 2601
t 02 6205 2949 | e childdeathcommittee@act.gov.au