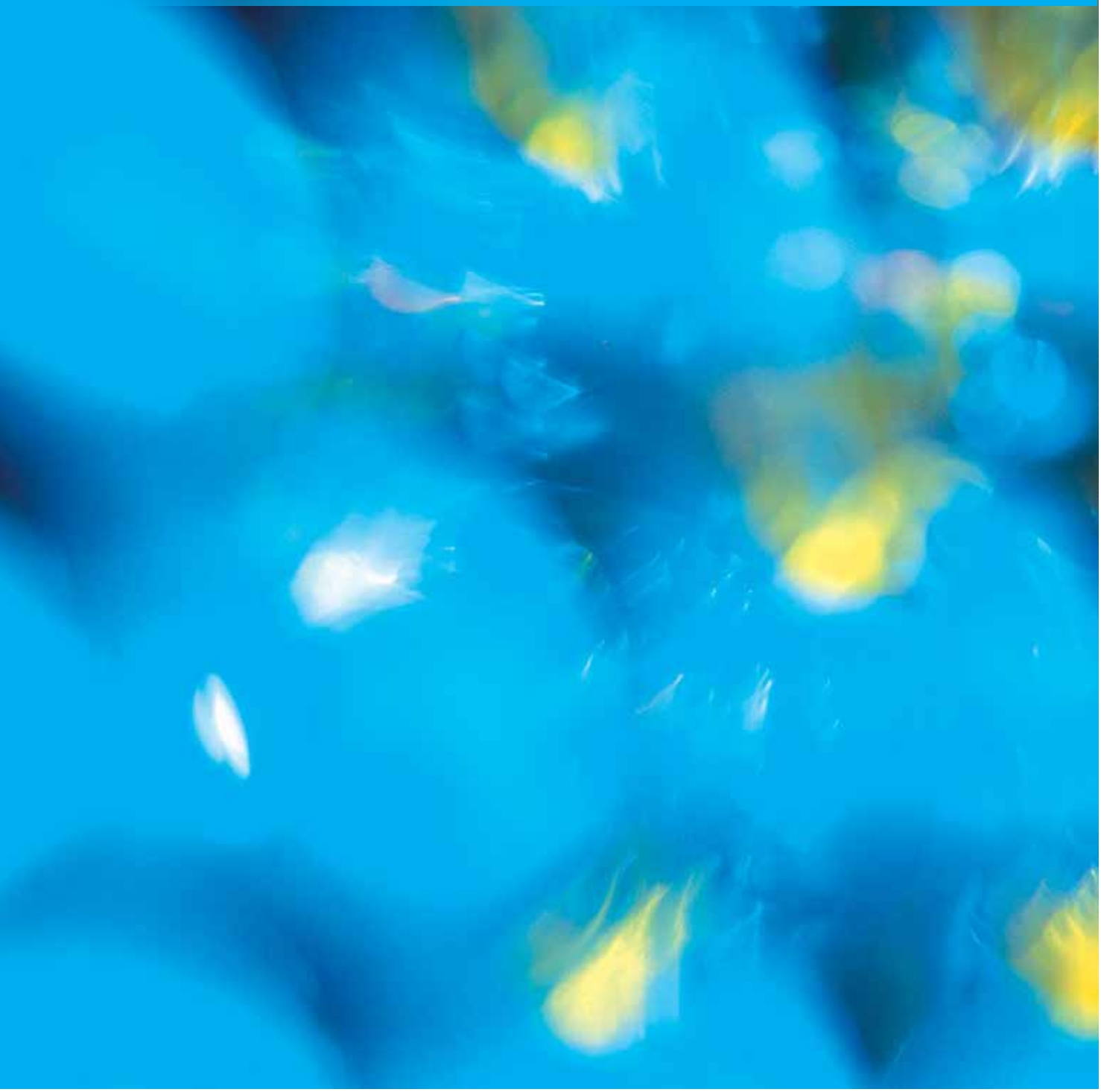
ACT Children & Young People
Death Review Committee

ANNUAL REPORT 2011–12



ACT Children & Young People Death Review Committee

LETTER OF TRANSMISSION

The Minister for Community Services
ACT Legislative Assembly
London Circuit
Canberra ACT 2601

Dear Minister

I am pleased to present you with the first Annual Report of the ACT Children and Young People Death Review Committee. The report has been prepared in accordance with Section 727S of the *Children and Young People Act 2008*.

The report considers information for the 2009–10 to 2011–12 financial years and fulfils the Committee's statutory obligations.

Yours sincerely

Dr Judith Gibbs
Chair
29 October 2012

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

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ACT Government

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FOREWORD

This is the first annual report of the Australian Capital Territory (ACT) Children and Young People Death Review Committee (the Committee). This independent, multi-sectoral committee was established under the *Children and Young People Act 2008* in September 2011, with Committee members appointed by the Minister for Community Services, Ms Joy Burch MLA, in January 2012.

On behalf of the members of the Committee, I would like to extend our sincere condolences to the families, friends and communities who knew and loved the children and young people whose deaths are cited in this first report.

As a committee convened under new legislation, we are aware that work has to be done to help members of the ACT community and professionals working with children and young people to understand our role and the value of our work. There may be an understandable level of anxiety and uncertainty about the purpose of reviewing the deaths of children and young people. The Committee is prioritising the development of an approach that gives families and relevant people an opportunity to contribute to the review process and to learn from these tragic events.

As the Committee moves into examining the causes of child deaths and receiving individual reviews, our work will be approached with the utmost sensitivity and we will always respect the right of the child and their family to privacy. Our role in reviewing these deaths is neither about attributing blame nor identifying individual underperformance. It is about learning from what has happened and making recommendations and changes that might help to prevent future deaths and improve services.

As this is the Committee's first annual report, we are restricted by time in what we can report on beyond demographic information pertaining to children and young people who died in the ACT during the period from July 2009 to June 2012. The report includes discussion of activities associated with the establishment of the Committee and what structures and processes we are putting in place to support our work. In our next annual report, we expect to be able to begin sharing what we are learning from an in-depth analysis of the deaths of ACT children and young people.

Based on our review of deaths the Committee will be able to make recommendations to the Minister for Community Services aimed at reducing preventable deaths and improving associated services. If we are to be effective, the Committee will need to critically study the full complexities surrounding the death of each child or young person. It will be important that we are able to obtain information from the wide range of sources outlined in the legislation. Over time, and with the use of comparative national and international data, we hope to be able to identify and learn about those things that could be done differently to reduce the number of deaths in the ACT. This commitment to learn underpins the way in which the Committee will review and analyse child deaths.

I would like to take this opportunity to acknowledge the assistance given to us by a number of people in other jurisdictions who have been generous with their time and willing to share their experiences and advice about the establishment of similar committees.

Finally, I would like to thank the members of the Committee, the staff of the Community Services Directorate and the many people I have consulted in the ACT for the support given to the Committee in this first year of operation.

Dr Judith Gibbs Chair
ACT Children and Young People Death Review Committee
October 2012

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EXECUTIVE SUMMARY

This is the first annual report of the ACT Children and Young People Death Review Committee; it covers Committee work undertaken for a six-month period.

Background and establishment of the Committee

Chapter 1 of the report provides historical information relating to reviewing the deaths of children and young people in the ACT. The establishment of this independent Ministerial Committee marks the first time in the ACT that the practice of reviewing these deaths has been enshrined in legislation. The legislation represents a children's rights approach and ensures that a broad and comprehensive picture of those who die each year will be recorded, information will be analysed and the findings will be used to contribute to improving the lives of this age group in the ACT.

The independent, multi-sectoral committee was established under Chapter 19A of the *Children and Young People Act 2008*, which was passed by the ACT Legislative Assembly on 9 March 2011. The Minister for Community Services appointed the Chair and members of the Committee in January 2012 and the Committee held its first meeting on 2 March 2012.

The Committee is chaired by Dr Judith Gibbs and comprises nine members appointed by the Minister for Community Services, as well as the Children and Young People Commissioner and the Director-General, Community Services Directorate. The Committee is a multi-disciplinary group with expertise in the areas of psychology, paediatrics, epidemiology, child forensic medicine, public health administration, engineering and child safety products, working with Aboriginal and Torres Strait Islander children and young people, social work and policing. As required by the legislation, efforts are underway to have a member appointed from the education sector.

The Committee's functions include establishing a register of deaths of children and young people in accordance with Section 727N of the *Children and Young People Act 2008*, identifying patterns and trends in relation to the deaths of children and young people and determining research that would be valuable in this area.

The Committee is able to make recommendations about legislation, policies, practices and services for implementation by government and non-government bodies with the aims of preventing or reducing the number of deaths of children and young people in the ACT and improving services.

Under the legislation, the Committee is required to report annually to the Minister for Community Services and to report retrospectively within a six-year period on the deaths of children and young people in the ACT for the period starting 1 January 2004 until the commencement of the legislation in September 2011.

Issues relating to the Child Death Register and reviews

As described in **Chapter 2**, the initial focus of the Committee has been to establish a register to record information relating to the deaths of children and young people in the ACT and the deaths of ACT children and young people that occur outside the ACT. Discussions have been undertaken to determine what information is required to enable the Committee to carry out its role and functions and from which agencies, departments and organisations the information can be accessed.

Under the legislation, the register must include the following information in relation to the death of a child or young person: the cause of death; the age and sex; whether the child or young person is an Aboriginal or Torres Strait Islander; and whether, within three years prior to the child or young person's death, the child or young person, or a sibling of the child or young person, was the subject of a Child Protection Report received by the Director-General, Community Services Directorate.

The register may include other demographic information available to the Committee and information about the circumstances of the child's death that the Committee considers relevant.

Occasionally, children and young people die in the ACT although they usually resided in another state or territory. A number of these may have been receiving specialist medical care in a regional health facility. Given the requirements for inclusion on the register under Section 727N (1) (a) and (b), the Committee will need to consider information gathering and sharing with other jurisdictions and similar death review bodies in relation to children and young people who die outside their usual state or territory.

The Committee has been exploring its needs and powers under the legislation to obtain the required information from a number of different sources so that the register can be established and reviews can be undertaken effectively. This work is well underway with the relevant service institutions and government departments. The Committee has become aware that in some instances the information-gathering process involves a resolution between the legislative requirements under which a number of government departments and organisations operate and the *Children and Young People Act 2008*.

The Committee has discussed the requirements for the secure database that will store the information about children and young people and consideration is being given as to which system will meet the needs of the Committee.

This year the Committee has reported causes of death using broad mortality categories and is exploring the use of the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10 AM), to code underlying and multiple causes of death for future reporting. Neonatal deaths will be reported on in the future using the PSANZ Perinatal Death Classification System, which is used nationally for reporting perinatal deaths.

Consideration has been given to the reporting requirements as set down in the legislation. The Committee must report information about the children who die during a financial year, not by calendar year, as is the case with the Australian Bureau of Statistics, other jurisdictions and other health reporting entities. This will make comparisons more difficult and the Committee will need to consider whether to make a recommendation to the government for legislative change.

Fortunately, the number of children and young people who die in the ACT is small. This raises a particular challenge to report accurate, evidence-based information and learnings in such a way that the privacy of children and their families is respected.

The Committee has identified a need to direct additional staffing resources towards supporting the work of the Committee. A senior reviewer is to be appointed to gather information, conduct research and prepare individual case reviews for the Committee.

In order to strengthen the independent nature of the work of the Committee, the secretariat, including the senior reviewer, will be transferred to the Consumer Advocacy and Quality Service Section (CAQS) of Policy and Organisational Services within the Community Services Directorate. This section (CAQS) provides a point of contact for external oversight bodies such as the Human Rights Commission and, given the role of the Committee to review cases where the child or young person who has died was previously known to Care and Protection Services, appears to be a preferable location within the Community Services Directorate. CAQS is functionally and administratively separate from Care and Protection Services, which are located within the Office for Children, Youth and Family Support.

Child deaths in the ACT, July 2009–June 2012

Chapter 3 reports on the deaths of children and young people for the period from July 2009 to June 2012.

During this reporting period, there were 80 deaths of children and young people in the ACT. Of the 80 deaths, six cases are awaiting coroner findings and will be included in subsequent reports when the cases are finalised. Accordingly, this report covers 74 children.

Summary of key findings

Given the short length of time that the Committee has been established, it has considered demographic information only as there has not been sufficient time to undertake analysis work and to identify learnings from the sad events. The report is based on information provided by the Births, Deaths and Marriages Registry and from the Community Services Directorate.

The major findings contained in this report with respect to the 74 deaths are:

- forty-four (59.5 %) occurred in the neonatal period (under 28 days)
- fifty-two (70.3 %) were children less than one year old (includes neonatal deaths)
- seven (9.5 %) were the subject of a Child Protection Report
- five (6.8 %) were identified as Aboriginal and Torres Strait Islander
- the child and young people death rates for the ACT in each age category are in line with Australian rates.

Future directions for the Committee

The final chapter of the report sets out the future directions for the work of the Committee.

The first six months of the Committee's operations have focused on establishing the Committee's working arrangements and the initial development of the register. With this work accomplished, and with the future recruitment of a senior reviewer, the Committee will be better placed to commence work on reviewing the deaths of children and young people in the ACT.

This year the Committee has reported on demographic information for the three years from July 2009 to June 2012 and is keen to gather retrospective information on those children and young people who died from 2004 to 2009 in order to be able to consider trends and patterns over time. Further work will be undertaken to determine what additional information the Committee requires and from whom it can be accessed. It is a priority for the Committee to start analysing the information about the individual children and young people who die and to provide the government and the community with important learnings.

The identification and establishment of a data storage system that meets the needs of the Committee will be integral to this work.

An important task for the senior reviewer will be to finalise agreements with a number of relevant agencies relating to gathering information about the children and young people who die in order that the Committee can effectively carry out its legislative functions.

The Committee is dedicated to establishing structures and processes that enable it to function effectively. This will include finding appropriate ways to invite families and relevant others who knew the child to be involved in the process.

The Committee intends to adopt a broad communication strategy to complement the annual report; this will include the establishment of a website.

It is important for the Committee to forge strong links with national and international bodies with similar roles and functions in order to access comparative data and gain from their valuable experience.

Definitions of terms

Aboriginal In the *Children and Young People Act 2008*, **Aboriginal** means a person who –

a is a descendant of the Indigenous inhabitants of Australia; and

b either –

i for any person – regards himself or herself as an Aboriginal; or

ii if the person is a child – is regarded as an Aboriginal by a parent or family member; and

c is accepted as an Aboriginal by an Aboriginal community.

Child In the *Children and Young People Act 2008*, **child** means a person who is under 12 years old and 'young people' means a person over the age of 12 years and not yet 18 years. The ACT does not provide guidance on when an individual becomes a 'child'. In accordance with common law, a child is a person who has been born alive, which means the child must be living outside its mother's body by virtue of the functioning of its own organs and indicated by breathing, beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. The term 'a child born alive' does not include stillbirths or other fetal deaths.

Child Protection Report Under the *Children and Young People Act 2008*, a person who believes or suspects child neglect or abuse may report the matter to Care and Protection Services. This report is known as a Child Concern Report, which is assessed by Care and Protection Services as to the veracity of the report and whether Care and Protection Services suspects on reasonable grounds that the child or young person may be in need of care and protection. The Child Concern Report may form the basis of a Child Protection Report.

Coroner refers to a coroner for the Territory appointed under the *Coroners Act 1997*.

Entity refers to: the ACT Chief Police Officer; the Registrar-General, the Births, Deaths and Marriages Registry; The ACT Coroner's Court; The Director-General, Community Services Directorate; The Director-General, Education and Training Directorate; The Director-General, Health Directorate; a licensed proprietor of a childcare service; another agency prescribed by regulation.

Infancy refers to the period from birth to one year of age.

Neonatal refers to the period from birth to 28 days of age.

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

Registrar-General refers to the Registrar-General under the *Register General Act 1993*, a statutory office held by the Executive Director, Office of Regulatory Services.

Report refers to the annual report of the ACT Children and Young People Death Review Committee. The report covers information for three financial years: 2009–10, 2010–11 and 2011–12, which is denoted throughout the report as July 2009–June 2012.

Reviews undertaken in the territory, reviews may include a coronial inquest uinto 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.

Torres Strait Islander in the *Children and Young People Act 2008* **Torres Strait Islander** means a person who –

a is a descendant of the Indigenous inhabitants of the Torres Strait Islands; and

b either –

i for any person — regards himself or herself as a Torres Strait Islander; or

ii if the person is a child — is regarded as a Torres Strait Islander by a parent or family member; and

c is accepted as a Torres Strait Islander by a Torres Strait Islander community.

Young people In the *Children and Young People Act 2008*, **young people** means a person over the age of 12 years and not yet 18 years.

Abbreviations

ACT	Australian Capital Territory
the Act	*Children and Young People Act 2008*
ANZCDR&PG	Australian New Zealand Child Death Review and Prevention Group
BDM	Births, Deaths and Marriages Registry
CHYPS	Children and Young People System
CPS	Care and Protection Services
CSD	Community Services Directorate
the Committee	ACT Children and Young People Death Review Committee
ICD-10 AM	International Statistical Classification of Diseases and Related Health Problems, Tenth Revision – Australian Modification
MLA	Member of the Legislative Assembly
NCIS	National Coronial Information System
OCYFS	Office for Children, Youth and Family Support
ORS	Office of Regulatory Services
PSANZ	Perinatal Society of Australia and New Zealand
the register	Child Death Register

ACT Children and Young People Death Review Committee

Members

Dr Judith Gibbs — Chair, ACT Children and Young People Death Review Committee
Dr Gibbs is a qualified social worker who has worked in child and family welfare in Victoria and the UK. She has taught at La Trobe University and now works as an independent consultant and trainer. Dr Gibbs has worked with statutory and community service organisations undertaking consultancies related to learning for professional practice, supervision and leadership. From 2001 to 2004, Dr Gibbs chaired the Victorian Child Death Review Committee and continues to undertake individual child death inquiries in Victoria.

Mr Eric Chalmers — Chief Executive, Kidsafe ACT Inc
Mr Chalmers has been the Chief Executive of Kidsafe ACT, the Child Accident Prevention Foundation of Australia, for the past 13 years. He has a strong background in management consulting, industry regulation at a commonwealth and state level and experience in the finance and banking sector. Mr Chalmers is linked internationally as Chair of the Network Advisory Council for the Safe Kids Worldwide network of 22 injury prevention organisations and is involved in a number of community organisations, including as Chair of ACT Playgroups and Chief Executive of the ACT School Sports Council.

Ms Louise Freebairn — Epidemiology Branch, ACT Health Directorate
Ms Freebairn holds the position of Acting Manager, Epidemiology Branch, Population Health Division, Health Services Directorate, ACT Government. She has expertise in population health informatics, epidemiological analysis and reporting, with a focus on maternal and perinatal health, children's health and health of Aboriginal and Torres Strait Islander people. Ms Freebairn is a member of the ACT Perinatal Mortality Committee.

She has worked with health services in both the ACT and NSW since 1997 in a number of roles including clinical psychology, health services planning and epidemiology.

Ms Natalie Howson — Director-General, Community Services Directorate
Ms Howson is the Acting Director-General of the ACT Government, Community Services Directorate. Ms Howson has held high-level senior executive positions within the Commonwealth Government, including Centrelink and the Department of Climate Change and Energy Efficiency. She is highly skilled in the areas of human service delivery and policy development, effective taskforce operation, strengthening relationships with stakeholders and knowledge of governance at state and federal levels. Ms Howson has long been involved in the implementation of projects aimed at helping the most vulnerable of Australia's citizens. In 2000, Ms Howson was honoured as the Telstra Australian Capital Territory Business Woman of the Year.

Associate Professor Alison Kent — Department of Neonatology, The Canberra Hospital
Associate Professor Kent is a Consultant Neonatologist who has worked at The Canberra Hospital for 11 years in the Neonatal Intensive Care Unit.

Associate Professor Kent established and has chaired the ACT Perinatal Mortality Committee since 2001, is a member of the Perinatal Society of Australia and New Zealand Special Interest Mortality Group and has been an active participant in the development and maintenance of the PSANZ Perinatal Mortality Guideline aimed at improving classification, reporting and research of perinatal deaths. She is currently the Chair of the Australian and New Zealand Stillbirth Association Clinical Practice and Education Committee and is a board member of SIDS and Kids ACT.

Ms Samantha Page — Executive Director, Family Relationship Services Australia
Ms Page holds a Bachelor of Arts (Psychology) and a Masters in Community Organisation Management. Ms Page has been an advocate for children, young people and parents and has served on governance boards and advisory groups including: the Australian Council of Social Service; the Australian Institute of Health and Welfare; the Child, Family and Communities Information Exchange Reference Group; the National Action Plan for Children and Young People Steering Group; the Family Law System Reference Group; the Family Law Council; and Parentline ACT Inc.

Dr Sue Packer AM — Paediatrician, The Canberra Hospital
Dr Packer has worked as a paediatrician since 1972. She has worked as a Community Paediatrician with a special interest in child abuse and abuse prevention since 1990.

Dr Packer undertakes a range of work including: working in a health-funded child abuse assessment unit in the ACT, which also serves adjacent NSW; teaching and consulting; and currently serving on the NAPCAN National Board. In 1999 Dr Packer was awarded an Order of Australia for services to paediatrics, child protection and the community.

Dr Michael Rosier — Paediatrician
Dr Rosier has been a Consultant Paediatrician in private practice in the ACT since January 1990. He is a Visiting Medical Officer at The Canberra Hospital and the Calvary Bruce and Calvary John James Hospitals. Dr Rosier has extensive experience in all fields of paediatric medical practice, including neonatology and children through to 18 years of age. He has a special interest in paediatric epilepsy and neurological conditions.

Mr Alasdair Roy — ACT Children and Young People Commissioner
Mr Roy, who holds a Masters in Counselling Psychology, is the ACT Children and Young People Commissioner within the ACT Human Rights Commission, a position he has held since 2008. He has lived and worked in Canberra for most of his life and has always worked with and for children and young people. Prior to becoming the Children and Young People Commissioner, Mr Roy was Deputy Public Advocate in the Public Advocate of the ACT. Mr Roy has also worked for Care and Protection Services, Youthline and the Streetlink Youth Support Program, as well as in children and young people policy areas, adolescent mental health and services for children with sexually harmful behaviour. He is committed to the rights of children and young people, and making Canberra a friendlier and safer place for them.

Dr Catherine Sansum — Staff Specialist, Clinical Forensic Medicine, Child at Risk Health Unit, The Canberra Hospital
Dr Sansum holds the position of Staff Specialist at The Canberra Hospital in the area of Clinical Forensic Medicine (Adult) and in paediatric forensic medicine at the Child at Risk Health Unit. She has worked as a doctor in the ACT for the past 26 years, initially in paediatrics and obstetrics and gynaecology, general practice and then specialising in forensic medicine. Dr Sansum is a Clinical Lecturer at the Australian National University Medical School and is a member of the Australian Academy of Forensic Sciences, the Australian and New Zealand Forensic Science Society and the Sydney Forensic Medicine and Science Network. She is the treasurer of FAMSACA (Forensic and Medical Sexual Assault Clinicians Australia).

Sergeant Sue Smith — Acting Officer in Charge, Crime Prevention, ACT Policing
Sergeant Smith joined the Australian Federal Police in 1989 after five years with the NSW Police Service. Since joining the AFP, Sergeant Smith has had community and national policing roles. In 1992 , Sergeant Smith took up a position within the ACT Police Juvenile Aid Bureau, the unit responsible for managing young offenders, young people who were victims of crime and young people who were engaging in 'at risk' behaviour. She is involved in a number of committees, including ACT Violence against Women and Children and the Domestic Violence Prevention Council.

Ms Julie Tongs OAM — Chief Executive Officer, Winnunga Nimmityjah Aboriginal Health Service
Ms Tongs has worked in Aboriginal and Torres Strait Islander affairs for 20 years. She has extensive experience in advising, formulating, implementing and evaluating public health initiatives, programs and policies at a local, regional and national level. Ms Tongs has been a national leader and strong advocate of quality improvement initiatives within the Aboriginal community controlled health sector. She was a recipient of the 2012 ACT Local Hero Award and was recognised in the 2012 Australia Day Honours List.

Previous member

Mr Martin Hehir	Director-General, Community Services Directorate

Secretariat and support

Ms Ingrid Cevallos	Manager, Strategic Partnerships, Office for Children, Youth and Family Support, Community Services Directorate
Ms Barbara Harrop	Project Officer, Strategic Partnerships, Office for Children, Youth and Family Support, Community Services Directorate
Ms Janet Plater	Senior Manager, Strategic Partnerships, Office for Children, Youth and Family Support, Community Services Directorate

CHAPTER 1 ESTABLISHMENT OF THE ACT CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE

Role of the Committee

The ACT Children and Young People Death Review Committee was established this year as an independent multi-sectoral Ministerial Committee. It was formed to help reduce preventable deaths of children and young people in the ACT by reviewing all deaths, including that of any child or young person whose death occurred outside the territory but who usually resided in the ACT.

The Committee was established under Section 727 of the *Children and Young People Act 2008*.[1] Its work has a children's rights approach, as enshrined in the United Nations Convention on the Rights of the Child (UNCROC).[2] In undertaking this key role, the Committee provides the ACT Government with a way to examine the current provision of medical, educational, cultural, legal and youth justice, community and welfare services available to children and young people. The Committee will make recommendations to the government about policies and service provision, which could improve the quality of those services. Findings and recommendations will be reported publicly in an annual report.

Background

The proposal for an ACT Child Death Review Team was first raised in 1999 by the Children's Services Council. At that time, similar Child Death Review Teams had already been established in NSW and Victoria.

In 2004, the proposal for a committee received further support from recommendations in the review undertaken by Ms Cheryl Vardon. This review focused on the safety of children in care and the management of Child Protection Services in the ACT. The review report, *The Territory as Parent: Review of the Safety of Children in Care in the ACT and of ACT Child Protection Management*,[3] was published in May 2004 and recommended that a child death review committee be established within a Commission for Children and Young People and that the commissioner should chair the committee. The report recommended that there should be a review of each child's death for all children and young people who died when in the care of Family Services (now known as Care and Protection Services) and/or when the Chief Executive had parental responsibility for the child and/or when the child was known to Family Services. These reviews would be carried out by an external reviewer and be provided to the Child Death Review Committee for consideration.

The government at that time agreed in principle with these recommendations, although the Commission for Children and Young People had yet to be established. A decision as to the most appropriate location of a Child Death Review Committee was therefore postponed.

In 2004, ACT Health established a model for a Child Death Review Team. This team relied on the powers of the ACT Chief Health Officer, under the *Public Health Act 1997*, to review child deaths from 1992 to 2003. The ACT Chief Health Officer chaired the Child Death Review Team. Membership of this multi-disciplinary team included those with a wide range of work expertise and experience. In June 2006, the Child Death Review Team published their work in a report entitled *Review of ACT Child Deaths 1992–2003*.[4] The report examined general issues and trends but did not report on individual child deaths. It also identified the need for appropriate legislation to guide the operation of an ongoing child death review mechanism.

1 *Children and Young People Act 2008*, Chapter 19A.
2 UNICEF, Convention of the Rights of the Child www.unicef.org/crc/files/Rights_overview.pdf.
3 Vardon Cheryl, *The Territory as Parent: Review of the Safety of Children in Care in the ACT and of ACT Child Protection Management*. May 2004.
4 Population Health Research Centre, *Review of ACT Child Deaths 1992–2003*. ACT Health, June 2006.

In 2006, the ACT Government commissioned a study of intervention by Care and Protection Services in the lives of children who had died or nearly died and who at some time in their lives were known to Care and Protection Services (known as the Murray–Mackie Study). This independent study was undertaken by experts, Ms Gwenn Murray and Mr Craig Mackie, and its findings were reported to the then Department of Disability, Housing and Community Services.

In September 2006, the then Minister for Disability and Community Services tabled the study, entitled *Recommendations from the Murray–Mackie Study into the Deaths and Near Deaths of Children Known to Care and Protection and the Government Response*,[5] in the ACT Legislative Assembly. The recommendations of this study reiterated the recommendation made in the Vardon Report (2004) relating to a Child Death Review Committee. The then government agreed to implement this recommendation and to consider joint ACT Health and Care and Protection Services clinical reviews of children who had died and who were known to both agencies prior to their death.

In January 2009, a memorandum of understanding was signed by ACT Health and the Department of Disability, Housing and Community Services, including the Office for Children, Youth and Family Support, establishing a joint case review by the ACT Clinical Audit Committee of clients known to both Health and Care and Protection Services. When a review follows the death of a child known to Care and Protection Services, the Clinical Audit Committee can make recommendations for systemic improvements involving individual agencies and in relation to collaborative practice between ACT Health Services and Care and Protection Services. In a small number of cases, Care and Protection Services has engaged an independent external reviewer to examine a death and produce a report for the department.

In August 2010, Ms Meredith Hunter MLA proposed amendments to the *Children and Young People Act 2008* enabling the establishment of an ACT Child Death Review Committee. The proposed independent committee would complement and draw on existing review mechanisms, such as the ACT Coroner's Court, the Clinical Audit Committee within ACT Health and any external or internal review process instigated by the then Department of Disability, Housing and Community Services (now the Community Services Directorate). However, the role of the proposed committee would be fundamentally different and would mean that, for the first time, a child death review mechanism would be enshrined in legislation specifically relating to the review of deaths of ACT children and young people.

The bill and proposed government amendments were debated in the ACT Legislative Assembly and a final bill was passed on 9 March 2011. These provisions became operational on 18 September 2011. The ACT Children and Young People Child Death Review Committee was established in accordance with the provisions contained in Chapter 19A of the Act (see Appendix I). The first meeting was held on 2 March 2012.

Functions of the Committee

The functions of the Committee as set out under Section 727B of the Act are:

a to keep a register of deaths of children and young people under part 19A.3

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

5 Recommendations from the Murray-Mackie Study into the Deaths and Near Deaths of Children Known to Care and Protection and the Government Response. Presented by Katy Gallagher MLA, Minister for Disability and Community Services, September 2006. Available: www.hansard.act.gov.au/hansard/2006/week09/3027.htm.

f to monitor the implementation of the Committee's recommendations

g to report to the Minister under part 19A.4

h any other function given to the Committee under this chapter.

During its first six months of operation, the Committee has considered how it might best function in order to fulfil these legislative requirements and achieve the outcomes described above. In order to establish the most effective operating arrangements the Committee has considered the foundational work undertaken by previous relevant committees in the ACT and the structures and processes that have been adopted by similar national and international bodies.

Establishment of the Committee

The ACT Community Services Directorate arranged for the Committee's secretariat support to be provided within its administrative arrangements (Section 727I (1)). The Chair and members of the Committee were appointed by the Minister for Community Services, Ms Joy Burch MLA, and notified on the ACT Legislation Register on 27 January 2012.

In accordance with the requirements of the Act, membership of the Committee reflects a multi-disciplinary approach to undertaking reviews of the deaths of children and young people resident in the ACT. The Committee also includes the Director-General of the Community Services Directorate as a standing member, as well as the Children and Young People Commissioner, who is an independent statutory officer based within the ACT Human Rights Commission. In addition, the Minister appointed nine members from government, private sector and independent agencies. Collectively, current members offer expertise in the areas of psychology, paediatrics, epidemiology, child forensic medicine, public health administration, engineering and child safety products, working with Aboriginal and Torres Strait Islander children and young people, social work and policing. As required by the legislation, the formal process has commenced to appoint a member from the education sector.

During this first year, Mr Martin Hehir resigned as Director-General of the Community Services Directorate to take up a position as Deputy Secretary, Department of Education, Employment and Workplace Relations, in the Australian Government. Ms Natalie Howson, the new Director-General of the Community Services Directorate, replaced him on the Committee.

Activities of the Committee

The inaugural meeting of the Committee was held on 2 March 2012. At this meeting, the Chair of the Committee welcomed the members and acknowledged the ground work to be undertaken in advance of undertaking child death reviews in the ACT. The Committee held two further meetings during the reporting period on 30 April 2012 and 18 May 2012.

In establishing a new committee that is prescribed under legislation, there are issues to be addressed to enable the work of the committee to progress. The Committee is in the early stages of developing a clear understanding of the roles of individual members and the structure and processes that will need to be put in place to ensure that the Committee can meet its statutory requirements and learn more about improving the lives of children and young people living in the ACT.

One of the main functions of the Committee is the development of a Child Death Register, which is a database that will contain information relating to the deaths of children and young people. This may include information relating to children who have died as well as the immediate causes and background factors that may have contributed to their deaths.

The identification and scope of information to be recorded in the Child Death Register has been a major focus of the Committee's deliberations. Chapter 2 of this Report outlines some of the complex issues being considered by the Committee with respect to the development of the register, the database and the operational structures and processes.

The legislation also requires certain services and organisations in the ACT to provide information to the Committee. Arrangements have been made for the Office of Regulatory Services to provide regular demographic information for the Child Death Register. The Committee has commenced developing processes to access information from other sources, such as the Education and Training Directorate, the Health Directorate, the Coroner's Office and ACT Policing.

Under the legislation, the Committee is required to report annually to the Minister for Community Services and to report retrospectively (within a six-year period) on the deaths of children and young people for the period starting 1 January 2004 until the commencement of the legislation in September 2011.

In view of the short time since the Committee was established, members have decided that the first annual report will only report on the information required by the legislation concerning the deaths of children and young people during the past three years. This is contained in Chapter 3 of the report. Work to date has not enabled individual reviews to take place, although the proposed direction of the Committee is to establish structures to enable such reviews to be undertaken and presented to the Committee for consideration.

CHAPTER 2 ISSUES RELATING TO THE REGISTER OF DEATHS AND REVIEWING CHILD DEATHS IN THE ACT

This chapter reports on the particular challenges facing the Committee at this early stage of its existence.

The register

Under the *Children and Young People Act 2008*, it is a statutory requirement for the Committee to develop and maintain a register of all deaths of children and young people that occur in the ACT. The register must also include deaths that occur outside the ACT of children and young people who normally live in the ACT (Section 727N (1)).

A major consideration for the Committee has been to explore what information is required to undertake individual child death reviews and to make sure that the database and the reports prepared can flexibly support the Committee's work. The database will be the source of information from which trends and patterns may be determined over time. It will also need to be structured to prompt a request for an individual review or piece of research based on a cluster of deaths. It will be very important for the Committee to draw on a comprehensive and holistic understanding of the children and young people who die to enable it to make evidence-based recommendations to the government about policy and practices that might reduce deaths and also improve service provision to children and young people.

The database must include specific demographic information relating to the cause of death, age, sex and Aboriginal or Torres Strait Islander status (Section 727N (2) (a) (b) (c)). The primary source of demographic information for the register will be the Office of Regulatory Services (Births, Deaths and Marriages Registry).

On 4 June 2012, a memorandum of understanding (MOU) was finalised between the Office of Regulatory Services and the ACT Children and Young People Death Review Committee in relation to how the Committee would obtain information for the register. Information from the Births, Deaths and Marriages Registry was received on 26 June 2012 and the register is being populated with this information on a monthly basis.

The Births, Deaths and Marriages Registry will also provide the Committee with retrospective information to enable a review of deaths of children and young people from 1 January 2004 to 17 September 2011.

The Committee has received valuable assistance from the Office of Regulatory Services in the development of the MOU and we thank them for their assistance. Information has also been shared with similar Child Death Review Committees in other jurisdictions to assist with the development of the ACT register and database structure.

Other sources of information to be accessed by the Committee

The *Children and Young People Act 2008* provides the Committee with the power to obtain information from other sources, including the ACT Chief Police Officer, the Coroner's Court, the Community Services Directorate, the Education and Training Directorate and a licensed proprietor of a childcare service (Section 727O (6)). It may also receive information from other entities as prescribed by regulation.

Work is underway to formalise agreements between the Committee and the ACT Coroner's Court and the Education and Training Directorate to gather information as set out in the legislation. Further agreements will follow.

The Act requires that the register includes information as to whether, within three years prior to the child or young person's death, the child or young person, or a sibling of the child or young person, was the subject of a Child Protection Report received by the Director-General, Community Services

Directorate (Section 727N (2) (d)). The Committee will have a role in relation to identifying specific issues relating to the deaths of identified vulnerable and at risk children and the provision of services prior to their deaths.

The Committee has obtained this information on children and young people who have been the subject of a Child Protection Report from the Community Services Directorate for the three years of data that are reported on in this report.

As the Committee begins to review the deaths of individual children and young people it will be important to have access to information about the government and non-government services that knew the deceased child and their family and to any other review that has been undertaken following the death. This will be achieved within the powers provided by the legislation and through collaborative, respectful and confidential processes.

In establishing the register, the Committee is aware of the importance of the legislative requirements under which a number of government departments operate. The interaction of various pieces of legislation relating to sharing information will require further consideration by the Committee.

Other relevant reviewing bodies in the ACT

In addition to the ACT Children and Young People Death Review Committee, there are a number of other review bodies in the ACT including:

- Coronial Inquiries held in accordance with the *Coroner's Act* Section 13
- the ACT Health Clinical Privileges Committee
- the Paediatrics Mortality and Morbidity Committee Quality Assurance Committee
- the ACT Perinatal Mortality Committee
- the Maternal, Perinatal and Gynaecological Clinical Review Committee – Calvary Health Care ACT Quality Assurance Committee
- The Canberra Hospital Clinical Review Committee Quality Assurance Committee
- the Clinical Review Committee — Mental Health Quality Assurance Committee
- The Canberra Hospital Perinatal Morbidity and Mortality Committee Quality Assurance Committee
- the Calvary John James Hospital Clinical Review Committee Quality Assurance Committee.

The Committee notes that every five years the ACT Perinatal Mortality Committee, ACT Health, provides a published report on perinatal deaths (fetal and neonatal deaths) in the ACT, with the most recent report entitled *Perinatal Mortality in the ACT 2001–2005*. Although some information from that report is likely to be cited in future annual reports of the ACT Children and Young People Death Review Committee, the functions of these committees and reports are different. The ACT Perinatal Mortality Committee reviews both fetal and neonatal deaths in the ACT, whereas the ACT Children and Young People Death Review Committee reviews information concerning neonatal deaths only. The causes of perinatal deaths require a separate focus, which is provided by the ACT Perinatal Mortality Committee.

Confidentiality of information — protecting the privacy of children, young people and families

Fortunately, very few children and young people die in the ACT. However, this means the Committee must pay particular attention to the way it reports information.

There is a commitment to report sensitively to the government and the community and in a way that respects the rights and needs for privacy of families, friends and all those who knew the child or young person. At the same time, the Committee must strive to contribute to a reduction in deaths and to improve the quality of the broad range of services delivered to children and young people in the ACT.

In deciding how to report sensitive and potentially distressing information the Committee has been guided by a number of sources.

The legislation requires the Committee to not disclose the identity of a child or young person who has died or allow the identity of a child or young person who has died to be worked out (Section 727T (2) and Section 727U (3)).

Article 16 of the United Nations Convention on the Rights of the Child relating to their right to privacy states:

> **Children have a right to privacy. The law should protect them from attacks against their way of life, their good name, their families and their homes.**[6]

The Committee must also adhere to the information-sharing provisions of Chapter 25 of the *Children and Young People Act 2008*. Information obtained under the Act is only to be used for a function of the Committee.

In meeting these obligations, the Committee has undertaken a range of measures to ensure confidentiality of the information including:

- raising awareness among members of the Committee to their individual responsibilities regarding protected and sensitive information
- development of a secure database with access limited to authorised people
- aggregation of three years of information for the initial annual report to limit the likelihood of the identity of a child being disclosed.

As the Committee is presented with information and reviews reports about children and young people who die, members will continue to wrestle with the complex demands for privacy, sensitivity, confidentiality, transparency and rigorous evidence-based analysis in the way they report their deliberations and conclusions.

Limitations on information to be recorded in the register

If the death of a child or young person is subject to a coronial inquest or review by the territory, the Committee must not include any information on the register about the cause or circumstances of the death until the coronial inquest or review has been finalised (Section 727N (4)).

The Committee will be provided with a range of information from the coroner on the completion of a coronial inquest. This will enhance the value of deliberations about individual deaths, reporting and what can be learnt.

Reviews undertaken by the Committee will not investigate the cause of death nor will they seek to identify underperformance or to allocate blame. The Committee's aim is to identify what may be learnt from the circumstances of the death of the child or young person.

Gathering information on interstate deaths of ACT children for the register

The Committee is required to include on the register the deaths of ACT children and young people that occur outside the ACT (Section 727N (1)(b)). The Committee is in the process of examining ways of obtaining this information through registries of births, deaths and marriages in other jurisdictions. This information, and the processes for gathering the information, are yet to be clarified and are not included in this report.

The Committee is also liaising with the National Coroners Information System (NCIS) to obtain authorisation for access to their database, which contains information about every death reported to a coroner in Australia since July 2000.

6 UNICEF, *Convention on the Rights of the Child*. Available: www.unicef.org/crc/files/Rights_overview.pdf.

Children and young people who die in the ACT and usually resided in other states

Under Section 727N (1) (a), the Committee is required to include on the register the deaths of all children and young people who die in the ACT. Each year some children and young people are likely to die in the ACT although they and their families usually resided in another state or territory. A number of these will have been receiving specialist medical care in a regional health facility. The Committee will need to analyse this group of deaths and consider matters concerning information sharing with other jurisdictions and similar death review bodies in relation to children and young people who die outside their usual state or territory.

Date of death reporting for the register

The Committee has established that occasionally there is a time lag between the date of death and the registered date of the death. This occurs when there are coronial inquiries pending and towards the end of the calendar year when there may be a backlog of registrations to be processed in the new year.

For the purpose of the first annual report, the Committee has determined that 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 deaths for the reported three-year period. 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 Births, Deaths and Marriages Registry, which uses the registered date of death.

Coding causes of death

This year the causes of death have been reported in the broad mortality categories associated with the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10 AM)[7] code sets and as identified in child death review reports from other jurisdictions. These categories are: extreme prematurity, diseases, congenital/genetic conditions and external causes (drowning, suicide/self-inflicted, non-intentional injury/accident, fatal assault, unknown).

The Committee is exploring the use of the ICD-10 AM to code underlying and multiple causes of death for future reporting. The advantage of using this coding system is that it provides an opportunity for the Committee to access and draw upon comparable data from other states and the Northern Territory. In the future, neonatal deaths will be described according to the PSANZ Perinatal Death Classification System, a nationally accepted method of reporting neonatal deaths.

Annual reporting requirements

The legislation requires the Committee to report to the Minister for Community Services on a financial year basis, with the report required to be presented to the Minister within four months after the end of each financial year. The Minister is required to table the report in the ACT Legislative Assembly within six sitting days after the day the report is given to the Minister (Section 727S(5)).

Given the short period of time that the Committee has been established, it has relied on records held by the Office of Regulatory Services, the Births, Deaths and Marriages Registry (BDM) and the Community Services Directorate to provide information regarding the deaths of children and young people in the ACT to include in the first annual report. Information in the report covers the financial years 2009–2010 to 2011–2012.

The primary mechanism for reporting will be the annual report. However, the Committee has already commenced work on an additional range of communication strategies and processes to ensure that maximum learning occurs across the system and the community.

The multi-disciplinary composition of the Committee membership holds significant advantages in terms of a broad communication strategy. A website is to be established this year.

7 National Casemix and Classification Centre, University of Wollongong, *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision* (ICD-10 AM).

Retrospective report of child deaths 1 January 2004–17 September 2011

Within six years of it being established (Section 727(U)), the Committee must produce a separate report analysing the retrospective information about children and young people who died in the ACT between 1 January 2004 and 17 September 2011 and present the report to the Minister. The Committee recognises the importance of this work and will endeavour to oversee its completion as a priority once the standard collection items are agreed.

Senior reviewer to undertake child death reviews and report preparation

The Committee has considered a number of options in relation to establishing a structure and process whereby it can operate effectively and carry out the legislative functions described above. A request has been made to the Minister to support provision of the necessary financial resources to employ a senior reviewer within the Community Services Directorate to undertake this key role.

The Community Services Directorate has accepted this request in principle and the Committee is anticipating that a senior reviewer will be recruited in the coming months.

Location of secretariat and senior reviewer position

Given the independent role of this Committee to review the deaths of children and young people who have been reported to Care and Protection Services, the secretariat and senior reviewer position will be located in the Consumer Advocacy and Quality Service (known as CAQS), a section of Policy and Organisational Services within the Community Services Directorate and organisationally separate from the Office for Children, Youth and Family Support.

Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG)

Given the size of the ACT and the relatively small size of its population, it is of paramount importance that the Committee learns from the work of comparable bodies and reviewing teams nationally and internationally. The Committee will compare statistical data but also more qualitative, thematic learning.

The Committee is a member of the ANZCDR&PG and will be represented there by the Chair and other Committee members, depending on the ANZCDR&PG meeting focus and the relevant expertise of the ACT Committee member.

The ANZCDR&PG is a collective group comprising representatives from child death review teams across Australia and has the aim of identifying, addressing and potentially decreasing the numbers of infant, child and youth deaths by sharing information and reporting of these deaths and working collaboratively towards national and international reporting. The ANZCDR&PG held its inaugural meeting in December 2005.

The chairing arrangement of the ANZCDR&PG has recently changed and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Department of Health, Victoria, has taken over the role of chair following on from the previous chair, the Queensland Child Death Review Team.

CHAPTER 3 INFORMATION ON CHILDREN AND YOUNG PEOPLE DEATHS IN THE ACT

This chapter provides information in relation to the children and young people who have died in the ACT during the period from 1 July 2009 to 30 June 2012.

Data about deaths are largely based on the information provided by the ACT Births, Deaths and Marriages Registry. The Committee is able to provide the demographic information that is required under the legislation for this report; however, it is the intention of the Committee to draw on other sources of information in future years to gain an understanding of broader contextual factors relevant to the deaths and a more holistic understanding of the children and young people who die.

Once there has been a finding of death, the coroner is able to provide useful information to the Committee, particularly in more complex cases. When looking at the data in this report, the reader should note that those cases awaiting a finding from the coroner are not included in the data. This explains the discrepancy with the total number of deaths that occurred in the reporting period. Adjustments will be made to total numbers in subsequent reports.

The cause of death has been broadly categorised based on the cause provided on the child's death certificate and caution therefore needs to be applied to interpretation. The cause of death on the death certificate provides limited information on which to categorise the cause of death, but for this annual report it has been used to allow some level of categorisation. In the future, the Committee will determine which system of coding the cause of death most appropriately supports the Committee's work and enables comparison with national and international data.

As the Committee has not yet been able to consider any individual reviews of the death of a child or young person, it is limited in its ability to draw meaningful conclusions or make recommendations from the information provided in this report.

Reporting of deaths in the ACT

The Committee is dedicated to respecting the child and their family's right to privacy. Under the legislation 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 worked out (Section 727S (3) *Children and Young People Act 2008*).

The Committee has decided that this year the most sensitive and useful way of proceeding is to report on a three-year period, including information for the period from July 2009 to June 2012.

It is important to sound a note of caution about the value of drawing conclusions from numerical data alone. Given the small number of deaths in the ACT, the data are susceptible to random variations in relation to the number of children and young people who die. For this reason, the Committee intends to prioritise the work in relation to gathering data on the retrospective deaths from 1 January 2004. Analysis of the data needs to be based on trends and patterns over time and, in the future, the Committee intends to compare the ACT picture with other national and international jurisdictions.

Furthermore, once the Committee is in a position to critically reflect on more qualitative, contextual data about individual deaths, it will be possible to consider what this might mean for the many services and interventions directed at children and young people, including those provided by the health, education, welfare and youth justice sectors.

An overview of the ACT population

The Australian Capital Territory has a small population of 357,222. The number of children and young people in the ACT aged less than 18 years was 79,660,[8] representing 22.3 per cent of the total ACT population. The total number of children and young people in the ACT and Australia by age and gender is presented in Table 3.1.

Table 3.1 Population of children and young people in the ACT and Australia, by age and sex, 2011

Age (yrs)	MALES		FEMALES		TOTAL		ACT AS % OF AUSTRALIAN POPULATION
	ACT	Australia	ACT	Australia	ACT	Australia	
<1	2485	141 778	2245	134 163	4730	275 941	1.7
1–4	9901	588 190	9213	556 917	19 114	1 145 207	1.7
5–9	11 066	694 561	10 346	657 360	21 412	1 351 921	1.6
10–14	10 757	703 307	10 332	667 748	21 089	1 371 055	1.5
15–17	6782	435 363	6533	410 721	13 315	846 084	1.6
Total	**40 991**	**2 563 199**	**38 669**	**2 426 909**	**79 660**	**4 990 108**	**1.6**

Source: ABS Census Community Profile, Australian Capital Territory, 2011, Cat. no. 2001.0

In 2011, 5184 ACT residents identified as being Aboriginal or Torres Strait Islander.[9] Of these residents, 2149 were aged less than 18 years, representing 41.5 per cent of the total Aboriginal and Torres Strait Islander population in the ACT.

Deaths of children and young people in the ACT, July 2009–June 2012

The total number of deaths of children and young people in the ACT from July 2009 to June 2012 was 80, with the number of deaths each year ranging from 23 to 33 (Table 3.2). Of the 80 deaths registered during this period, six are awaiting coroner findings.

Almost three quarters (70.3 %) of deaths of children and young people in the ACT were infant deaths (occurring at less than one year of age) (Table 3.3). A small number of deaths occurred in each of the older age groups. Due to the very small number of deaths in the 5–9 years and 10–14 years age groups, these groups have been combined in the following analysis.

Table 3.2 Deaths of children and young people, July 2009–June 2012

YEAR	TOTAL NUMBER OF DEATHS OF CHILDREN & YOUNG PEOPLE
2009–10	33 (1)*
2010–11	23 (1)*
2011–12	24 (4)*
Total	**80 (6)***

* *( ) indicates number awaiting coroner findings.*
Source: ACT Births Deaths and Marriages Registry

Table 3.3 Deaths of ACT children and young people by age, July 2009–June 2012

AGE (YRS)	NO. OF DEATHS	%
<1	52	70.3
1–4	8	10.8
5–14	6	8.1
15–17	8	10.8
Total	**74**	**100.0**

Source: ACT Births Deaths and Marriages Registry

8 Australian Bureau of Statistics, Census Community Profile, Australian Capital Territory. Cat. no. 2001.0, 2012.
9 Australian Bureau of Statistics, Census Indigenous Profile, Australian Capital Territory. Cat. no. 2002.0, 2012.

ACT and Australian age-specific mortality rates per 1000 people are presented in Table 3.4. The mortality rates of children and young people who have died in the ACT are highest for children under one year (infant mortality rate). The national rates recorded in Table 3.4 are based on calendar years whereas the ACT rates are based on financial years. Overall, however, the ACT rates are similar to the national rates.

Table 3.4 Age-specific mortality rates for children and young people by age: ACT, July 2009–June 2012, and Australia, 2008–2010

AGE (YRS)	NO. OF DEATHS	MORTALITY RATE PER 1000 POPULATION	
	ACT	Australia*	ACT*
<1	52	4.0	3.5
1–4	8	0.2	0.1
5–14	6	0.1	0.06
15–17	8	0.3	0.2
Total	**74**		

* *ACT data are from 2009–12 and Australian data are from 2008–10. Excludes deaths of children and young people without a coroner's finding.*
Sources: ACT Births, Deaths and Marriages Registry, Estimated Resident Population (3101.0, Table 58, Dec 2011) for 2009–10 and Population Projections (3222.0, Table A8, Sept 2008) for 2011–12 from ABS.

Neonatal deaths

A significant proportion of the total deaths of children and young people in the ACT are neonatal deaths (infants under 28 days). During the three-year period from July 2009 to June 2012, there were 44 neonatal deaths, representing 59.5 per cent of the total deaths of children and young people in the ACT in this period (not awaiting a coroner's finding).

Classification of the cause of neonatal deaths during this period falls broadly into the categories of extreme prematurity, congenital and genetic disorders, and other diseases.

Detailed work on the categorisation of cause of death for a proportion of this population in the ACT has occurred through the work of the ACT Perinatal Mortality Committee, and a detailed analysis of perinatal deaths will be provided in the upcoming ACT Health Directorate report on Perinatal Mortality in the ACT, 2006–10. Their 2001–05 report found that the most frequent causes of ACT neonatal deaths between 2001 and 2005 were extreme prematurity (25.0 %), neurological conditions (20.3 %), cardio-respiratory disorders (18.8 %) and congenital abnormalities (17.2 %).[10]

Vulnerable and at risk children, young people and their families

The Committee has a wide remit to report on all deaths of children and young people in the ACT. However, as an independent and multi-disciplinary committee, it is well positioned to take a particular interest in the deaths of vulnerable children and their families.

Section 727S (1) (b) of the *Children and Young People Act 2008* requires the Committee to report if a child who dies was, within three years of their death, the subject of a Child Protection Report or had a sibling who, within three years of their death, was the subject of a Child Protection Report.

In the period from July 2009 to June 2012, seven children and young people died who, within three years of their death, were the subject of a Child Protection Report.

Five of these children also had a sibling or siblings who were the subject of a Child Protection Report.

In addition to these seven children who were the subject of a report, there were five children and young people who, within three years of their death, were not the subject of a Child Protection

10 ACT Health, Perinatal Mortality in the ACT, 2001 to 2005. ACT Government, Canberra ACT, 2008.

Report but had a sibling who was the subject of a Child Protection Report. These five children are not included in the numbers of children who were the subject of a Child Protection Report prior to their death.

As the Committee commences its reviewing work, it will seek more information about these children and young people as a priority and will review the cases in some detail.

Aboriginal and Torres Strait Islander children and young people

According to the Australian Institute of Health and Welfare, the Australian mortality rate for Aboriginal and Torres Strait Islander children aged 0–14 years was twice the rate of non-Aboriginal and Torres Strait Islander children between 2003 and 2007. For Aboriginal and Torres Strait Islander children aged 5–14 years, external causes were the leading cause of death between 2003 and 2007; this was three times the rate for non-Aboriginal and Torres Strait Islander children.[11]

Five (6.8%) ACT children and young people who died in the three-year period July 2009 – June 2012 identified as Aboriginal and Torres Strait Islander. All of these children were under one year of age.[12] This figure is reliant on accurate reporting of Aboriginal and Torres Strait Islander status at time of death.

Causes of death

Child Death Committees nationally use the International Statistical Classification of Diseases and Related Health Problems (ICD-10) to present data about causes of deaths. The Committee has not yet established classification procedures.

For the purposes of this report the causes of death indicated in the data have been broadly categorised by applying the high level categories used by the majority of states and territories reporting on child deaths that sit above the more detailed ICD-10 categorisations. More detailed analysis has not occurred and caution must be applied in interpreting the data.

The aim of presenting this information is to begin to provide a picture of children and young people who have died in the ACT. Most deaths of children and young people are due to congenital and genetic disorders and diseases (Table 3.6). A small number of deaths are due to external causes such as drowning, suicide and non-intentional injuries.

Table 3.6 Number of deaths of ACT children and young people by age* and indicative cause of death, July 2009 – June 2012

INDICATIVE CAUSE	<1 YR**	1–4 YRS	5–14 YRS	15–17 YRS
Extreme prematurity	<5	0	0	0
Congenital/genetic	<5	<5	<5	<5
Disease	<5	<5	<5	<5
Drowning	0	0	<5	<5
Suicide	0	0	0	<5
Non-intentional injury/ accident	0	0	<5	0
Unascertained	<5	0	0	0

* *The number of children is less than five but greater than zero. Number does not include the deaths of children and young people awaiting Coroner's findings.*

** *Does not include children aged less than 28 days.*

Source: ACT Births, Deaths and Marriages Registry.

In addition to the children aged less than one year presented in Table 3.6, 44 children aged less than 28 days of age (neonatal deaths) died between July 2009 and June 2012.

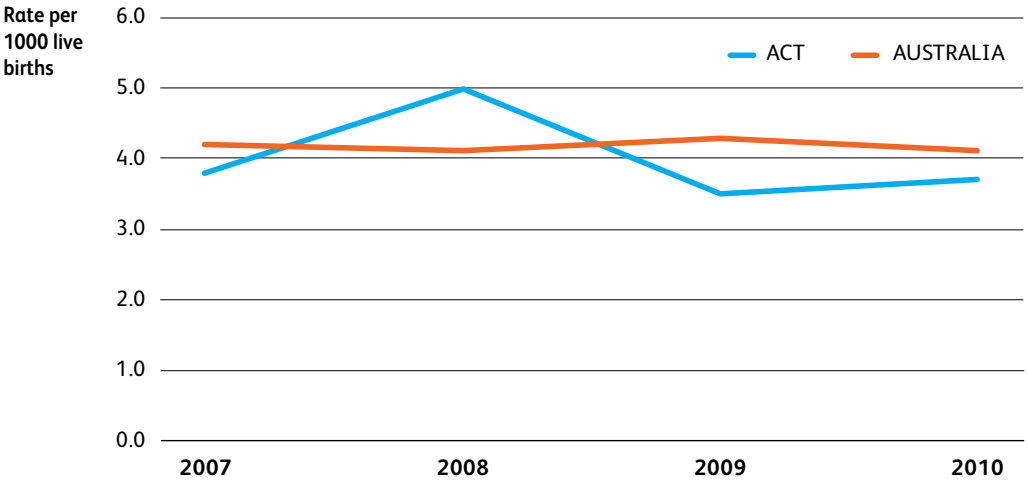
The majority of child deaths in the ACT involve children aged less than one year and the causes are extreme prematurity, congenital and genetic disorders and disease.

11 Australian Institute of Health and Welfare, *The health and welfare of Australia's Aboriginal and Torres Strait Islander People, an overview 2011.*
12 ACT Registry of Births, Deaths and Marriages 2012. Unpublished data.

Trends in mortality rates, ACT and Australia

Infant mortality rates for the ACT and Australia for the years 2007 to 2010 are presented in Figure 1. Over this period, the Australian rates remained stable at around 4.0 infant deaths per 1000 live births. The ACT infant mortality rates are generally similar to the Australian rates; however, they fluctuate from 3.5 to 5.0 infant deaths per 1000 live births. This is most likely to be due to the small number of births and infant deaths in the ACT each year.

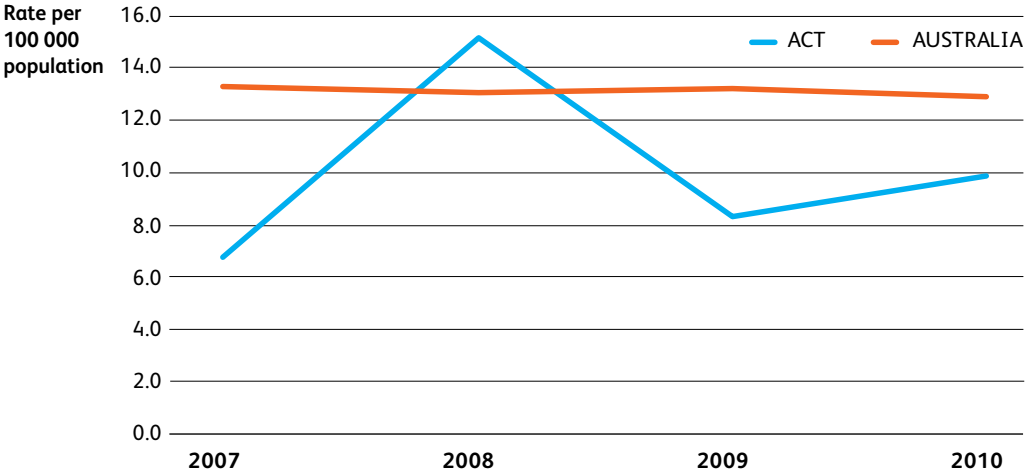
Figure 1 Infant mortality rates*, ACT and Australia, 2007–10



* *Deaths of children aged less than one year per 1000 live births.*
Source: ABS. Causes of Death, Australia, Cat. no. 3303.0.

ACT and Australian age-specific mortality rates for children aged 1–14 years per 100 000 population are presented in Figure 2. The Australian rates remained stable over this period at around 13 deaths per 100 000 population, whereas the ACT rates fluctuated from 6.8 to 15.2. This is, again, likely to be due to the very small number of deaths of children in this age group in the ACT.

Figure 2 Child mortality rates (aged 1–14 years)*, ACT and Australia, 2007–10



* *Deaths of children aged 1–14 years per 100 000 population.*
Source: ABS. Causes of Death, Australia, Cat. no. 3303.0.

CHAPTER 4 SUMMARY OF KEY FINDINGS AND FUTURE DIRECTIONS OF THE COMMITTEE

Key findings

The information presented for July 2009 to June 2012 provides the reader with a broad picture of the current situation pertaining to the deaths of children and young people in the ACT. The key findings contained in this report with respect to the 74 deaths are:

- forty-four (59.5 %) occurred in the neonatal period (under 28 days)
- fifty-two (70.3 %) were children less than one year old (includes neonatal deaths)
- seven (9.5 %) were the subject of a Child Protection Report
- five (6.8 %) were identified as Aboriginal and Torres Strait Islander
- the child and young people death rates for the ACT in each age category are in line with Australian rates.

Carrying out the role and functions of the Committee

The Committee's priority for the next 12 months is to continue to access information from a broad range of agencies cited within the legislation under which the Committee is established. Over time, the Committee will begin to determine patterns and trends in relation to the deaths of children and young people in the ACT.

The legislation sets out basic requirements in relation to information that must be obtained and recorded on the register. The Committee has more work to do to determine what information additional to that provided by the Births, Deaths and Marriages Registry is required, and who might hold this information.

It is a priority for the Committee that it is presented with information about the circumstances of individual children and young people who died in a form that enables members to critically review, analyse and draw conclusions from the information. While carrying out this important role the Committee will consider the range of services that were accessed by the children, young people and their families. The multi-disciplinary composition of the Committee means it is well positioned to make recommendations to the government about service improvement.

Given the requirement under Section 727N (1) (a) to register all deaths of children and young people, the Committee will need to consider arrangements for information gathering and sharing in relation to the group of children and young people who die in the ACT and usually resided in another state or territory.

In the future the Committee is keen to consider how best to invite the families of those children who died to be involved in the review process.

The independence of this Committee is of paramount importance and the major mechanism through which it can publicly report findings and recommendations is the annual report, which will be tabled in the ACT Legislative Assembly.

Regular meetings with the Minister for Community Services have been established and will continue to ensure that the government is kept informed about the Committee's findings and recommendations for addressing preventable deaths and enhancing service provision to this age group.

In the future, the Committee may also be able to recommend useful research that will provide important information about child deaths.

Ensuring privacy and confidentiality for families

The Committee has prioritised the ongoing challenge of honouring the right to privacy of all children and their families cited in this report and the need to find ways to report sensitive and distressing information about the deaths of children and young people. The size of the ACT and the small numbers of children who die underscore the importance of this issue.

Over the next 12 months, the Committee will continue to consider how best to communicate what it is learning about the implications for government policy and service provision. The Committee will strive to draw evidence-based conclusions founded on a holistic picture of the circumstances surrounding the children and young people at the time they died.

Establishment of the register

The establishment of the Committee's register is of paramount importance, as it will contain the information on which the Committee will base its reviewing work. Finalisation of memoranda of understanding with relevant agencies included in the legislation will be critical in gathering information about the circumstances of the deaths of children and young people in the ACT. The Committee will also endeavour to have access to the National Coronial Information System (NCIS) as this is an important source of information in undertaking reviews of children and young people.

In particular, the Committee is keen to access information from clinical case reviews relating to individual children and young people who have died. In some instances these children will also have been known to Care and Protection Services. In requesting potentially sensitive and confidential information, the Committee acknowledges the need to resolve how various pieces of legislation relating to sharing information, under which certain government departments and organisations operate, can be reconciled.

During the next 12 months, the Committee will determine the best way to code the data about cause of death and will be mindful of the importance of being able to access and utilise comparable national and international data.

Arrangements with other jurisdictions regarding deaths of ACT children and young people

The Committee is required to keep a register of the deaths that occur outside the ACT of children and young people who normally live in the ACT (Section 727N (1) (b)). At present, there are no legislative provisions for other jurisdictions to provide the Committee with this information. The Committee proposes to contact registries of births, deaths and marriages in other states and the Northern Territory with the view to developing an agreement to receive information on the deaths of ACT children and young people in their jurisdictions.

Report on the deaths of children and young people in the ACT 1 January 2004–17 September 2011

In accordance with the Act, the Committee is required to report on the deaths of children and young people in the ACT for the period from 1 January 2004 to 17 September 2011 (Section 727U). The Committee is required to provide the report to the Minister for Community Services within the next six years (Section 727U (4)). The Committee is treating this work as a priority as it believes it is important to examine if any trends or patterns concerning the deaths of children or young people are evident. If any trends are demonstrated, the legislation empowers the Committee to consider possible recommendations about legislation, policies, practices and services to reduce or prevent further deaths occurring (Section 727B (e)).

Working arrangements for undertaking reviews

The Committee considered several options to provide a support structure for their review function and decided that a two-tiered approach, using Community Services Directorate personnel to gather information and to prepare initial reports and case synopses, would be the most suitable way to support the Committee's review work.

This two-tiered approach will require the recruitment of a senior reviewer to undertake the initial case reports and will necessitate additional funding, as the position was not included in the original budget measures. The Minister has accepted the Committee's recommendation in principle and it has been referred to the Community Services Directorate for advice as to how the position can be recruited.

Once a reviewer is appointed the Committee will seek to contribute to the formalising of a review approach, methodology and theoretical framework for the work.

Communication strategy

It is important for members of the community and for government and non-government agencies to learn more about the role and functions of the Committee. The work directed at achieving this will continue over the next 12 months and will include the development of the Committee's website.

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APPENDIX 1 CHILDREN AND YOUNG PEOPLE ACT 2008 CHAPTER 19A CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE

Part 19A.1 Establishment and functions of committee

727A Establishment of committee

The Children and Young People Death Review Committee (the *CYP death review committee*) is established.

727B Functions of committee

1 The CYP death review committee has the following functions:

a to keep a register of deaths of children and young people under part 19A.3;

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;

h any other function given to the committee under this chapter.

2 The CYP death review committee has no function in relation to reviewing the cause of death of a particular child or young person.

727C Committee members

The CYP death review committee is made up of—

a the director-general; and

b the children and young people commissioner; and

c the members appointed by the Minister under section 727D; and

d the chair appointed under section 727E.

727D Appointment of committee members

1 The Minister must appoint at least 8, but not more than 10, members to the CYP death review committee.

Notes (1) For the making of appointments (including acting appointments), see the Legislation Act, pt 19.3.; (2) In particular, a person may be appointed for a particular provision of a law (see Legislation Act, s 7 (3)) and an appointment may be made by naming a person or nominating the occupant of a position (see Legislation Act, s 207); and (3) Certain Ministerial appointments require consultation with an Assembly committee and are disallowable (see Legislation Act, div 19.3.3).

2 The Minister must, unless it is not reasonably practicable, ensure that the committee includes—

a people with experience or expertise in the following:

i psychology;
ii paediatrics;
iii epidemiology;
iv child forensic medicine;
v public health administration;
vi education;
vii engineering and child safety products or systems;
viii working with Aboriginal and Torres Strait Islander children and young people; and

b a social worker with expertise or experience in working with children and young people and families; and

c a police officer with experience in working with children and young people and families.

3 The Minister must not appoint someone to the committee under this section unless satisfied that the person is suitable to be a member of the committee.

4 In considering whether someone is suitable to be a member of the committee, the Minister—

a must consider relevant information mentioned in section 65 (1), definition of suitability information, paragraphs (a), (b) and (c) about the person; and

b may consider other suitability information about the person.

5 The appointment of a member under this section is for not longer than 3 years.

6 The conditions of appointment of a member under this section are the conditions stated in the appointment, subject to any determination under the Remuneration Tribunal Act 1995.

727E Appointment of chair of committee

1 The Minister must appoint someone as the chair of the CYP death review committee.

2 However, the chair must not be someone who is otherwise a member of the CYP death review committee.

3 Also, the Minister must not appoint someone unless satisfied that the person—

a has the expertise or experience to be the chair of the CYP death review committee; and

b is otherwise suitable to be the chair.

4 In considering whether someone is suitable to be a chair of the CYP death review committee, the Minister—

a must consider relevant information mentioned in section 65 (1), definition of suitability information, paragraphs (a), (b) and (c) about the person; and

b may consider other suitability information about the person.

5 The appointment of the chair is for not longer than 3 years.

6 The conditions of appointment of the chair are the conditions stated in the appointment, subject to any determination under the *Remuneration Tribunal Act 1995*.

727F Conflict of interest

A member of the CYP death review committee must take all reasonable steps to avoid being placed in a position where a conflict of interest arises during the exercise of the committee's functions.

727G Appointment of advisers

1 The Minister may, on the request of the CYP death review committee, appoint a person as an adviser to the committee.

Note 1 For the making of appointments (including acting appointments), see the Legislation Act, pt 19.3.

Note 2 In particular, a person may be appointed for a particular provision of a law (see Legislation Act, s 7 (3)) and an appointment may be made by naming a person or nominating the occupant of a position (see Legislation Act, s 207).

Note 3 Certain Ministerial appointments require consultation with an Assembly committee and are disallowable (see Legislation Act, div 19.3.3).

2 However, the Minister must not appoint someone unless satisfied that the person has the experience or expertise to exercise the functions of an adviser.

3 An appointment may be subject to conditions stated in the appointment.

4 An adviser must, on request of the CYP death review committee, provide advice to the committee in relation to the committee's functions and otherwise in accordance with any conditions of appointment.

5 The Minister may end the appointment of an adviser if the adviser breaches a condition of appointment.

727H Ending member appointments

The Minister may end the appointment of a member of the CYP death review committee appointed under section 727D or the chair—

a for misbehaviour; or

b if the member is convicted, or found guilty, in Australia of an indictable offence; or

c if the member is convicted, or found guilty, outside Australia of an offence that, if it had been committed in the ACT, would be an indictable offence; or

d if the member is absent from 3 consecutive meetings of the committee, otherwise than on approved leave; or

e for physical or mental incapacity, if the incapacity substantially affects the exercise of the member's functions.

Note *A person's appointment also ends if the person resigns (see Legislation Act, s 210).*

727I Arrangements for staff

1 The director-general must, on request of the CYP death review committee, make arrangements with the committee to use public servants in the administrative unit under the director-general's control.

Note *The director-general means the director-general of the administrative unit responsible for this section (see Legislation Act, s 163 (References to a director-general or the director-general)). Administrative units are established under the administrative arrangements (see Public Sector Management Act 1994, s 13).*

2 The *Public Sector Management Act 1994* applies to the management by the committee of public servants who are the subject of an arrangement under subsection (1).

Part 19A.2 Meetings of committee

727J Meetings

1 The CYP death review committee must meet at least once each year.

2 The chair must give the committee at least 14 days written notice of a meeting.

727K Presiding member at meetings

The chair presides at all meetings of the CYP death review committee.

727L Quorum at meetings

1 Business may be carried on at a meeting of the CYP death review committee only if at least $^{2}/_{3}$ of the members (other than the chair) are present.

2 A member must not be represented at a meeting by anyone else.

727M Voting at meetings

1 At a meeting of the CYP death review committee, each member, other than the chair, has a vote on each question to be decided.

2 A question is decided by a majority of the votes of the members present and voting.

3 Despite subsection (1), if the votes are equal, the chair has a deciding vote.

Part 19A.3 Register of deaths of children and young people

727N Children and young people deaths register

1 The CYP death review committee must keep a register (the children and young people deaths register) of—

a the deaths of children and young people that occur in the ACT; and

b the deaths that occur outside the ACT of children and young people who normally live in the ACT.

Note *Information in the register is protected information (see ch 25).*

2 The register must include the following information in relation to the death of a child or young person that is available to the CYP death review committee:

a the cause of the death of the child or young person;

b the age and sex of the child or young person;

c whether the child or young person is Aboriginal or a Torres Strait Islander;

d whether, within 3 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 section 360 (5), was a child protection report;

e anything else prescribed by regulation.

3 The register may contain—

a any other demographic data available to the CYP death review committee; and

b any information about a child or young person, or the circumstances of the child or young person's death, that the committee considers relevant to exercise its reporting functions under part 19A.4; and

c anything else the committee considers relevant.

4 If the death of a child or young person is subject to a coronial inquest or review by the Territory, the CYP death review committee must not include any information on the register about the cause or circumstances of the death until the coronial inquest or review has ended.

Examples—review by Territory

- an internal review by the Office for Children, Youth and Family Support
- a joint review by ACT Health and the Office for Children, Youth and Family Support

Note *An example is part of the Act, is not exhaustive and may extend, but does not limit, the meaning of the provision in which it appears (see Legislation Act, s 126 and s 132).*

5 The CYP death review committee—

a must index the deaths on the register according to cause of death and age and sex of the children and young people; and

b may also index the deaths in any other way the committee considers relevant.

6 The CYP death review committee—

a must use its best endeavours to include on the register information about the deaths of children and young people that occurred during the period starting on 1 January 2004 and ending the day before the commencement of this section; and

b may include on the register information about the deaths of children and young people that occurred before 1 January 2004.

7 This subsection and subsection (6) expire 6 years after the day this subsection commences.

727O Obtaining information from certain entities

1 A relevant entity must give the CYP death review committee the following information in relation to the death of a child or young person:

a information required under section 727N (2) to be included on the register;

b other information requested in writing by the committee that the committee considers is necessary to exercise its functions.

2 Information mentioned in subsection (1) (a) must be given within 3 months after the death of the child or young person.

3 Information mentioned in subsection (1) (b) must be given as soon as practicable after the request is made.

4 However, information mentioned in section 727N (4) must be given as soon as practicable after the end of the inquest or review.

5 A relevant entity is only required to give information under this section that is within the knowledge of the entity because of the exercise of its functions.

6 In this section:

relevant entity means each of the following:

a the chief police officer;

b the registrar-general;

c the Coroner's Court;

d the director-general responsible for administering this Act, chapter 10;

e the director-general responsible for administering the *Education Act 2004*, chapter 2;

f the director-general responsible for administering the *Health Act 1993*, part 3;

g a licensed proprietor of a childcare service;

h an entity prescribed by regulation.

727P Exchanging information with corresponding interstate entities

The CYP death review committee may enter into an agreement with an entity who exercises a function under a law of a State, that corresponds or substantially corresponds to a function of the committee, to exchange information relevant to the function.

727Q Power to ask for information, documents and other things

1 This section applies if the CYP death review committee believes on reasonable grounds that a person can give information or produce a document or something else that the committee considers necessary to allow it to exercise its functions.

2 The CYP death review committee may, by written notice given to the person, require the person to give the information in writing or produce the document or other thing.

Note *Information given or contained in a document or something else produced is protected information (see ch 25).*

3 However, the CYP death review committee must not require a family member of a child or young person who has died to give information or produce a document or something else in relation to the child or young person.

4 The notice must state how, and the time within which, the person must comply with the requirement.

5 A person commits an offence if—

a the person is required by a notice under this section to give information in writing or produce a document or other thing to the CYP death review committee; and

b the person fails to give the information or produce a document or other thing to the committee as required.

Maximum penalty: 50 penalty units.

Note 1 *The Legislation Act, s 170 and s 171 deal with the application of the privilege against self-incrimination and client legal privilege.*

Note 2 *Giving false information is an offence against the Criminal Code, s 338.*

6 Subsection (5) does not apply if the person has a reasonable excuse for failing to give the information or produce the document or other thing to the CYP death review committee as required.

727R Children and young people deaths register—who may have access?

1 The CYP death review committee must ensure that the register is accessed only by the following:

a committee members;

b staff mentioned in section 727I;

c advisers appointed under section 727G;

d someone authorised by the committee to have access to the register.

2 An authorisation is a notifiable instrument.

Note *A notifiable instrument must be notified under the Legislation Act.*

3 The committee must notify a person who can access the register of the person's obligations to deal with information on the register in accordance with the requirements under chapter 25 (Information secrecy and sharing).

Note *Information on the register is protected information (see ch 25).*

Part 19A.4 Annual reports about deaths of children and young people

727S Annual report

1 For each financial year, the CYP death review committee must report to the Minister about the following in relation to the deaths of children and young people included on the children and young people deaths register during the year:

a the number of deaths of children and young people;

b the age and sex of each child or young person who died and whether, within 3 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 section 360 (5), was a child protection report;

c the patterns or trends (if any) identified in relation to the deaths of children and young people—

i generally; and

ii who, within 3 years before their death were, or had a sibling who was, the subject of a report the director-general decided, under section 360 (5), was a child protection report.

Note *There are restrictions on recording and divulging protected and sensitive information (see ch 25).*

2 The CYP death review committee may include in the report—

a its recommendations (if any) 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; and

b information about the implementation of any previous recommendations of the committee; and

c any other matter it considers relevant.

3 However, the CYP death review committee must not include in the report any information that would—

a disclose the identity of a child or young person who has died; or

b allow the identity of a child or young person who has died to be worked out.

4 The CYP death review committee must give the Minister the report within 4 months after the end of the financial year.

5 The Minister must present the report in the Legislative Assembly within 6 sitting days after the day the report is given to the Minister.

727T Other reports

1 The CYP death review committee may at any time prepare a report for the Minister on any matter arising in connection with the exercise of the committee's functions.

2 The CYP death review committee must not include in the report any information that would—

a disclose the identity of a child or young person who has died; or

b allow the identity of a child or young person who has died to be worked out.

3 The Minister must present the report to the Legislative Assembly within 6 sitting days after the report is given to the Minister.

4 Within 3 months after receiving a report under subsection (1), the Minister must give information to the CYP death review committee about any action the Minister has taken, or will take, in relation to the matters raised in the report.

727U Reporting on deaths of children and young people before the commencement of ch 19A

1 For the period starting on 1 January 2004 and ending the day before the commencement of this chapter, the CYP death review committee must use its best endeavours to report about the following in relation to the deaths of children and young people included on the register for that period:

a the number of deaths of children and young people;

b the age and sex of each child or young person who died and whether, within 3 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 section 360 (5), was a child protection report;

c the patterns or trends (if any) identified in relation to the deaths of children and young people—

i generally; and

ii who, within 3 years before their death were, or had a sibling who was, the subject of a report the director-general decided, under section 360 (5), was a child protection report.

Note *There are restrictions on recording and divulging protected and sensitive information (see ch 25).*

2 The CYP death review committee may include in the report—

a its recommendations (if any) 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; and

b any other matter it considers relevant.

3 However, the CYP death review committee must not include in the report any information that would—

a disclose the identity of a child or young person who has died; or

b allow the identity of a child or young person who has died to be worked out.

4 The CYP death review committee must give the Minister the report within 6 years after the day this section commences.

5 The Minister must present the report in the Legislative Assembly within 6 sitting days after the day the report is given to the Minister.

6 This section expires 6 years after the day it commences.

ACT Children & Young People
Death Review Committee