ACT Children & Young People Death Review Committee

Child Deaths in the ACT 2016–2020

This fact sheet is a summary of key information from the Committee's Annual Report 2020.

Between 2016 and 2020, 127 ACT resident children aged 0 to 17 were recorded in the ACT Child Death Register. Due to ongoing coronial proceedings, 10 of these deaths were not reported on in the annual report.

Over the five-year period, the average number of deaths of ACT resident children was 25 per year and the age-specific mortality rate was relatively stable from year to year.

Age is a key predictor of mortality risk

As shown in Table 1, a higher number of deaths occurred in the early years and in adolescence.

Table 1: ACT resident children who died in 2016–2020*

	Number	Per cent
Total		
Persons 0–17 years of age	117	
Sex		
Female	59	51
Male	58	49
Age		
< 28 days	60	51
28–365 days	13	11
1–4 years	10	9
5–9 years	5	4
10–14 years	13	11
15–17 years	16	14

*Not including coronial cases.

Causes of death differ between life stages

As shown in Table 2, medical causes and extreme prematurity were the most frequent causes of death for young children with older children and young people primarily dying from unintentional injuries, accidents or suicide.

Table 2: Cause of death—ACT resident children who died in 2016–2020

	Number	Per cent
Total		
Persons 0–17 years of age	117	
Cause of death		
Medical causes	65	56
Extreme prematurity	30	26
Suicide	10	9
Unintentional injury/accident	6	5

Deaths of vulnerable children and young people in the ACT

Between 2016 and 2020, neonates and infants represented 65% of all deaths, which was consistent with trends from previous years. Most were neonates under 28 days, born preterm.

The next highest number of deaths occurred in the 15 to 17 age group representing 14% of all deaths during the five-year period. Suicide was the leading cause of death for this age group.

Of the children and young people who died during the five-year period, 14% were known to Child and Youth Protection Services (CYPS) with females having a slightly higher representation. A larger group of children (31%) were known to ACT Policing, noting that for the latter, most contact related only to the death incident.

Progress made on previous recommendations

The Committee reported significant progress on most recommendations made, such as improving messaging about safe sleeping, educating staff on child-focused practice and increasing support for families with a history of intergenerational trauma.

The following concerns were noted:

- Lack of progress on pool regulation in the ACT.
- Delayed completion of Emergency Management of Button Battery Ingestion guidelines.
- Further uptake of some recommendations from the Changing the Narrative for Vulnerable Children: Strengthening ACT Systems Report.

The Committee will continue to monitor progress to improve systems and policies to achieve better outcomes for the safety and wellbeing of children and young people in the ACT.

Contact us

If you have comments about this review, the ACT Children and Young People Death Review Committee is keen to receive feedback from interested ACT residents.

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