

**2023**

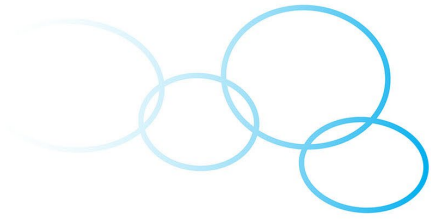
**THE LEGISLATIVE ASSEMBLY FOR THE  
AUSTRALIAN CAPITAL TERRITORY**

**TENTH ASSEMBLY**

**ACT Children and Young People Death Review Committee - Annual Report 2022**

**Presented by  
Rachel Stephen-Smith MLA  
Minister for Families and Community Services  
June 2023**

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ACT Children & Young People  
Death Review Committee

## **Annual Report 2022**

## ABOUT THE ACT CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE

### WHO ARE WE?

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

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

### WHAT DO WE DO?

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

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

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

### WHAT DO WE DO WITH THE INFORMATION ON THE REGISTER?

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

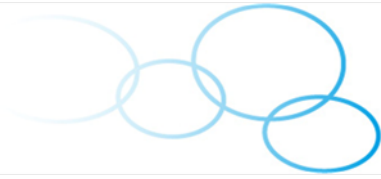
We also issue reports and fact sheets to government, public organisations and the community on various topics to raise awareness regarding child safety or to distribute child death prevention messages.

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

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

### LETTER OF TRANSMISSION

Minister for Families and Community Services  
ACT Legislative Assembly  
London Circuit  
CANBERRA ACT 2601

Dear Minister

As chair of the ACT Children and Young People Death Review Committee, I am pleased to present you with the *Children and Young People Death Review Committee 2022 Annual Report*.

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

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

Yours sincerely

Ms Megan Mitchell, AM  
Chair  
28 April 2023

## FOREWORD

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

I was appointed as the new chair of the Committee in August 2022 for a three-year term. Ms Margaret Carmody, the third chair of the Committee, completed the second and final term of her appointment as established in the ACT Governance Principles. Ms Carmody led the Committee for six years, working towards the Committee's core objective to prevent or reduce the likelihood of the death of children and young people in the ACT.

During her time as Chair, the Committee produced six annual reports and undertook significant specialist pieces of work, including completing the 2018 review into young children known to the child protection system, overseeing the 2021 review of deaths by intentional self-harm, and advocating on several safety issues such as pool safety and the risk of button batteries. The Committee and I extend our gratitude to her for her guidance and stewardship in progressing the Committee's work.

Since my commencement in the role, I have met with key stakeholders in the ACT service system, and I am eager to work to improve policies and systems intended to support children, young people and their families and to ensure they are effective in preventing harm. The Committee has undertaken several individual reviews in 2022 which demonstrate, in particular, ongoing challenges in relation to sharing information when there are known risks in a child or young person's life. It is envisaged this will be a priority focus of the Committee in 2023.

Finally, I would like to thank the secretariat and members of the Committee, who have done an outstanding job in preparing this report and in drawing out the key messages from the data. I would also like to extend our sincere condolences to the families, friends and communities who knew and loved the children and young people whose deaths are reported here.

**Ms Megan Mitchell AM**

Chair, ACT Children and Young People Death Review Committee

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## EXECUTIVE SUMMARY

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

In accordance with s. 727S of the Act, this report provides information regarding the deaths of 163 children and young people under the age of 18 years who were included on the Committee's Child and Young Person Deaths Register in the five-year period 2018–2022. Of the 163 deaths across the latest five-year period, 17 are awaiting the findings of a Coroner and are therefore not able to be included in the majority of this report. The remaining 146 deaths on the register include 31 deaths of children and young people who did not normally reside in the ACT.

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

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

**Chapter 3** examines the deaths of all ACT residents (0–17 years old), excluding those children and young people who normally resided interstate or elsewhere. The chapter provides analysis of demographic and individual characteristics.

**Chapter 4** focuses on infant (0–365 days) deaths. It includes ACT and non-ACT resident deaths.

**Chapter 5** focuses on the deaths of ACT resident children and young people (1–17 years old).

**Chapter 6** examines the deaths of ACT resident children and young people (0–17 years old) known to child protection services.

**Chapter 7** examines injury-related deaths on the Committee's register.

**Chapter 8** describes the Committee's activities during 2022 and its continuing work for the next calendar year.

**Chapter 9** details the recommendations made by the Committee since its establishment and the progress of these towards implementation.

**Appendix A** provides the relevant population and data tables.

**Appendix B** describes the methodology used in this report.

**Appendix C** provides copies of advice provided by the relevant directorates in relation to recommendations.



The ACT Children and Young People Death Review Committee is an independent committee established under the *Children and Young People Act 2008* (ACT) (the Act) to review information about the deaths of children and young people in the ACT, identify emerging patterns and undertake research aimed at preventing or reducing the deaths of children. The Committee reports directly to the Minister for Families and Community Services.

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

All previous annual reports and additional reports on identified issues of concern can be found on the Committee's website: [www.childdeathcommittee.act.gov.au](http://www.childdeathcommittee.act.gov.au)

## WHO WE ARE

Since 2012, the Committee has been responsible for reporting to the ACT Legislative Assembly on all deaths of children and young people under the age of 18 years in the ACT. Membership is prescribed by the Act and requires members to have qualifications, experience or expertise in one or more of the following:

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

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

## COMMITTEE MEMBERS 2022

### CHAIR

**Ms Megan Mitchel AM**

**(August 2022 – Current)**

Social policy and strategic human service delivery

**Previous Chair: Ms Margaret Carmody PSM**

**(August 2016 – August 2022)**

Social policy and strategic human service delivery

### DEPUTY CHAIR

**Mr Eric Chalmers AM CF**

Engineering and child safety products or systems

### EX-OFFICIO COMMITTEE MEMBERS

Director-General, Community Services Directorate

**Ms Catherine Rule**

Children and Young People Commissioner

**Ms Jodie Griffiths-Cook**

### COMMITTEE MEMBERS

**Dr Judith Bragg**

Paediatrics

**Ms Barbara Causon**

Working with Aboriginal and/or Torres Strait Islander children and young people

**Dr Amanda Dyson**

Paediatrics and neonatology

**Dr Louise Freebairn**

Epidemiology

**Emeritus Professor Morag McArthur**

Social work and child protection

**Dr Bronwen Phillips**

Epidemiology

**Dr Catherine Sansum**

Child forensic medicine

**Ms Jane Simmons PSM**

Deputy Director-General, Education

**Station Sergeant Dennis Gellatly**

ACT Policing – Officer in Charge, Judicial Operations

Police officer with experience in working with children and young people and families

## OUR FUNCTIONS

The Committee has the following functions:

- a) to keep a register of deaths of children and young people under Part 19A.3 of the Act
- b) to identify patterns and trends in relation to the deaths of children and young people

- c) to undertake research that aims to prevent or reduce the likelihood of the death of children and young people
- d) to identify, by the Committee or another entity, areas requiring further research arising from recognised 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 prevent or reduce the likelihood of the death of children and young people
- f) to monitor the implementation of the Committee's recommendations
- g) to report to the Minister under Part 19A.4 of the Act
- h) to perform any other function given to the Committee.

## ANNUAL REPORT

This annual report covers the period 2018 to 2022. It presents data on the deaths of all children and young people who died in the ACT as well as children and young people who usually reside in the ACT but who died elsewhere.

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

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

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

As in previous years, the Committee has reported the incidence of death over a five-year period. This is mainly due to the small number of deaths that occur in the jurisdiction each year. Conducting and reporting on analyses over a five-year period brings a level of stability to the data, allows for generalisations to the broader population and minimises the risk of identification of any individual. Although greater rigour may be generated through analysing aggregate data, limitations to aggregation are noted, and caution should be exercised when interpreting results.

The annual report presents the Committee's activities during 2022 and outlines the continuing work for 2023. In 2018, the report included, for the first time, a chapter reviewing the progress on the recommendations made since the Committee's establishment. In discussion with the Minister for Families and Community Services, the Committee decided to undertake this activity every two years. This year's annual report provides an update on the progress of Committee recommendations.

## USING THIS REPORT

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

### CORONIAL COUNTS

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

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

The Committee notes that there is an increase in open coronial matters compared to previous annual reports. As of 10 February 2023, there were 17 relevant cases before the Coroner in the ACT and other jurisdictions for the period 2018–2022. This high number of open cases limits the Committee's ability to effectively communicate patterns and trends within the report.

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

### INTERNATIONAL CLASSIFICATION OF DISEASES

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Since the inception of the Children and Young People Death Register, in 2012, reporting on main cause of death or leading cause of death has centred largely on indicative causes, with reference made to the International Classification of Diseases (ICD). The Committee has transitioned to reporting on the ICD framework, in line with World Health Organization standards (WHO, 2016). This report will continue the format adopted in the previous reports and include both the indicative causes of death and the ICD code(s). Version or 'revision' 10 of the ICD codes (ICD-10) are used in this report.

## REPORTING FEWER THAN FIVE CASES

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

## DATE-OF-DEATH REPORTING FOR THE REGISTER

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

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 information reported by the ACT Registrar of Births, Deaths and Marriages and other Australian jurisdictions.

## DATA QUALITY

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

The Child Death Register database continues to be compromised in terms of complexity and reliability. The Committee is currently working with the Office of the Coordinator-General for Family Safety to establish if capabilities could be shared with the yet-to-be-established Family Violence Death Review Committee's data system.

## DATA SOURCES

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Unless otherwise stated, all figures reported in this document are sourced from the ACT Children and Young People Deaths Register. The information in this register is compiled from information sourced from ACT Births, Deaths and Marriages, ACT Coroner's Court, Ombudsman Western Australia, South Australia Child

Death and Serious Injury Review Committee, Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity, NSW Ombudsman, Tasmanian Council of Obstetric and Paediatric Mortality and Morbidity, Northern Territory Office of the Coroner, Queensland Family and Child Commission and the National Coronial Information System. The Committee also has provisions to exchange data with Child Youth and Families, ACT Policing, Emergency Services Agency and the Federal Circuit and Family Court of Australia.

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

## TIME PERIODS

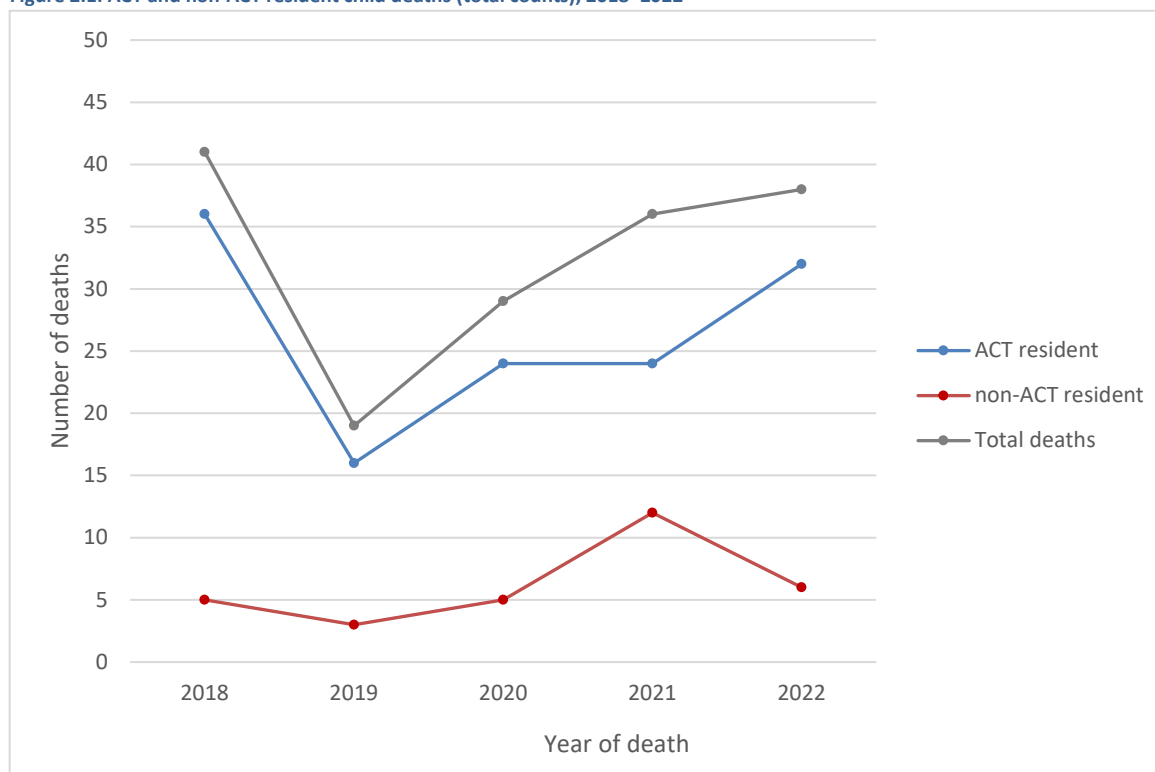
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The Committee uses counts aggregated over five years due to the relatively small number of children and young people deaths in the ACT. In this year's annual report, the Committee has also used fifteen-year aggregations for total death counts of infants and children and young people, to better identify patterns and trends.

## CHAPTER 2 OVERVIEW OF ALL ACT DEATHS

This section describes the overall incidence of mortality among children and young people in the ACT. Figure 2.1 provides a summary of all deaths on the ACT Children and Young People Death Register for the five-year period 2018 to 2022 and includes open coronial matters.

Figure 2.1: ACT and non-ACT resident child deaths (total counts), 2018–2022



Includes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of non-ACT residents occurred in the ACT.

All deaths of ACT residents occurred either in the ACT or elsewhere.

In total, 163 children and young people died in the five-year period 2018–2022. Of these, 132 were children and young people who normally resided in the ACT and 31 usually resided interstate.

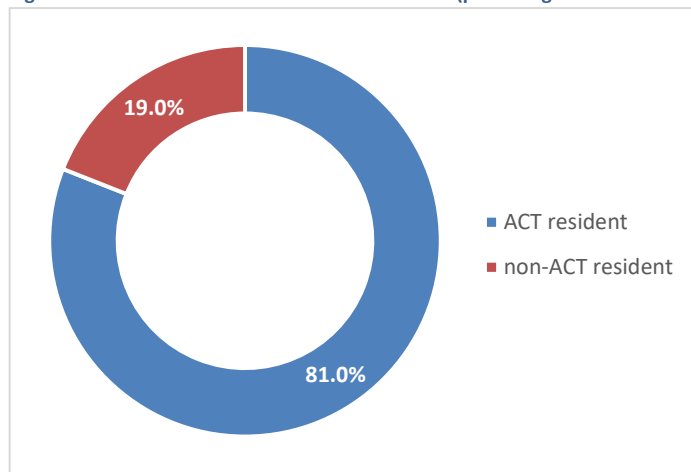
Of the 132 ACT residents who died, 21 of these deaths occurred elsewhere.

As of 10 February 2023, there were 17 cases relating to these deaths before the Coroner in the ACT and other jurisdictions.

### ACT RESIDENTS AND NON-RESIDENTS

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

**Figure 2.2: ACT and non-ACT resident child deaths (percentage of total deaths), 2018–2022**



Regarding all deaths over the five-year period 2018–2022, 19.0% of all registered deaths of children and young people on the Committee’s register were not residents of the ACT (Figure 2.2).

The 31 interstate resident deaths on the ACT Children and Young People Deaths Register (Child Death Register) were all NSW residents.

Includes open coronial cases.

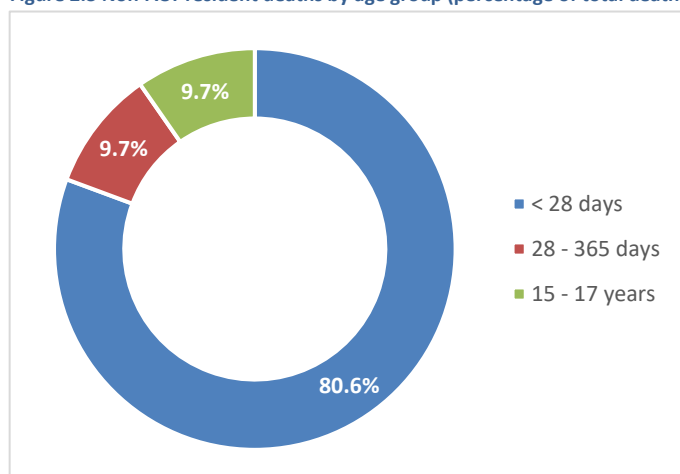
Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of non-ACT residents occurred in the ACT.

All deaths of ACT residents occurred either in the ACT or elsewhere.

## DISTRIBUTION OF NON-RESIDENT CHILD DEATHS IN THE ACT

**Figure 2.3 Non-ACT resident deaths by age group (percentage of total deaths), 2018–2022**



Over the five-year period 2018–2022, 80.6% of all non-resident deaths were infants aged under 28 days (Figure 2.3).

Including infants aged 28–365 days, 90.3% of all non-ACT resident deaths in the territory were infants under one year of age.

There were no non-resident deaths for the age groups 1–4 and 5–9 years of age recorded over the five-year period.

Includes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of non-ACT residents occurred in the ACT.

The Committee has considered interstate resident deaths over a fifteen-year period (2008–2022) to investigate where these deaths originate. In the fifteen years to 2022, 25% of registered deaths in the ACT were non-resident children and young people. More than one-quarter (27.4%) were children and young people who resided in communities within the local vicinity of the ACT, including Queanbeyan, Jerrabomberra, Googong and Gundaroo (Figure 2.4). For almost all deaths of children and young people who were not residents of the ACT, The Canberra Hospital was the nearest principal referral hospital. These principal referral hospitals are offering a range of highly specialised service units and are generally located in major cities (AIHW, 2015).



Figure 2.4 Distribution of non-resident deaths, 2008–2022



Includes open coronial cases.

Deaths include ages 0–17 years in the 2008–2022 period.

All deaths of non-ACT residents occurred in the ACT.

Almost 85% of non-ACT resident children and young people who died in the ACT between 2008 and 2022 were under one year of age (compared to approximately 70% of all children and young people who died in the ACT in the 15-year period 2008–2022).

Around 77% of non-resident children and young people who died in the ACT between 2008 and 2022 were under the age of 28 days, compared to almost 56% of all children and young people who died in the ACT in the same period.

Non-ACT resident children and young people who have died in the ACT are likely to have sought specialist medical services in Canberra that are unavailable in smaller regional hospitals. The differing age profile of non-ACT residents compared to all deaths on the register over the period, 2008–2022 indicates that this likely includes the Neonatal Intensive Care Unit and other infant specialist medical services. The analysis of infant deaths in Chapter 4 will consider both residents and non-residents of the ACT to capture the true pressures on the ACT health system.

This chapter examines the registered deaths of ACT residents (0–17 years of age) that occurred in the ACT or interstate in the last five years (that is, excluding the interstate residents who were included in Chapter 2). Table 3.1 provides the numbers of deaths considered in this chapter.

Table 3.1: Deaths of children and young people in the ACT, 2018–2022

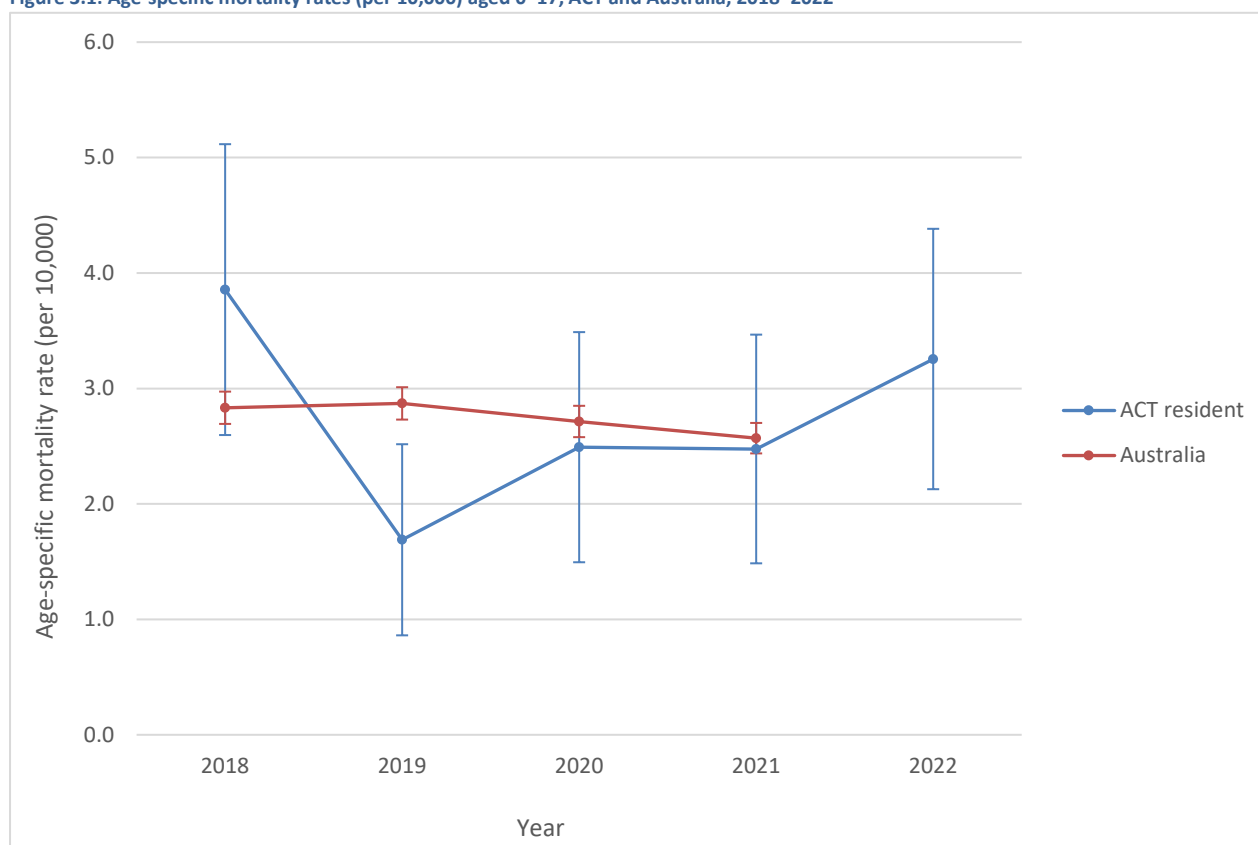
Deaths <sup>a</sup>	Number
Total ACT resident deaths	132
ACT residents who died elsewhere	21
Open coronial cases	15

<sup>a</sup> Coronial cases appear in more than one category.

Includes only ACT residents aged 0–17 years who died in the ACT or elsewhere.

Figure 3.1 shows the age-specific mortality rate for the ACT and Australia across the reporting period 2018–2022. The ACT annual mortality rate for children and young people fluctuates, ranging from a low of 1.7 deaths per 10,000 population in 2019 to a high of 3.9 in 2018.

Figure 3.1: Age-specific mortality rates (per 10,000) aged 0–17, ACT and Australia, 2018–2022



Includes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Data Sources— <https://explore.data.abs.gov.au/> (Quarterly Population Estimates (ERP), by State/Territory, Sex and Age)

—Australian Bureau of Statistics (2021), [Deaths, Australia](#), (number of deaths by age in Australia, currently available to 2021 only).

The annual figure for the age-specific mortality rate should be interpreted with caution, as statistical fluctuations are known to occur with small numbers. The Committee will continue to monitor trends over time. The mean age-specific mortality rate for the five-year period 2018–2022 was 2.8 deaths per 10,000 ACT children aged under 18 years, similar to the rate for the whole of Australia (Figure 3.1).

In total, 111 ACT residents under the age of 18 years died in the ACT and 21 ACT residents died elsewhere in the 2018–2022 period.

The following discussion relates to the 117 **children and young people** normally **resident in the ACT** who died in the last five years and **excludes** deaths of ACT residents before the Coroner as of 10 February 2023.

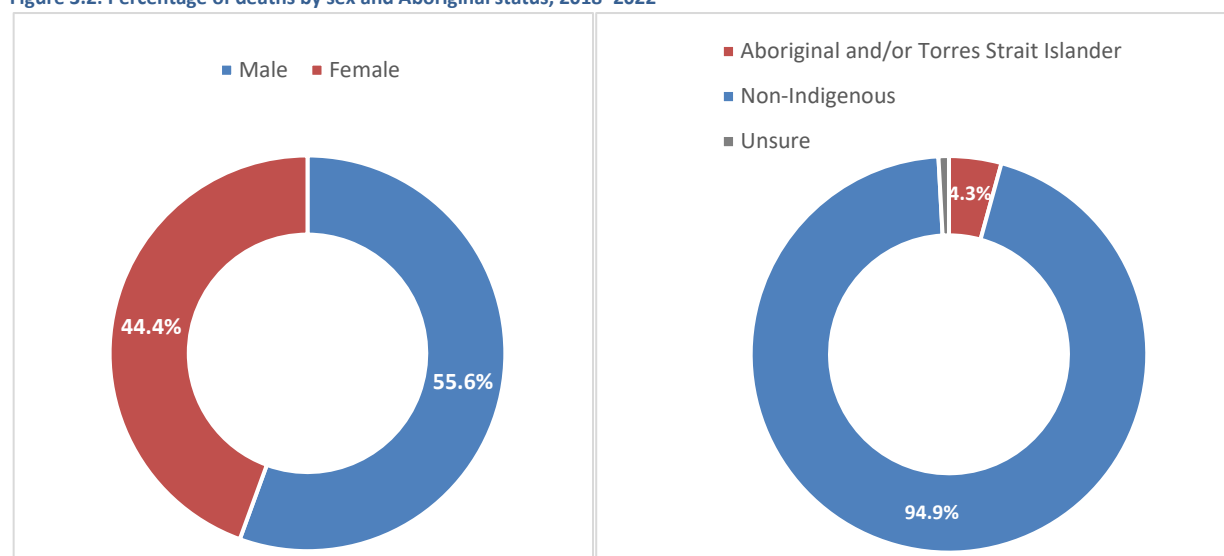
## CHARACTERISTICS OF CHILDREN AND YOUNG PEOPLE WHO DIED

Examination of demographic and individual characteristics for **ACT resident** children and young people who died between 2018 and 2022 allows comparisons between groups and identification of trends within the total population. Examined here are sex, age and cause of death.

In the five years 2018–2022, 55.6% percent of recorded ACT resident deaths under the age of 18 years were male (Figure 3.2). In 2022, 69.7% of deaths were male. The 2022 figure is considered a statistical fluctuation due to small numbers. The Committee will continue to monitor this over time.

Of the total ACT resident deaths in the 2018–2022 period, 4.3% were Aboriginal and/or Torres Strait Islander children or young people. This figure should be interpreted with caution due to small numbers and should not be compared to any other data. Demographic characteristics of the ACT Aboriginal and/or Torres Strait Islander population differ from the national Aboriginal and/or Torres Strait population, the non-Indigenous ACT population and the non-Indigenous Australian population. Therefore, comparisons and/or inferences cannot be made.

Figure 3.2: Percentage of deaths by sex and Aboriginal status, 2018–2022



Excludes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

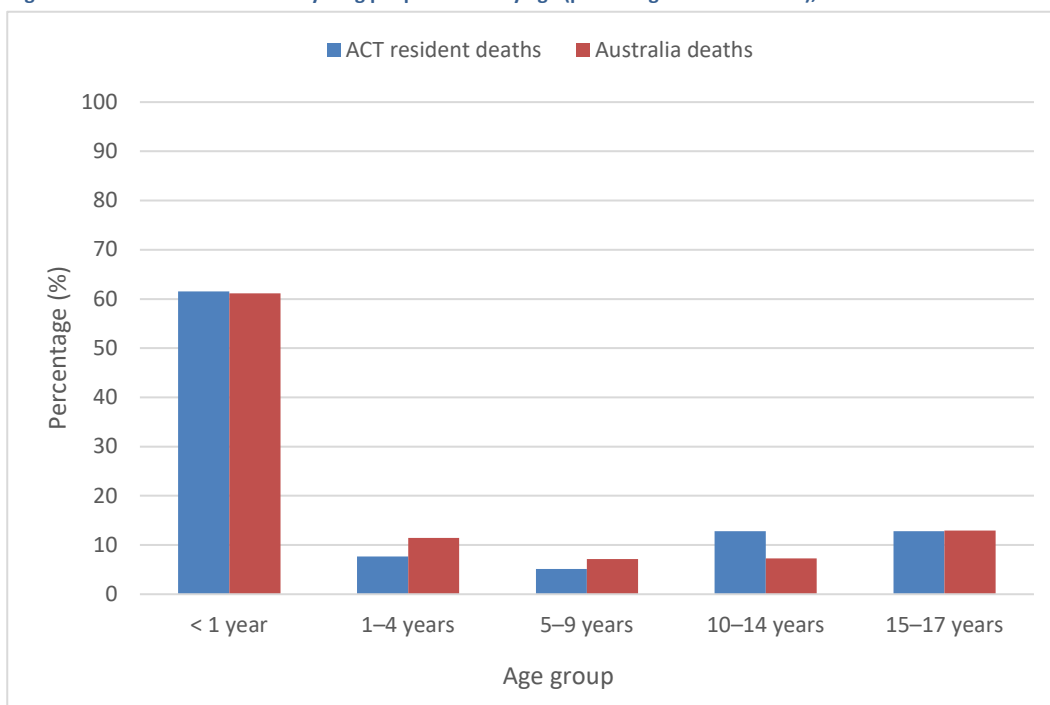
0.9% of ACT resident deaths were registered as unsure of Aboriginal status.

Age is a consistent predictor of mortality risk. Figure 3.3 shows a higher number of deaths occurring in the early years followed by a reduction through primary years, with an increase again in adolescence and late teens.

By far the greatest mortality risk is in infants aged less than 28 days (known as a neonatal death), accounting for nearly half (47.9%) of all ACT resident deaths. All deaths under one year of age account for more than

60% of all ACT resident deaths under 18 years of age. This is consistent with the percentages of deaths registered in these age groups for all of Australia (Figure 3.3).

Figure 3.3: ACT resident child and young people deaths by age (percentage of total deaths), 2018–2022



Excludes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

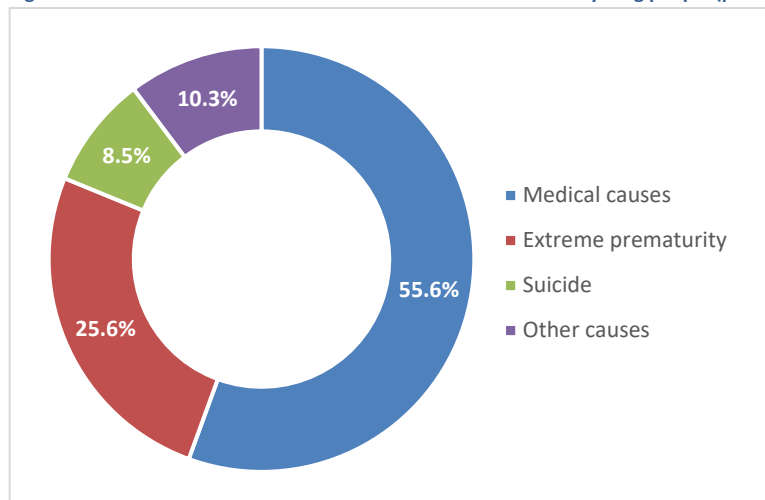
Data source for Australia deaths—Australian Bureau of Statistics (2021), [Deaths, Australia](#), (currently available to 2021 only).

The small numbers of deaths in the ACT compared to national totals limits the ability to draw direct comparisons. The Committee will continue to monitor deaths by age group and provide any relevant commentary in subsequent annual reports.

## CAUSE OF DEATH

Figure 3.4 presents the causes of all deaths for the five-year period 2018–2022. The cause of death provided includes both indicative causes and those categories outlined in the International Classification of Diseases, Tenth Revision (ICD-10). A full list of tables relating to cause of death can be found in appendix A.

**Figure 3.4: Indicative cause of death of ACT resident children and young people (percentage of total deaths), 2018–2022**



Medical causes accounted for more than half (56.4%) of all ACT resident deaths under 18 years of age, and deaths attributed to extreme prematurity accounted for an additional 25.6% of all deaths.

Suicide was the third-most common indicative cause of death, accounting for 8.5% of all ACT resident deaths under 18 years of age.

Excludes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

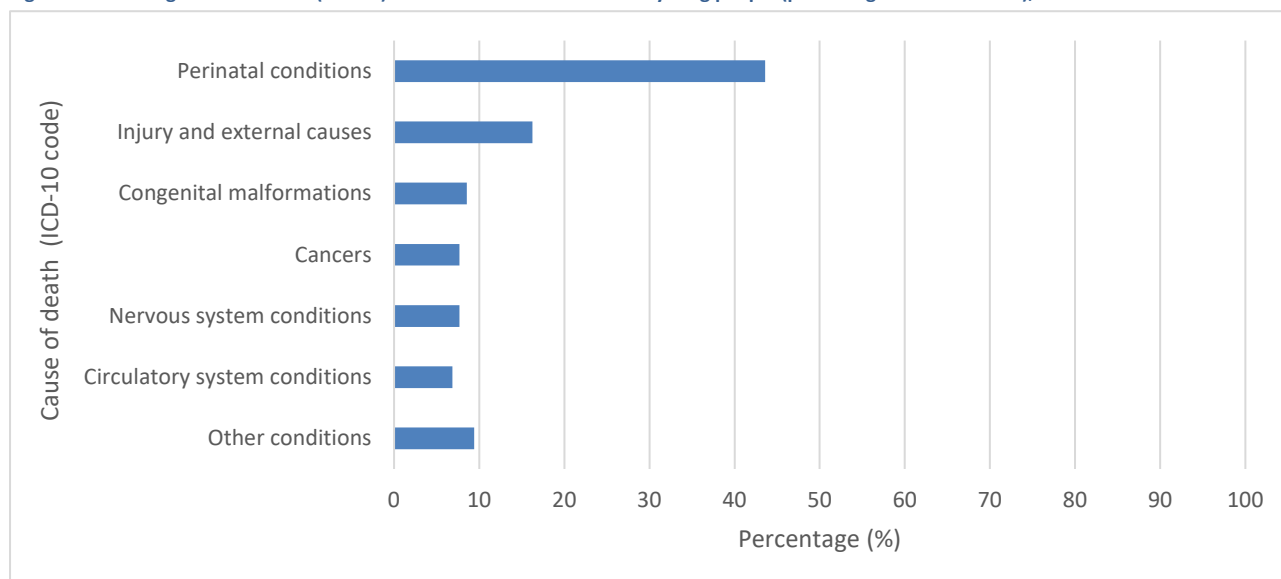
Other causes include fatal assault, transport, unascertained, drowning, SIDS and undetermined and unintentional injury/accident.

A neonatal death is one that occurs in a baby born at any gestational age with signs of life and within the first 28 completed days of life. Some neonatal deaths occur in babies who are born before they are mature enough to survive outside the womb, even with intensive care support. These deaths are coded as extreme prematurity in the Committee's data set. The gestational age of viability at which babies could be offered intensive care support in the ACT is 23 completed weeks of pregnancy. Unfortunately, despite receiving medical care, some babies die each year because of complications of extreme prematurity or other medical conditions. The proportion of babies in this group has not changed significantly from previous years.

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

More than two in five (43.6%) ACT resident deaths under the age of 18 years were due to conditions originating in the perinatal period (Figure 3.5).

Figure 3.5: Leading cause of death (ICD-10) for ACT resident children and young people (percentage of total deaths), 2018–2022



Excludes open coronial cases.

Deaths include ages 0–17 years in the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Injury and external causes includes deaths due to assault, transport accidents, unintentional injury and intentional self-harm (suicide).

Other conditions include diseases of the respiratory system, endocrine, nutritional and metabolic diseases, and symptoms, signs and other abnormal clinical findings not elsewhere defined.

Deaths by injury and external causes, which accounted for 16.2% of all registered deaths under 18 years of age, included deaths due to assault, transport accidents, unintentional injury and suicide, and these were more prominent in older children and young people. Deaths attributed to cancers, diseases of the nervous system and congenital malformations each represented approximately 8% of the total deaths and were distributed across all age groups.

This section looks at mortality among infants (0–365 days of age) in the ACT, with a focus on neonatal (under 28 days) deaths. As previously discussed, health services in the ACT provide care for high-risk pregnancies in the surrounding geographical regions and area often the closest Neonatal Intensive Care Unit available to people in the NSW surrounding regions. This section of the report considers all deaths of infants (see Table 4.1) including interstate resident deaths in the ACT. The Committee has considered infant mortality rate over a fifteen-year period to review possible trends over a longer time period.

**Table 4.1: Breakdown of infant deaths, 2018–2022**

Deaths	Number	Per cent
<b>Total <sup>a</sup></b>	<b>105</b>	
ACT residents who died in the ACT	67	63.8
ACT residents who died elsewhere	10	9.5
Interstate residents who died in the ACT	28	26.7
Cases before the Coroner	5	4.8

<sup>a</sup> These figures do not sum due to coronial cases appearing in categories.

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

The Committee works closely with the ACT Maternal and Perinatal Mortality Committee to review the causes of death that occur in the perinatal period. While the analyses in this report examine the numbers of deaths within this cohort, more detailed analyses are available through the reports of the ACT Maternal and Perinatal Mortality Committee, which can be found on the ACT Health website:  
<https://health.act.gov.au/about-our-health-system/data-and-publications>

There are four hospitals (two public and two private) in the ACT that provide maternity services to ACT residents and residents of the surrounding regions of NSW. Women in surrounding areas are often referred to the Centenary Hospital for Women and Children, Canberra Hospital, for tertiary-level maternal and neonatal care for high-risk pregnancies and births. Rates of neonatal deaths in the ACT are higher than those of ACT residents alone due to ACT hospitals providing supports to more high-risk pregnancies from surrounding areas.

For the purposes of the ACT Children and Young People Death Review Committee, a child is a person who has been born alive, which means the child must be living outside its mother’s body by virtue of the functioning of its own organs and indicated by breathing, beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. The term ‘a child born alive’ does not include stillbirths or other foetal deaths.

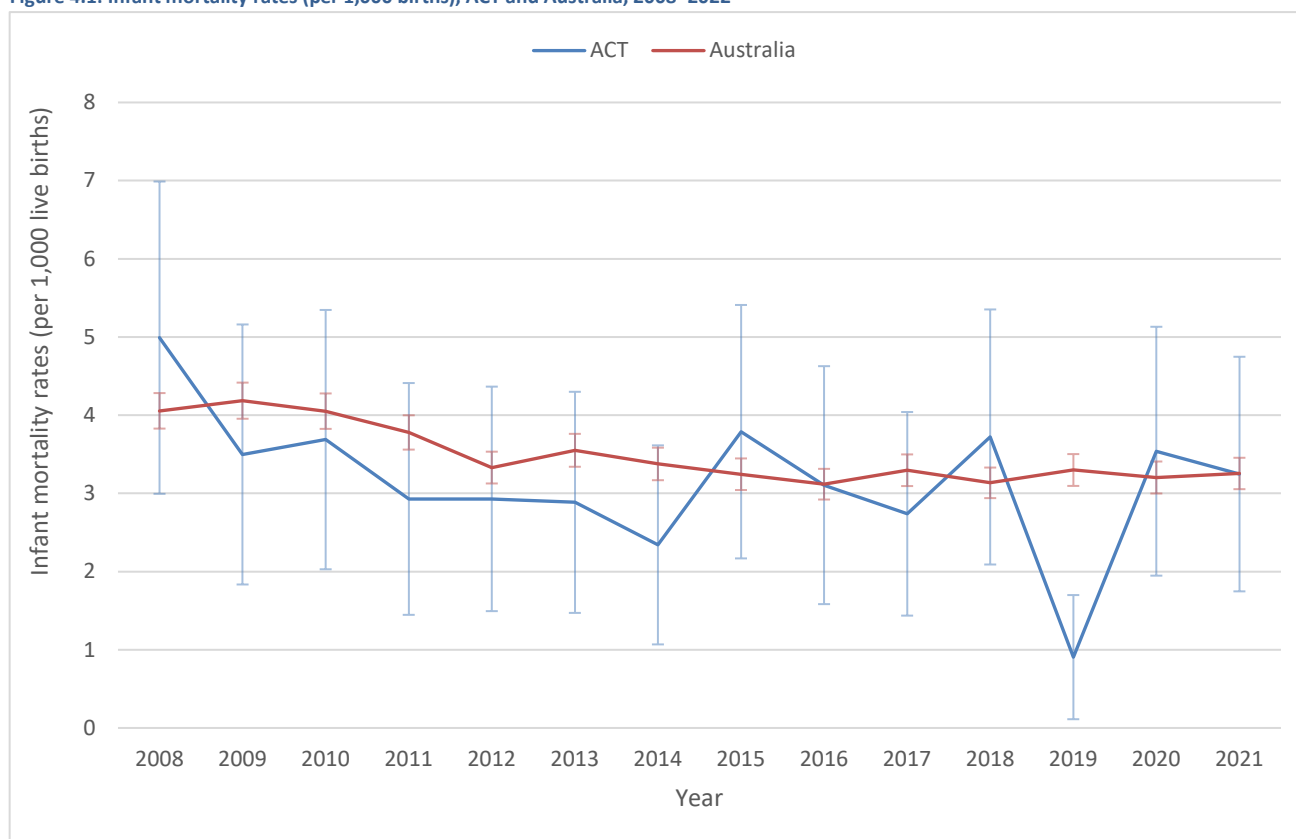
Several late terminations of pregnancy (termination at 20 weeks gestation or more) for severe and lethal congenital abnormalities and other medical conditions are included in the Committee’s data collection.

The following discussion provides figures for either ACT residents only, in the case of infant mortality rates, or ACT and non-ACT resident deaths to capture the overall mortality in the ACT health system.

Over the 15-year period 2008–2022, the infant mortality rate fluctuated between a high of 6.7 per 1,000 live births in 2008 to a low of 1.3 in 2019 (Figure 4.1). The national rate remained more consistent, with a slow

lowering from 4.1 per 1,000 live births in 2008 to 2.8 in 2021. The year-on-year fluctuations within the ACT are considered to be statistically consistent with small jurisdictions producing small counts.

Figure 4.1: Infant mortality rates (per 1,000 births), ACT and Australia, 2008–2022



Excludes open coronial cases.

Deaths include ages less than 365 days over the 2008–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Infant mortality rates are the number of deaths of infants aged <365 days, per 1,000 live births, in the ACT or in Australia in the year specified.

Data Sources— [https://explore.data.abs.gov.au/Births\\_summary\\_by\\_state](https://explore.data.abs.gov.au/Births_summary_by_state)

—Australian Bureau of Statistics (2021), [Deaths, Australia](#), (number of deaths by age in Australia, currently available to 2021 only).

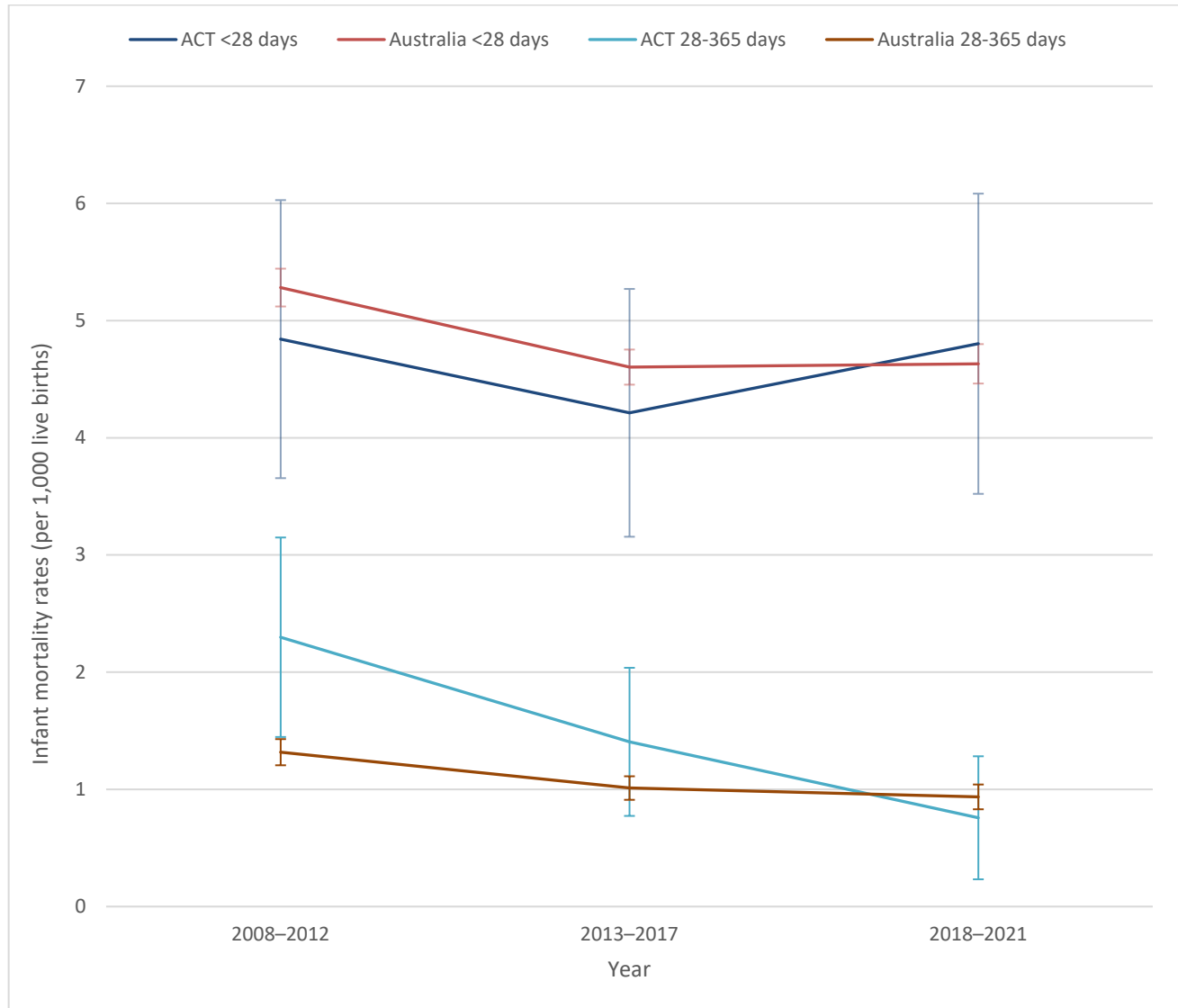
The number of interstate resident deaths in this age group also fluctuated with a high in 2021 around five to six times that of previous years and included a significant increase of Aboriginal and/or Torres Strait Islander neonatal deaths. Interstate movement was heavily impacted in 2020 and 2021 due to the Covid19 pandemic-related lockdowns which affected access to timely medical treatment for much of the Australian population.

In this chapter, 15-year aggregated data has been used when considering age-specific mortality rates. The use of data over a 15-year period better allows for the identification of patterns and trends in mortality within the ACT and enhances the ability to compare those trends with national rates.



Figure 4.2 shows 15-year mortality rates for infants in the ACT and Australia. Over the 10-year period 2008–2017, the mortality rates for ACT resident neonate (<28 days of age) deaths remained consistent with the Australian average. For the five-year period 2018–2022, the ACT mortality rate is slightly higher. During the 15-year period there has been a decline in the mortality rate for ACT resident infants aged 28–365 days, from 1.4 deaths per 1,000 live births to 0.8. The Committee is interested in both these trends and will continue to monitor them over time.

**Figure 4.2: Neonate and infant mortality rates (per 1,000 births), ACT and Australia, 2008 – 2022**



Excludes open coronial cases.

Deaths include ages less than 365 days over the 2008–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Infant mortality rates are the number of deaths of infants aged <365 days, per 1,000 live births, in the ACT or in Australia in the year specified.

Data Sources— [https://explore.data.abs.gov.au/Births\\_summary\\_by\\_state](https://explore.data.abs.gov.au/Births_summary_by_state)

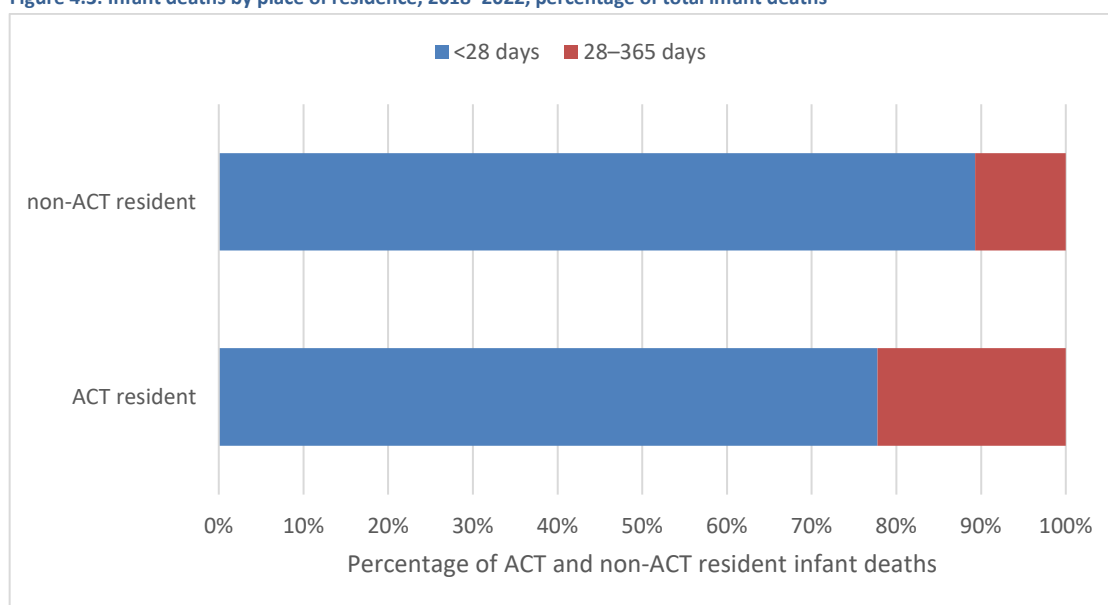
—Australian Bureau of Statistics (2021), [Deaths, Australia](#), (number of deaths by age in Australia, currently available to 2021 only)

## CHARACTERISTICS OF INFANTS WHO DIED

The following discussion focuses on demographic and individual characteristics of infants who died in the five-year period 2018–2022. Examined here are age, sex and cause of death.

The following discussion relates to the **100 infants** who were either ACT residents (who died in the ACT or NSW) or non-ACT residents who died in the ACT in the last 5 years and **excludes** open coronial matters. This section provides figures for both ACT and non-ACT resident deaths to capture overall mortality.

Figure 4.3: Infant deaths by place of residence, 2018–2022, percentage of total infant deaths



Excludes open coronial cases.

Deaths include ages less than 28 days or between 28 and 365 days for the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

All deaths of non-ACT residents occurred in the ACT only.

Over the five years to 2022, 81% of infant deaths on the Committee’s death register occurred during the neonatal period. Of these neonatal deaths, most deaths occurred within the first 7 days of life. There is a higher percentage of neonatal deaths for non-ACT resident deaths than ACT resident deaths (Figure 4.3). This is likely due to clinical referral pathways for high-risk pregnancies from surrounding regions of NSW.

Between 2018 and 2022, there is an even distribution between males and females in neonatal deaths. For infants aged 28 to 365 days, most of the deaths (79%) were in males.

## CAUSE OF DEATH

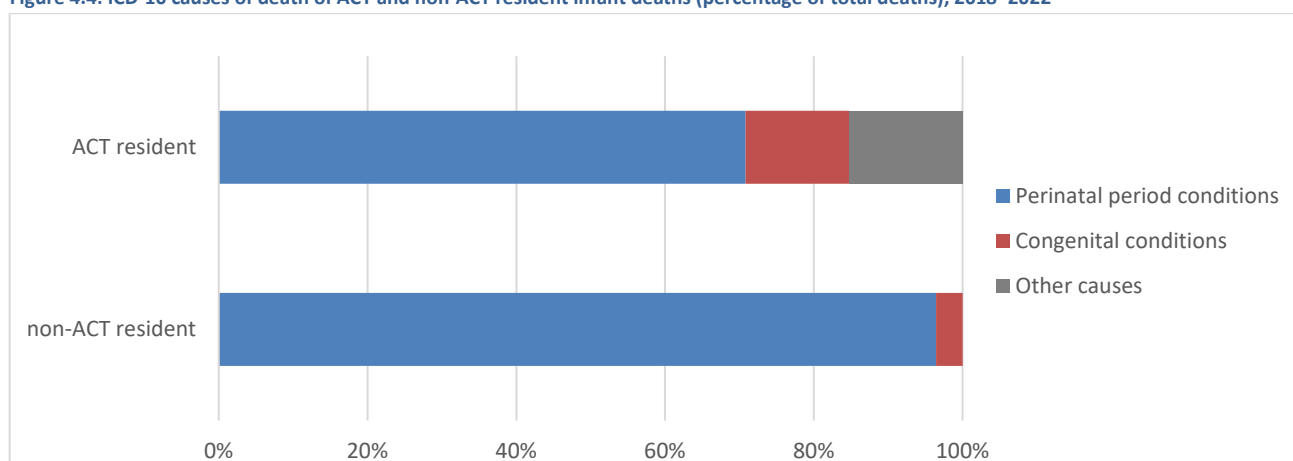
Considering all deaths of infants in the ACT, the main indicative cause of death of children under the age of one year during the 2018 to 2022 period was medical causes (52.2%), followed by extreme prematurity (45.6%). Most deaths in this age group (83.8%) were attributed to ‘certain conditions originating in the perinatal period’.

Some babies are born too early and too small to survive outside of the womb or to be offered intensive care support. This can happen for many different reasons. Some extremely premature or pre-viable babies are

born showing signs of life which means they are counted in our report as a child death as a result of extreme prematurity. As these deaths contribute to the numbers of deaths related to extreme prematurity, it is important to note that survival rates for newborns born from 23 weeks gestational age and offered intensive care support continues to improve Australia wide.

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

Figure 4.4: ICD-10 causes of death of ACT and non-ACT resident infant deaths (percentage of total deaths), 2018–2022



Excludes open coronial cases.

Deaths include ages less than 365 days for the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

All deaths of non-ACT residents occurred in the ACT only.

Other causes include the ICD-10 chapter; Injury, Diseases of the circulatory system, Diseases of the nervous system, Neoplasms (cancers), Endocrine, nutritional and metabolic diseases SUDI, SIDS, poisoning and certain other consequences of external causes, Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified.

Perinatal conditions are the major cause of death (70.8%) for ACT resident infants (Figure 4.4). Of the NSW resident infant deaths that occurred in the ACT, 96.4% were attributed to perinatal conditions. Congenital malformations, deformations and chromosomal abnormalities are the second-most prevalent cause for both ACT and Non-ACT infant deaths.

There were less than five deaths attributed to other causes for the reporting period. All perinatal conditions and congenital malformations deaths on the Committee’s child death register are infants under one year.

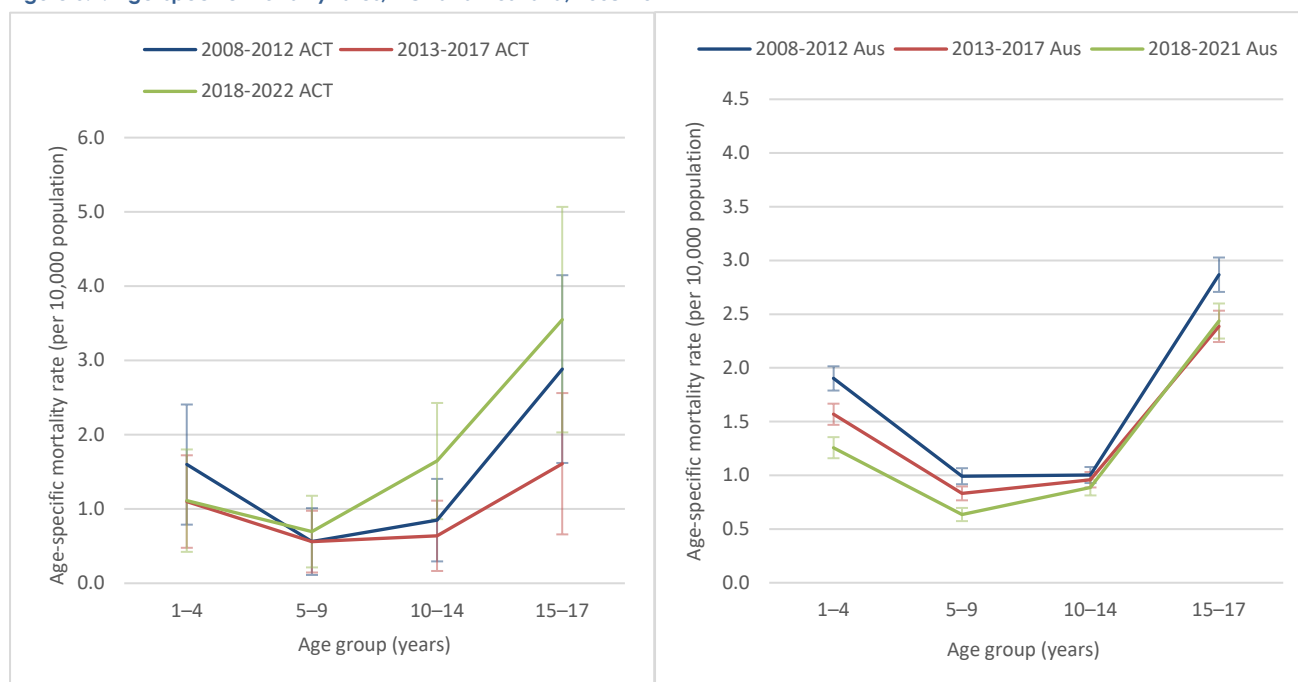
This chapter provides an overview of the registered deaths of ACT resident children and young people (1–17 years old) that occurred in the ACT or interstate in the last five years, 2018–2022. It will examine the incidence and causes, as well as other demographic and individual characteristics, of those deaths of ACT residents 1–17 years old.

Between 2018 and 2022, 55 ACT resident children and young people died in the ACT or other Australian jurisdictions. Of these 55 children and young people, 11 died in other jurisdictions and 10 are open coronial matters.

In this chapter, 15-year aggregated data has been used when considering age-specific mortality rates (Figure 5.1).

The proportion of child and young person deaths increases during adolescence and is partially explained by an increase in death by suicide in the 10–14 and 15–17 age groups. The Committee continues to review deaths by suicide, and additional discussion of these deaths can be found in Chapter 7.

Figure 5.1: Age-specific mortality rates, ACT and Australia, 2008–2022



Includes open coronial cases.

Deaths include ages 1–17 years over the 2008–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Data Sources— <https://explore.data.abs.gov.au/> (Quarterly Population Estimates (ERP), by State/Territory, Sex and Age)

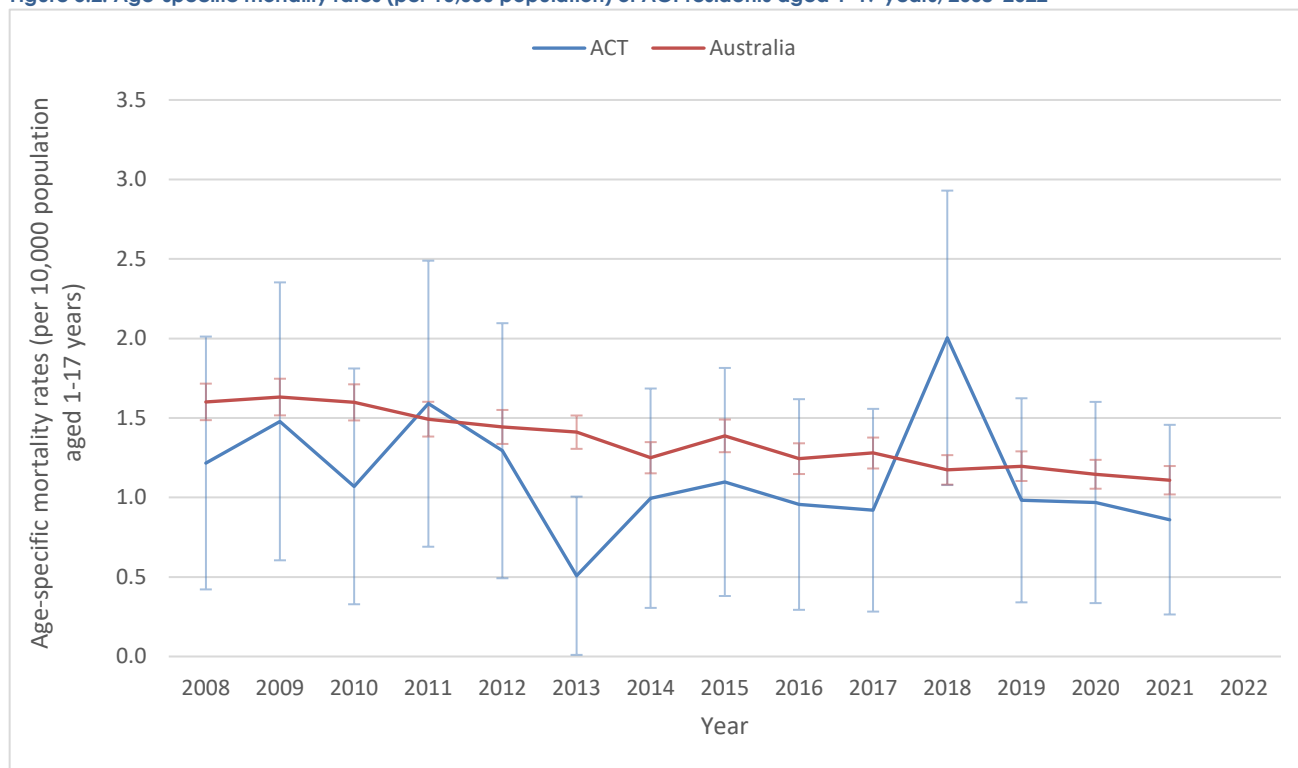
—Australian Bureau of Statistics (2021), [Deaths, Australia](#), (number of deaths by age in Australia, currently available to 2021 only)

—ACT death totals sourced from ACT Child Death Register.

Over the 15 years to 2022, there was a decrease in the mortality rate for the 1–4-year-old age group in the ACT. Mortality rates for the 5–9-year-old age group remained stable over this period. Mortality rates for young people aged 10–17 years increased across the 15 years in the ACT, with 47% of these deaths between 2018 and 2022 attributed to injury or external causes.

The age-specific mortality rate for children 1–17 years in the ACT fluctuates year-on-year while the Australian rate remains stable (Figure 5.2). The year-on-year fluctuations are consistent with small jurisdictions that have small numbers of deaths for children and young people.

**Figure 5.2: Age-specific mortality rates (per 10,000 population) of ACT residents aged 1–17 years, 2008–2022**



<sup>a</sup> The rates in this table are not directly comparable to previous reports. ASMR = age-specific mortality rate per 10,000 population.

Includes open coronial cases.

Deaths include ages 1–17 years over the 2008–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

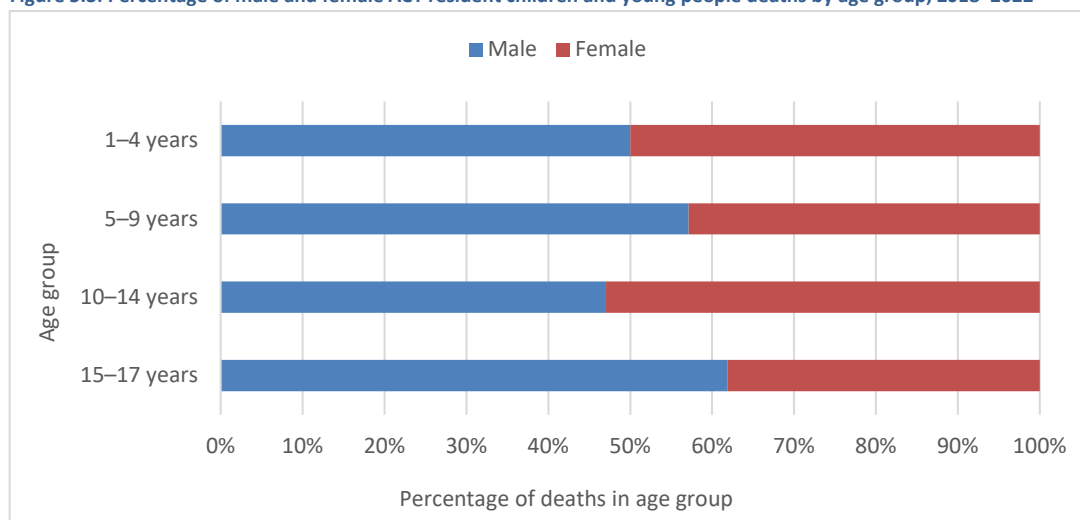
Data Sources— <https://explore.data.abs.gov.au/> (Quarterly Population Estimates (ERP), by State/Territory, Sex and Age) and annual estimated resident population for Australia

—Australian Bureau of Statistics (2021), [Deaths, Australia](#), (number of deaths by age in Australia, currently available to 2021 only)

—ACT death totals sourced from ACT Child Death Register.

More than half (54.5%) of ACT resident child and young person deaths aged 1–17 years were male. The highest percentage of males compared to females was in the 15–17 age group, with 61.9% of deaths in this age group being male (Figure 5.3). However, numbers of deaths were small and therefore results should be interpreted with caution.

**Figure 5.3: Percentage of male and female ACT resident children and young people deaths by age group, 2018–2022**



Includes open coronial cases.

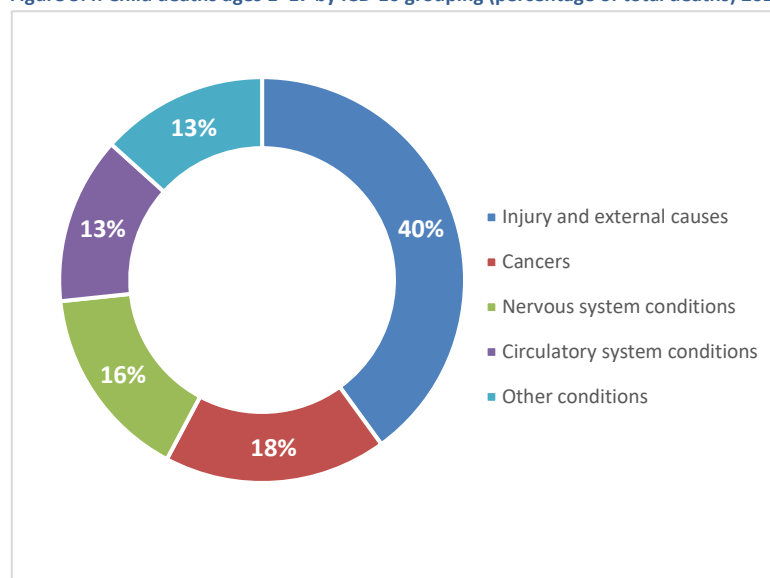
Deaths include ages 1–17 years over the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Percentages are of total deaths for all genders and for ages 1–17 years.

The most common cause of death for ACT Children and Young People aged 1–17 years was injury and external causes (40%) (Figure 5.4). This increases with age; in the five years to 2022, 53.5% of deaths of young people aged 15–17 which can be reported on (that is, excluding open coronial matters) were attributed to injury and external causes.

**Figure 5.4: Child deaths ages 1–17 by ICD-10 grouping (percentage of total deaths) 2018–2022**



Excludes open coronial cases.

Deaths include ages 1–17 years over the 2018–2022 period.

All deaths of ACT residents occurred either in the ACT or elsewhere.

Other conditions include respiratory system conditions and symptoms, signs and abnormal findings not elsewhere classified.

Of all these deaths, more than half (53%) were suicides and were predominantly young people between 15–17 years.

Approximately two-thirds of deaths attributed to cancers (67%) were children aged ten years or older.

There were less than five deaths attributed to other causes for the reporting period.

This section outlines the overall incidence of mortality among children and young people in the ACT who were experiencing identified vulnerability risk factors at the time of death. While the Committee acknowledges that all children and young people are vulnerable and in need of safe environments in which to grow and be nurtured, in this and previous reports, the involvement of Children and Youth Protection Services (CYPS) were a proxy indicator of increased vulnerability. There are two reasons why the Committee focuses on child protective services. First, it is a requirement of the legislation. But more importantly, these are the systems that are often involved when difficulties arise in a child's life and are therefore indicators of vulnerability.

Children known to child protection services may have experienced a range of risk factors within their lives, including domestic and family violence, parental substance misuse, mental illness and involvement with the criminal justice system. The following discussion considers both children and their siblings known to child protection services within three years of the child's death.

Most children and young people known to child protection (60%) had child concern reports recorded (that is, any report made to CYPS). However, a much smaller percentage of children (25%) had child protection reports recorded (that is, a second stage of assessment conducted by CYPS to establish if there is a reasonable belief that a child is in need of care and protection) or appraisals (that is, investigations undertaken).

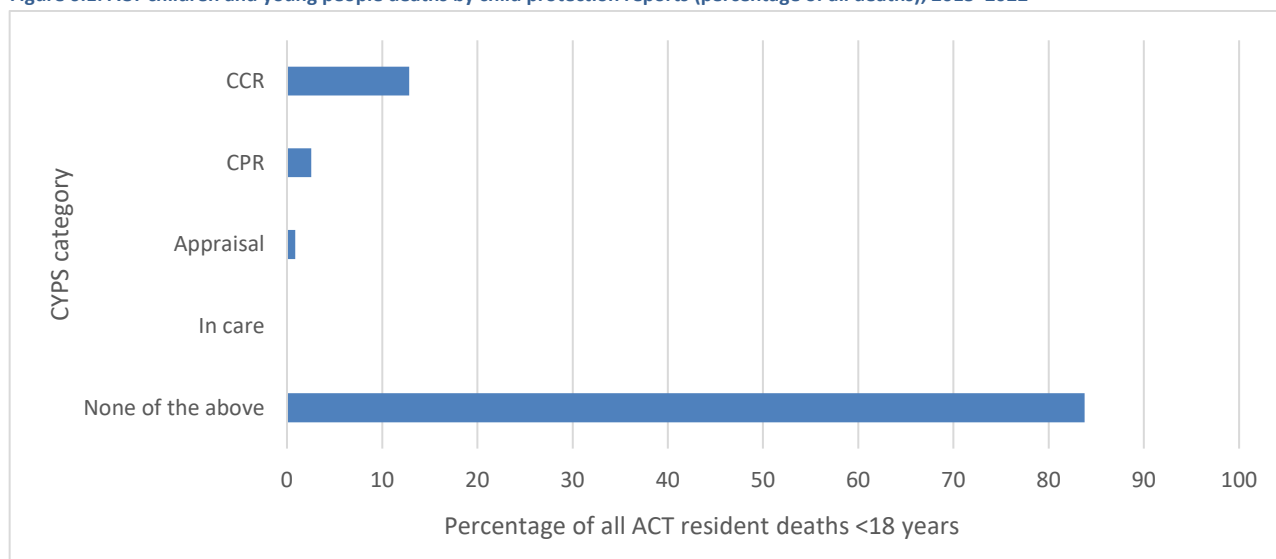
#### **Known to CYPS**

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

Most (84%) children and young people who died between 2018–2022 were not known to child protection services (Figure 6.1).

No children or young people who died in the reporting period were in the care of the Director-General.

Figure 6.1: ACT children and young people deaths by child protection reports (percentage of all deaths), 2018–2022



Excludes open coronial matters.

Includes deaths of ACT residents 0–17 years of age for the 2018–2022 period.

CCR = child concern report

CPR = child protection report

Appraisal = a care and protection appraisal

In care = taken into care following appraisal. There were zero cases of child or young person deaths in care in the 2018–2022 period.

A substantial proportion (71%) of the children and young people who died of suicide in the five-year period 2018–2022 were known to the child protection system. The Committee’s reviews of these deaths indicates that multiple services may have been aware of risks potentially affecting the child or young person at or near the time of their death.

The Committee has undertaken specific reviews in 2022 that considered how information in the ACT is shared when there are known risks in a child or young person’s life. The results of these reviews are addressed in the following chapter.



## CHAPTER 7 INJURY-RELATED DEATHS

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

While the Committee reviews all deaths of children and young people in the ACT, often the greatest learnings can be identified through deaths that were not attributed to natural causes.

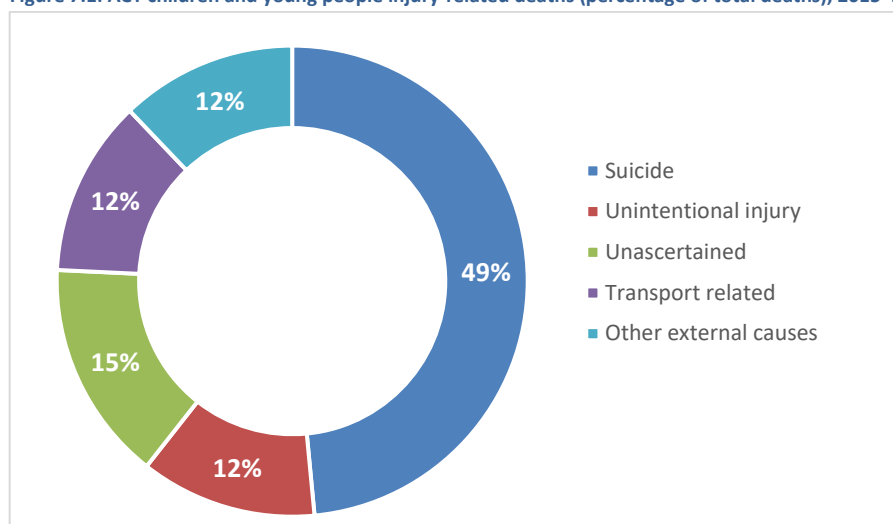
Fortunately, the recorded number of injury-related deaths in the ACT is small. Due to these low numbers and the requirement of the Committee not to disclose the identity of any individual on the child death register, the ability to report on these cases is limited. The Committee has commenced a retrospective process of reviewing individual deaths due to external causes between 2015 and 2022, to consider patterns and trends in injury-related deaths in a larger sample. While details of specific cases cannot be conveyed, it is envisaged that aggregated observations and recommendations from these investigations will be published in future annual reports.

### CAUSE OF DEATH

Figure 7.1 presents the indicative causes of death for ACT resident children and young people during the period 2015–2022, excluding medical causes and extreme prematurity.

Between 2015 and 2022, there was a total of 41 injury-related deaths recorded on the Committee’s child death register. Of these, 44% were attributed to suicide. There were less than five deaths attributed to ‘other external causes’ in this reporting period. Due to the small numbers, the causes of these deaths cannot be disclosed in this report.

Figure 7.1: ACT children and young people injury-related deaths (percentage of total deaths), 2015–2022



Excludes open coronial matters.

Includes deaths of ACT residents 0–17 years of age for the 2015–2022 period.

Includes external causes of death only and excludes medical causes, extreme prematurity, SIDS and undetermined deaths.

Other external causes include drowning and fatal assault.

## SUICIDE

Suicide is the third-most common indicative cause of death of all ACT resident deaths under 18 years. In the past twelve months, the Committee has undertaken work to review all child and young person deaths by suicide since 2015. In 2021, the Committee completed a review of children and young people who died as a result of intentional self-harm (2018–2020). The Committee has continued to use the life course approach used in the 2021 review to build on the identified themes categorised into the following broad suicide pathways:

- Group 1 — Children and young people who had family, learning and/or social challenges in their lives from an early age.
- Group 2 — Children and young people who engaged normally with family, school and friends until the emergence of challenges to their mental health, such as depression and/or anxiety.
- Group 3 — Children and young people who had stable home lives and no evidence of mental health challenges, but who had experienced challenges in romantic/sexual or social relationships immediately prior to the event.

Consistent with the previous review, most young people who died by suicide would be in the Group 2, involving factors such as the emergence of mental health issues in adolescence; a relatively stable home life that included at least one supportive parent; engagement in education prior to development of mental health issues; challenges in interpersonal relationships before their death; disclosures of self-harm and suicidal ideation to family, friends, and services; and some engagement with mental health services.

Through undertaking these reviews, the Committee has assessed interactions between children and young people at risk of suicide and those services they were engaged with prior to their deaths. Subsequent Committee discussions have identified the following needs:

- professionals working with children and young people at risk of suicide being more attentive to precursor trauma
- a focus on holistic care and support, placing a broader focus than just the young person's symptoms or mental health condition
- early intervention to include the development of a relationship with the primary caregiver and service providers
- more active information sharing between mental health services, schools, primary healthcare professionals and family members
- a central lead agency bringing everyone together for coordinated case management.

This chapter provides an overview of the activities of the Children and Young People Death Review Committee throughout 2022.

### **COMMITTEE MATTERS 2022**

The Committee met four times in 2022.

The Committee worked with the ACT Epidemiology Division of ACT Health to undertake a review of serious injury data of children and young people from Canberra hospitals. The yet-to-be published paper by the ACT Epidemiology Division will allow the Committee to consider serious injury data in both specific reviews and broader commentary of patterns and trends in child mortality.

The Committee has developed a process to undertake in-depth reviews upon completion of other review processes within the ACT. It has also undertaken several in-depth individual and small cohort reviews during the year. This process better utilises member expertise and knowledge of how the existing system is operating.

The Committee continued to work across the following areas:

- collecting timely and accurate information about the circumstances and causes of death for children and young people in the ACT
- contributing, through its annual report to Government and community, knowledge and understanding of the causes and circumstances of children and young people's deaths
- actively promoting the Committee's work with relevant ACT agencies and individuals to offer informed perspectives to assist in the prevention or reduction of deaths or injury
- maintaining links with interstate and national bodies undertaking similar work.

### **COMMITTEE MEMBERSHIP**

The Committee farewelled its long-standing Chair, Ms Margaret Carmody in August 2022. During the six years to 2022, Ms Carmody oversaw several significant reviews, worked to improve the Committee's data quality, advocated for the safety and wellbeing of children and young people in the ACT and has ensured that the functions of the Committee are fulfilled. The Committee commends her for her service as Chair and her commitment to the role.

### **CONTINUING WORK**

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

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

- Ongoing in-depth reviews — The Committee will continue to undertake in-depth and thematic reviews and provide these to government with relevant recommendations to improve legislation, systems and processes that aim to reduce deaths of children and young people in the ACT. The Committee will look at undertaking reviews into those deaths which are likely to provide significant insights or learnings.
- Promoting understanding of the cause and impact of child deaths in the ACT — The Committee will continue to increase public awareness and advocate for the issues that affect the health and safety of children and young people in the ACT by disseminating information through its Annual Report, the Committee’s website and the Committee’s involvement at a national level with the Australian and New Zealand Child Death Review and Prevention Group.

## DISCLOSURE OF INFORMATION

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Under s. 727P of the Act, the Committee may exchange information with an entity that exercises a function under a law of state that corresponds or substantially corresponds to a function of the Committee. In 2021, the Committee provided information to entities in Queensland and NSW. The NSW child death register includes children who normally live in NSW, but whose death occurred in the ACT. In August 2022, the Committee provided the NSW Child Death Review team with information about the deaths of NSW resident children who died in the ACT. In June 2019, the ACT signed an information exchange agreement with the NSW Child Death Review Team under s. 34D(3) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

Under s. 727B of the Act, a function of the Committee is to provide expert advice and make recommendations about legislation, policies, practices and services for implementation by government and non-government bodies. Monitoring the implementation of recommendations is also a legislated function of the Committee under s. 727B of the Act.

In the 2020 annual report, for the second time, the Committee formally reported on the implementation of its previous recommendations in its annual report. This was facilitated by seeking responses from the relevant ACT Government directorates on their progress to address recommendations made by the Committee. Original correspondence from the directorates is provided in Appendix C. The Committee acknowledges that in some circumstances, recommendations generated by other reviews overlap with those of this Committee.

Recommendations made by the Committee directly to government through reports under s.727T of the Act or by writing directly to directorates are considered in this review. These 18 recommendations primarily come from the following three special reports:

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

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

Advice provided through submission are not included in this review as they do not relate specifically to the Child and Young People Death Review dataset. The Committee considers these recommendations complete once the relevant inquiry is finalised.

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

The Committee recognises that changes need to be implemented within the broader context of the relevant directorate's work and programs.

## INDICATIONS OF CHANGE

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

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

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

## REDUCING RISKS TO CHILDREN IN AND AROUND THE HOME

### THE COMMITTEE'S RECOMMENDATIONS

The Committee made several recommendations relating to the safety of children in and around the home to reduce the risks associated with swimming pools and button battery ingestion.

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

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

Reduce risks to children in and around the home

Swimming pool regulation

Ongoing

Button batteries

Achieved

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

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

### PROGRESS ON RECOMMENDATIONS

#### SWIMMING POOL REGULATION

The Environment, Planning and Sustainable Development Directorate informed the Committee that new regulatory reforms will require all home swimming pools to have a barrier compliant with modern safety standards.

Public consultation for the reforms ran from 1 February to 15 March 2023, with the outcomes of the consultation informing the final design of the reforms. The reforms will be introduced in 2023, with a specified transition period for pool owners to meet the new requirements.

## BUTTON BATTERIES

Canberra Health Services wrote to the Committee in October 2021 to advise that a guideline for the Emergency Management of Button Battery Ingestion had been developed. The Practice Guideline provides clinicians with guidance on the management of paediatric patients with suspected or actual ingestion of a foreign body.

## OUR COMMENTS

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The Committee welcomes the proposed regulatory reforms for swimming pools and will review their implementation in the 2024 annual report.

The Committee is satisfied that a suitable process for managing the suspected or actual ingestion of button batteries. The Committee also notes that in June 2022 the ACCC introduced mandatory safety and information standards to reduce the risk of injury and death to children from exposure to button/coin batteries.

## IMPLEMENTING AND EVALUATING YOUTH SUICIDE PREVENTION PROGRAMS

### THE COMMITTEE'S RECOMMENDATIONS

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

Implement and evaluate youth suicide prevention programs

Ongoing

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

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



## PROGRESS ON RECOMMENDATIONS

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The Committee received responses relating to the progress on recommendations from the Office of Mental Health and Wellbeing (OMHW) and the Division of Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS).

### INVOLVING YOUNG PEOPLE WITH LIVED EXPERIENCES

The OMHW described three pieces of work involving young people with lived experiences of suicide, including the MindMap – ACT Youth Portal achieved through a co-design process with young people, parents/carers and service providers and a co-designed youth systems modelling tool for the ACT youth mental health sector. The OMHW's 2022 Missing Middle report, which considered children and young people with moderate to severe mental health concerns who experienced difficulties accessing services, recommended the establishment of a dedicated youth reference group to support key initiatives across youth mental health, including suicide prevention initiatives, where relevant. It is anticipated this group will be operational in 2023.

### EVALUATING CURRENT YOUTH MENTAL HEALTH AND SUICIDE PREVENTION PROGRAMS

In recent years, the ACT has implemented or trialled several youth mental health and suicide prevention programs initiatives. More detailed information on the following programs can be found at the OMHW's response in Appendix C:

- The trial of the Lifespan framework in the ACT with Black Dog Institute (BDI) concluded 30 June 2021, and the final ACT LifeSpan report will be prepared once data is finalised (hospital admissions data and coronial suicide data).
- Question, Persuade, Refer (QPR) is a free online suicide prevention training program available in the ACT since 2020. In 2022, OMHW reviewed the qualitative and quantitative feedback relating to QPR and found strong evidence for the continuation of similar gatekeeper training. The OMHW is currently determining next steps.
- MindMap is an online youth navigation portal to support children and young people to navigate and access mental health supports and services in the ACT. MindMap has been operational since October 2021 and is currently in the process of an initial evaluation to measure the effectiveness of the portal for the community. Noting the timeframe of this portal, a more detailed evaluation will take place over the coming years.
- Youth Aware of Mental Health (YAM) is an evidence-based mental health and suicide prevention program for young people aged 14–16 years. The ACT Health Directorate (ACTHD) received the findings from the BDI's research evaluation of YAM in ACT schools in September 2022. There was insufficient data to reach any meaningful conclusions about program efficacy in the ACT. However, there continues to be strong support for YAM in the ACT, with numerous bookings by schools for 2023.

### IMPLEMENTING INFORMATION CAMPAIGNS

The OMHW provided information on two programs that disseminate information campaigns that target young people at risk and include practical intervention skills for peers and family. The YAM program is a school-based program that actively engages the ACT's year 9 students with the topic of mental health

through role-play and student-led discussions supported by a trained YAM Instructor. MindMap is marketed both on social media and within schools. MindMap has a range of resources and information on suicide prevention and links to appropriate services within the ACT.

#### IMPLEMENTING AND EVALUATING THE CONNECTING WITH PEOPLE PROGRAM

The Connecting with People (CwP) program was planned to commence within MHJHADS on 1 March 2023. In October 2022, due to the introduction of the Digital Health Record, the Division of MHJHADS postponed CwP training until mid-2023. The OMHW is currently revising the 2023 CwP training program, with a focus on the non-government organisation (NGO) sector.

#### IMPLEMENTING A SUPPORT PLAN PROCESS IN CLINICAL SETTINGS THAT ACTIVELY ENGAGES YOUNG PEOPLE FOLLOWING A SUICIDE ATTEMPT

Child and Adolescent Mental Health Services (CAMHS) is a program within MHJHADS. CAMHS provides assessment and treatment for children and young people up to the age of 18 who are experiencing moderate to severe mental health conditions.

CAMHS provided details to the Committee on the current work undertaken by the Hospital Liaison Team and Adolescent Intensive Home Treatment Team (AIHTT). This includes development of safety plans in hospital, engagement with young people within seven days of hospital discharge and the development of a care plan. CAMHS noted that a revision of the safety and care plan process could be undertaken to include clear timeframes, establish a key worker and combine the two teams to ensure continuity of care.

#### IMPLEMENTING EVIDENCE-BASED, ASSERTIVE OUTREACH GUIDELINES INTO ACT GOVERNMENT POLICY THAT INCLUDE FACE-TO-FACE CONTACT WITH YOUNG PEOPLE WHO HAVE ATTEMPTED SUICIDE

The Adolescent Mobile Outreach Service and AIHTT within CAMHS conduct outreach support and provide intensive case management following a suicide attempt. CAMHS identified improvements in outreach support advising that safety plans could be updated to explicitly advise who to contact within first 24 hours after a suicide attempt and that the hospital team provide the child/young person and their family with a date/time for a face-to-face appointment prior to discharge to prevent phone tag. The OMHW monitor the effectiveness of suicide prevention planning and inform ACT suicide prevention outreach programs.

#### TRAINING STAFF FROM RELEVANT ORGANISATIONS ON RESPONSIBLE INFORMATION SHARING

Currently the CAMHS Hospital Liaison Team writes a letter to a young person's school (with their consent) to advise when they have presented to hospital following an attempted suicide. CAMHS are developing a memorandum of understanding with Women, Youth and Children and the Education Directorate regarding responsible information sharing. Members of the working group have been identified and will commence work on the document in late Feb 2023.

#### OUR COMMENTS

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The Committee notes the range of activities that have been implemented to support children and young people at risk of suicide. Through the Committee's 2022 review of suicides it is evident that often peers of young people who die were aware of their distress. The Committee welcomes the establishment of the MindMap resource and strongly advocates for the continuation of the YAM and QPR suicide prevention

programs within ACT schools. The Committee will continue to engage with the Office for Mental Health and Wellbeing and looks forward to the publication of the final ACT LifeSpan report. The advice from CAMHS that improvements could be made to improve support plan and outreach processes is a positive acknowledgement. The Committee will seek to engage with MHJHADS to provide further observations from recent reviews to assist in this process.

## REVIEWING THE PRACTICE OF ADDRESSING THE RISK FACTORS IN CHILDREN'S LIVES

### THE COMMITTEE'S RECOMMENDATIONS

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

A particular finding of the Committee's Changing the Narrative report was the identification of cumulative risk for those children who had died. The Committee made the following recommendations to help better address risk factors:

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

Ongoing

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

### PROGRESS ON RECOMMENDATIONS

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

Primarily, the recommendations from the Changing the Narrative report relate to CSD. In its response, the Directorate described the establishment of a pre-natal pilot program. The pilot program will offer case management to women pregnant with an Aboriginal and/or Torres Strait Islander child who have been prenatally reported to CYPS with the view to the mother and child being supported postnatally within the community.

CYPS are also establishing a team of experienced case workers to work alongside Aboriginal and Torres Strait Islander families and reconsidering the child protection intake model to ensure consistent and timely risk assessment. CSD's Strategic Policy Division are currently reviewing the *Children and Young People Act 2008* to modernise the Act, ensuring it sufficiently enables CYPS to identify and respond to cumulative harm.

## OUR COMMENTS

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The Committee notes that these recommendations were made in 2018 and that the service system supporting children in the ACT has changed since this time. The Committee welcomes the ongoing initiatives implemented to address the practice of assessing risk factors in children's lives. While the specific recommendations of the Changing the Narrative report have not been fully addressed (namely Recommendation 3) the Committee plans to meet with representatives of CYPS to better understand if these recommendations continue to be relevant to the ACT Child Protection system.

## IMPROVING CONSISTENCY IN ASSESSING PARENTING CAPACITY

### THE COMMITTEE'S RECOMMENDATIONS

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

1. The introduction of standardised empirically validated assessment tools for use in the prenatal and postnatal periods, in order to identify vulnerable families requiring further support. This should include necessary training for practitioners.
2. The establishment of a high-quality parenting capacity assessment service and support for parents with children where four reports have been received that identify the following risk factors: domestic and family violence, substance misuse, unstable housing and limited parental service engagement. These should include any prenatal reports about a child by CYPS.
3. The need for information and reports from parents to be tested through accessing information from other services, particularly in regard to reports of parental drug and alcohol use or instances of domestic violence.

Improve consistency in assessing parenting capacity

Ongoing

### PROGRESS ON RECOMMENDATIONS

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

Consistent with the response provided by CSD in 2020, several programs currently in place were noted to help families through intensive support, including functional family therapy and the Child and Family Centres (CFC) and Child Development Service. See the Directorate response (Appendix C) for full details.

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

The team of experienced CYPS case workers to work alongside Aboriginal and/or Torres Strait Islander families will be encouraged to test standardised and empirically validated assessment tools like Structured Decision Making, Signs of Safety and the North Carolina Family Assessment Scale. Learnings from this team will be used to support CYPS to move towards a family services approach.

## OUR COMMENTS

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As with the previous set of recommendations the Committee notes the work of the ACT child protection system to improve consistency in assessing parenting capacity. The Committee acknowledges that these recommendations were agreed in principle by the ACT Government and will seek to better understand the relevance of them in the current service landscape.

## CONCLUSION

The Committee acknowledges the work undertaken across the ACT Government to improve outcomes for children and minimise the risk of serious injury or death. The Committee welcomes the regulation of backyard swimming pools to bring the ACT in line with other jurisdictions. The responses from directorates demonstrate changes to policy and practice in a range of areas to improve those systems that interact with children and their families. The ability for these systems to effectively share information when there are known risks to children or young people will be a focus of the Committee's work in 2023.

## REFERENCES

- ABS (Australian Bureau of Statistics) (2021a). Causes of Death, Australia. Canberra: ABS.  
<https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release>
- ABS (Australian Bureau of Statistics) (2021b). Deaths, Australia. Canberra: ABS.  
<https://www.abs.gov.au/statistics/people/population/deaths-australia/latest-release>
- ABS (Australian Bureau of Statistics) (2016). Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2031. Canberra: ABS. <https://explore.data.abs.gov.au/>
- ABS (Australian Bureau of Statistics) (2022a). Infant deaths and Infant mortality rates, Year of registration, Age at death, Sex, States, Territories and Australia  
[https://explore.data.abs.gov.au/vis?tm=infant%20mortality&pg=0&df\[ds\]=PEOPLE\\_TOPICS&df\[id\]=INFANT\\_DEATHS\\_REGISTRATIONYEAR&df\[ag\]=ABS&df\[vs\]=1.0.0&pd=2015%2C&dq=3%2B4%2B9....A&ly\[cl\]=TIME\\_PERIOD&ly\[rs\]=MEASURE](https://explore.data.abs.gov.au/vis?tm=infant%20mortality&pg=0&df[ds]=PEOPLE_TOPICS&df[id]=INFANT_DEATHS_REGISTRATIONYEAR&df[ag]=ABS&df[vs]=1.0.0&pd=2015%2C&dq=3%2B4%2B9....A&ly[cl]=TIME_PERIOD&ly[rs]=MEASURE)
- ABS (Australian Bureau of Statistics) (2022b). Quarterly Population Estimates (ERP), by State/Territory, Sex and Age, ABS. Cat. No 3101.0. Extracted 7 February 2023, <https://explore.data.abs.gov.au/>
- AIHW (Australian Institute of Health and Welfare) (2015). Australian hospital peer groups. Health services series no. 66. Cat. no. HSE 170. Canberra: AIHW. <https://www.aihw.gov.au/getmedia/79e7d756-7cfe-49bf-b8c0-0bbb0daa2430/14825.pdf.aspx?inline=true>
- WHO (World Health Organization) (2010). International Statistical Classification of Diseases and Related Health Problems 10th revision (ICD-10): Version for 2010. Geneva: WHO.  
<http://apps.who.int/classifications/icd10/browse/2010/en#!/XVI>
- WHO (World Health Organization) (2011). International Statistical Classification of Diseases and Related Health Problems 10th revision: Volume 2 Instruction manual. 2010 edn. Geneva: WHO.  
[http://apps.who.int/classifications/icd10/browse/Content/statichtml/ICD10Volume2\\_en\\_2010.pdf](http://apps.who.int/classifications/icd10/browse/Content/statichtml/ICD10Volume2_en_2010.pdf)
- WHO (World Health Organization) (2016). Classification of Diseases. Geneva: WHO. Viewed 25 February 2022, <http://www.who.int/classifications/icd/en/>

## APPENDIX A DATA AND POPULATION TABLES

### ACT QUARTERLY POPULATION ESTIMATES (ERP)<sup>a</sup>

	2018-Q2			2019-Q2			2020-Q2			2021-Q2			2022-Q2		
Age (years)	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
0–4	14,585	13,593	28,178	14,383	13,625	28,008	14,267	13,489	27,756	13,914	13,207	27,121	13,665	13,012	26,677
0	2,738	2,597	5,335	2,719	2,613	5,332	2,835	2,633	5,468	2,725	2,633	5,358	2,877	2,655	5,532
1	2,918	2,694	5,612	2,727	2,598	5,325	2,739	2,615	5,354	2,790	2,617	5,407	2,754	2,467	5,221
2	2,974	2,801	5,775	2,914	2,712	5,626	2,745	2,641	5,386	2,723	2,587	5,310	2,640	2,632	5,272
3	3,025	2,817	5,842	2,977	2,857	5,834	2,952	2,734	5,686	2,756	2,630	5,386	2,698	2,624	5,322
4	2,930	2,684	5,614	3,046	2,845	5,891	2,996	2,866	5,862	2,920	2,740	5,660	2,696	2,634	5,330
5–9	14,418	13,348	27,766	14,688	13,624	28,312	14,945	13,911	28,856	14,944	14,099	29,043	14,940	14,162	29,102
5	2,972	2,809	5,781	2,949	2,746	5,695	3,066	2,882	5,948	2,970	2,872	5,842	2,937	2,754	5,691
6	2,973	2,707	5,680	3,005	2,832	5,837	2,971	2,786	5,757	3,066	2,879	5,945	2,995	2,834	5,829
7	2,861	2,646	5,507	2,960	2,701	5,661	3,025	2,831	5,856	2,948	2,767	5,715	3,046	2,850	5,896
8	2,878	2,670	5,548	2,885	2,663	5,548	2,976	2,728	5,704	3,013	2,855	5,868	3,003	2,855	5,858
9	2,734	2,516	5,250	2,889	2,682	5,571	2,907	2,684	5,591	2,947	2,726	5,673	2,959	2,869	5,828
10–14	12,374	11,568	23,942	12,920	11,955	24,875	13,540	12,465	26,005	13,876	12,730	26,606	14,143	13,406	27,549
10	2,650	2,433	5,083	2,757	2,524	5,281	2,907	2,698	5,605	2,900	2,693	5,593	2,869	2,762	5,631
11	2,565	2,386	4,951	2,688	2,443	5,131	2,760	2,546	5,306	2,884	2,687	5,571	2,888	2,745	5,633
12	2,524	2,363	4,887	2,603	2,376	4,979	2,697	2,463	5,160	2,785	2,527	5,312	2,933	2,773	5,706
13	2,327	2,253	4,580	2,540	2,369	4,909	2,620	2,377	4,997	2,692	2,446	5,138	2,784	2,594	5,378
14	2,308	2,133	4,441	2,332	2,243	4,575	2,556	2,381	4,937	2,615	2,377	4,992	2,669	2,532	5,201
15–17	6,926	6,540	13,466	6,977	6,543	13,520	7,088	6,627	13,715	7,318	6,848	14,166	7,751	7,225	14,976
15	2,295	2,115	4,410	2,337	2,150	4,487	2,336	2,258	4,594	2,592	2,367	4,959	2,688	2,487	5,175
16	2,225	2,175	4,400	2,348	2,148	4,496	2,344	2,166	4,510	2,351	2,261	4,612	2,621	2,431	5,052
17	2,406	2,250	4,656	2,292	2,245	4,537	2,408	2,203	4,611	2,375	2,220	4,595	2,442	2,307	4,749
Total	48,303	45,049	93,352	48,968	45,747	94,715	49,840	46,492	96,332	50,052	46,884	96,936	50,499	47,805	98,304

<sup>a</sup> (ABS. Stat, 2022b) By state/territory, sex and age: ACT

## AUSTRALIA QUARTERLY POPULATION ESTIMATES<sup>a</sup>

	2018-Q2			2019-Q2			2020-Q2			2021-Q2			2022-Q2		
Age (years)	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total	Males	Females	Total
<b>0-4</b>	807,995	764,298	1,572,293	806,625	761,580	1,568,205	798,252	753,661	1,551,913	782,554	738,368	1,520,922	775,980	733,704	1,509,684
<b>0</b>	156,125	147,282	303,407	156,573	147,120	303,693	153,082	145,048	298,130	152,904	143,987	296,891	156,881	148,317	305,198
<b>1</b>	158,682	149,777	308,459	156,924	148,081	305,005	156,907	147,531	304,438	153,039	145,049	298,088	153,331	145,524	298,855
<b>2</b>	166,552	157,257	323,809	160,022	151,110	311,132	157,817	148,921	306,738	157,184	147,784	304,968	152,210	144,174	296,384
<b>3</b>	163,366	154,926	318,292	168,037	158,766	326,803	161,072	152,110	313,182	157,977	149,110	307,087	156,240	146,937	303,177
<b>4</b>	163,270	155,056	318,326	165,069	156,503	321,572	169,374	160,051	329,425	161,450	152,438	313,888	157,318	148,752	306,070
<b>5-9</b>	823,433	781,107	1,604,540	830,275	788,307	1,618,582	835,686	792,665	1,628,351	840,134	795,832	1,635,966	829,121	782,330	1,611,451
<b>5</b>	166,389	157,612	324,001	164,961	156,664	321,625	166,642	157,920	324,562	169,801	160,366	330,167	161,124	152,263	313,387
<b>6</b>	164,791	156,237	321,028	167,759	158,966	326,725	166,370	157,937	324,307	167,002	158,187	325,189	166,150	157,064	323,214
<b>7</b>	164,301	155,954	320,255	166,023	157,544	323,567	168,925	160,013	328,938	166,659	158,099	324,758	165,486	155,693	321,179
<b>8</b>	164,888	156,899	321,787	165,501	157,095	322,596	167,143	158,678	325,821	169,235	160,276	329,511	167,161	157,951	325,112
<b>9</b>	163,064	154,405	317,469	166,031	158,038	324,069	166,606	158,117	324,723	167,437	158,904	326,341	169,200	159,359	328,559
<b>10-14</b>	779,271	736,646	1,515,917	799,164	756,676	1,555,840	818,977	776,691	1,595,668	829,144	786,620	1,615,764	841,841	796,472	1,638,313
<b>10</b>	162,883	154,863	317,746	164,240	155,455	319,695	167,108	159,110	326,218	166,919	158,412	325,331	168,481	159,912	328,393
<b>11</b>	161,611	152,833	314,444	163,997	155,976	319,973	165,363	156,408	321,771	167,370	159,394	326,764	167,640	158,768	326,408
<b>12</b>	155,889	147,641	303,530	162,687	153,892	316,579	164,980	156,911	321,891	165,702	156,710	322,412	169,364	160,732	330,096
<b>13</b>	150,341	141,671	292,012	156,881	148,573	305,454	163,631	154,724	318,355	165,219	157,145	322,364	168,278	158,512	326,790
<b>14</b>	148,547	139,638	288,185	151,359	142,780	294,139	157,895	149,538	307,433	163,934	154,959	318,893	168,078	158,548	326,626
<b>15-17</b>	444,498	422,327	866,825	446,196	423,187	869,383	452,003	427,792	879,795	461,621	436,086	897,707	481,267	451,691	932,958
<b>15</b>	146,286	139,291	285,577	149,774	140,916	290,690	152,342	143,834	296,176	158,152	149,744	307,896	166,735	156,265	323,000
<b>16</b>	146,922	139,637	286,559	147,794	140,843	288,637	150,860	142,084	292,944	152,504	144,106	296,610	159,797	150,539	310,336
<b>17</b>	151,290	143,399	294,689	148,628	141,428	290,056	148,801	141,874	290,675	150,965	142,236	293,201	154,735	144,887	299,622
<b>Total</b>	2,855,197	2,704,378	5,559,575	2,882,260	2,729,750	5,612,010	2,904,918	2,750,809	5,655,727	2,913,453	2,756,906	5,670,359	2,928,209	2,764,197	5,692,406

<sup>a</sup> (ABS. Stat, 2022b) By state/territory, sex and age: Australia



## ACT POPULATION 2008 - 2021

Time Period	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Age	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
0-4	22,338	22,974	23,833	24,132	25,356	26,274	26,862	27,384	28,054	28,469	28,281	28,079	27,841	27,140
0	4,590	4,823	5,123	4,946	5,295	5,491	5,546	5,652	5,696	5,615	5,332	5,358	5,428	5,327
1-4	17,748	18,151	18,710	19,186	20,061	20,783	21,316	21,732	22,358	22,854	22,949	22,721	22,413	21,813
5-9	20,641	20,837	21,119	21,711	22,486	23,152	23,955	25,037	25,767	26,913	27,938	28,623	29,121	29,276
10-14	21,299	21,254	21,045	21,086	21,186	21,197	21,270	21,583	22,170	23,358	24,258	25,239	26,537	27,283
15-17	14,266	14,142	13,898	13,502	13,544	13,627	13,823	13,646	13,399	13,846	14,673	15,045	14,860	14,587
15	4,517	4,444	4,417	4,266	4,402	4,403	4,356	4,309	4,306	4,535	4,829	4,652	4,682	5,048
16	4,751	4,703	4,547	4,499	4,417	4,584	4,582	4,479	4,384	4,563	4,888	5,124	4,730	4,721
17	4,998	4,995	4,934	4,737	4,725	4,640	4,885	4,858	4,709	4,748	4,956	5,269	5,448	4,818
0-17	78,544	79,207	79,895	80,431	82,572	84,250	85,910	87,650	89,390	92,586	95,150	96,986	98,359	98,286
1-17	73,954	74,384	74,772	75,485	77,277	78,759	80,364	81,998	83,694	86,971	89,818	91,628	92,931	92,959

## AUSTRALIA POPULATION 2008 - 2021

Time Period	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Age	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
0-4	1,383,093	1,425,684	1,454,012	1,458,114	1,494,690	1,524,375	1,541,431	1,552,567	1,573,626	1,574,570	1,563,728	1,554,538	1,535,813	1,509,959
0	291,214	295,261	297,437	290,397	304,718	309,939	306,333	308,446	318,860	306,218	302,580	302,441	296,660	298,859
1-4	1,091,879	1,130,423	1,156,575	1,167,717	1,189,972	1,214,436	1,235,098	1,244,121	1,254,766	1,268,352	1,261,148	1,252,097	1,239,153	1,211,100
5-9	1,334,683	1,346,100	1,360,182	1,387,634	1,419,391	1,458,636	1,496,800	1,536,262	1,567,281	1,588,064	1,604,857	1,616,624	1,619,875	1,616,774
10-14	1,383,120	1,386,256	1,384,504	1,387,865	1,389,913	1,394,915	1,401,491	1,410,688	1,431,690	1,473,503	1,517,847	1,561,095	1,603,137	1,623,892
15-17	855,628	856,387	860,646	860,975	863,254	858,485	858,480	861,342	866,346	867,011	864,859	867,169	878,553	897,731
15	281,873	283,307	286,499	282,465	283,062	281,997	283,578	285,508	286,211	283,044	285,125	289,912	296,874	308,384
16	284,451	284,713	285,948	289,336	285,988	286,261	285,122	286,762	289,244	289,878	286,054	287,959	291,907	297,458
17	289,304	288,367	288,199	289,174	294,204	290,227	289,780	289,072	290,891	294,089	293,680	289,298	289,772	291,889
0-17	4,956,524	5,014,427	5,059,344	5,094,588	5,167,248	5,236,411	5,298,202	5,360,859	5,438,943	5,503,148	5,551,291	5,599,426	5,637,378	5,648,356
1-17	4,665,310	4,719,166	4,761,907	4,804,191	4,862,530	4,926,472	4,991,869	5,052,413	5,120,083	5,196,930	5,248,711	5,296,985	5,340,718	5,349,497

### AUSTRALIA LIVE BIRTH AND DEATH RATES<sup>A</sup>

Time Period	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Births</b>	302,272	301,253	303,318	301,617	309,582	308,065	299,697	305,377	311,104	309,142	315,147	305,832	294,369	309,996
<b>Deaths</b>	1,226	1,261	1,229	1,140	1,031	1,094	1,012	991	970	1,019	988	1,009	943	1,009

<sup>A</sup> Infant deaths and Infant mortality rates, Year of registration, Age at death. ABS (2022a)

### ACT LIVE BIRTH AND DEATH RATES<sup>A</sup>

Time Period	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
<b>Births</b>	4,808	4,860	5,152	5,121	5,461	5,545	5,552	5,542	5,152	6,207	5,374	5,520	5,368	5,543
<b>Deaths<sup>B</sup></b>	24	17	19	15	16	16	13	21	16	17	20	5	19	18

<sup>A</sup> Infant deaths and Infant mortality rates, Year of registration, Age at death. ABS (2022a)

<sup>B</sup> Deaths may differ to total deaths on ACT Children and Young People Death Register due to count by year of registration.

### ESTIMATED AND PROJECTED ABORIGINAL AND TORRES STRAIT ISLANDER POPULATION<sup>A</sup>

Australia						Australian Capital Territory				
Age (years)	2018	2019	2020	2021	2022	2018	2018	2019	2020	2022
<b>0–4</b>	93,985	94,555	96,116	98,035	100,586	901	882	893	913	947
<b>5–9</b>	93,853	93,927	93,592	93,602	93,741	817	866	872	850	850
<b>10–14</b>	88,189	89,951	91,773	93,333	93,803	696	697	722	776	792
<b>15–19</b>	83,089	84,427	85,124	85,530	86,517	788	783	766	747	763

<sup>A</sup> (ABS, 2016) Single year of age, Australian Capital Territory and Australia

## DEATHS OF CHILDREN AND YOUNG PEOPLE IN THE ACT, 2018–2022

Deaths	Number <sup>a</sup>	Per cent <sup>b</sup>
All deaths in the ACT	163	
Total ACT resident deaths	132	81.0%
Interstate resident deaths	31	19.0%
ACT residents who died elsewhere	21	12.9%
Open coronial cases	17	10.0%

<sup>a</sup> Figures do not sum; coronial cases appear in more than one category.

<sup>b</sup> Percentages are percentages of all child and young person deaths on the ACT death register (n=163).

## ANNUAL DEATHS OF CHILDREN AND YOUNG PEOPLE INCLUDING ACT RESIDENTS WHO DIED ELSEWHERE AND INTERSTATE RESIDENTS WHO DIED IN THE ACT, 2018–2022

Year <sup>a</sup>	All deaths <sup>b</sup>	ACT residents		non-ACT residents who died in the ACT	
Jan-Dec	Number	Number	Per cent	Number	Per cent
2018	41 (2)	36	87.8%	5	12.2%
2019	19 (0)	16	84.2%	3	15.8%
2020	29 (4)	24	82.8%	5	17.2%
2021	36 (2)	24	66.7%	12	33.3%
2022	38 (9)	32	84.2%	6	15.8%
Total 2018–2022	163 (17)	132	—	31	—
Mean (average)	32.6	26.4	81.1%	6.2	18.9%

<sup>a</sup> Figures not directly comparable to previous reports.

<sup>b</sup> Totals (All deaths) include open coronial cases. Number of open coronial cases appear in parentheses next to total number of deaths. Percentages are percentages of the total (all deaths) for the individual year.

## KEY DEMOGRAPHIC CHARACTERISTICS OF ALL DEATHS OF CHILDREN AND YOUNG PEOPLE IN THE ACT, 2018–2022

Characteristics	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total</b>		
Persons 0–17 years of age	146	
<b>Sex</b>		
Female	65	44.5%
Male	81	55.5%
<b>Age<sup>b</sup></b>		
Less than 28 days	81	55.5%
28–365 days	19	13.0%
1–4 years	9	6.2%
5–9 years	6	4.1%
10–14 years	15	10.3%
15–17 years	16	11.0%
<b>Aboriginal and Torres Strait Islander status</b>		
Aboriginal and/or Torres Strait Islander	10	6.9%
Neither Aboriginal nor Torres Strait Islander	●	●
Unknown	●	●

<sup>a</sup> Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.

<sup>b</sup> Percentages may not total 100 due to rounding.

## KEY DEMOGRAPHIC AND INDIVIDUAL CHARACTERISTICS OF ALL DEATHS OF CHILDREN AND YOUNG PEOPLE IN THE ACT, 2022

Characteristics	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total</b>		
Persons 0–17 years of age	29	
<b>Sex</b>		
Female	10	34.5%
Male	19	65.5%
<b>Age<sup>b</sup></b>		
0–4 years	23	79.3%
5–17 years	6	20.7%
<b>Aboriginal and Torres Strait Islander status</b>		
Aboriginal and/or Torres Strait Islander	●	●
Neither Aboriginal nor Torres Strait Islander	●	●
Unknown	●	●

<sup>a</sup> Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.

<sup>b</sup> Percentages may not total 100 due to rounding.

## INDICATIVE CAUSE OF DEATH OF ALL DEATHS OF CHILDREN AND YOUNG PEOPLE ON THE CHILD DEATH REGISTER, 2018–2022

Indicative cause of death	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total</b>	146	
<b>Medical causes</b>	81	55.5%
Extreme prematurity	43	29.5%
Suicide	11	7.5%
Unintentional injury/accident (including transport and drowning)	6	4.1%
Unascertained	●	●
Fatal assault	●	●
SIDS and or SUDI <sup>a</sup>	●	●

<sup>a</sup> SUDI=sudden unexpected death in infancy; SIDS=sudden infant death syndrome.

<sup>a</sup> Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.

## ICD-10 GROUPING CAUSE OF DEATH, AGES 0–17 YEARS, 2018–2022

ICD-10 grouping	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total</b>	146	
Certain conditions originating in the perinatal period	78	53.4%
Injury, poisoning and certain other consequences of external causes	15	10.3%
Congenital malformations, deformations and chromosomal abnormalities	11	7.5%
Neoplasms (cancers)	9	6.2%
Diseases of the nervous system	9	6.2%
Diseases of the circulatory system	8	5.5%
External causes of morbidity and mortality	5	3.4%
Diseases of the respiratory system	5	3.4%
Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified	5	3.4%
Other medical disorders	●	●

<sup>a</sup> Figures do not include open coronial cases. Figures include ACT resident deaths in the ACT or elsewhere and non-ACT resident deaths in the ACT.

## BREAKDOWN OF CASES INCLUDED IN ANALYSIS, ACT RESIDENTS ONLY, AGED 0–17 YEARS, 2018–2022

Deaths	Number	Per cent
All ACT resident deaths <sup>a</sup>	132	
ACT residents who died in the ACT	111	84.1%
ACT residents who died elsewhere <sup>b</sup>	21	15.9%
Open coronial cases	15	11.4%

<sup>a</sup> Figures do not sum, includes ACT residents only, regardless of place of death, coronial cases appear in more than one category.

<sup>b</sup> Includes ACT residents only who died in states and territories outside the ACT.

## AGE-SPECIFIC MORTALITY RATES (PER 10,000) OF ACT RESIDENTS AGED 0–17 YEARS, 2018–2022

Year	Population	Deaths <sup>a</sup>	ACT ASMR <sup>b</sup>
	0–17 years	Number	Per 10,000
2018	93,352	36	3.9
2019	94,715	16	1.7
2020	96,332	24	2.5
2021	96,936	24	2.5
2022	98,304	32	3.3

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

<sup>b</sup> The rates in this table are not directly comparable to previous reports.

ASMR = age-specific mortality rate.

Data Source - <https://explore.data.abs.gov.au/> (Quarterly Population Estimates (ERP), by State/Territory, Sex and Age)

## DEMOGRAPHIC CHARACTERISTICS OF ACT RESIDENT CHILDREN AND YOUNG PEOPLE WHO DIED, 2018–2022

Characteristics	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total</b>		
<b>Persons 0–17 years of age</b>	117	
<b>Sex</b>		
Female	52	44.4%
Male	65	55.6%
<b>Age</b>		
< 28 days	56	47.9%
28–365 days	16	13.7%
1–4 years	9	7.7%
5–9 years	6	5.1%
10–14 years	15	12.8%
15–17 years	15	12.8%

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

## INDICATIVE CAUSE OF DEATH, ACT RESIDENT CHILDREN AND YOUNG PEOPLE, 2018–2022

Indicative cause of death	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Medical causes</b>	66	56.4%
Extreme prematurity	30	25.6%
Suicide	10	8.5%
Unintentional injury/accident (including transport and drowning)	6	5.1%
Unascertained	●	●
Fatal assault	●	●
SIDS and or SUDI <sup>b</sup>	●	●

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

<sup>b</sup> SUDI=sudden unexpected death in infancy; SIDS=sudden infant death syndrome.



## ICD-10 GROUPING CAUSE OF DEATH, ACT RESIDENT CHILDREN AND YOUNG PEOPLE, 2018–2022

ICD-10 grouping	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total</b>	117	
<b>Certain conditions originating in the perinatal period</b>	51	43.6%
<b>Injury poisoning and certain other consequences of external causes</b>	14	12.0%
<b>Congenital malformations, deformations and chromosomal abnormalities</b>	10	8.5%
<b>Neoplasms (cancers)</b>	9	7.7%
<b>Diseases of the nervous system</b>	9	7.7%
<b>Diseases of the circulatory system</b>	8	6.8%
<b>Symptoms, signs and abnormal clinical and laboratory finds, not elsewhere classified</b>	5	4.3%
<b>External causes of morbidity and mortality</b>	5	4.3%
<b>Diseases of the respiratory system</b>	5	4.3%
<b>Other medical disorders</b>	•	•

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

## BREAKDOWN OF INFANT DEATHS, 2018–2022

Infant Deaths	Number <sup>a</sup>	Per cent <sup>b</sup>
<b>Total</b>	105	
<b>ACT residents who died in the ACT</b>	62	62.0%
<b>ACT residents who died elsewhere</b>	10	10.0%
<b>Interstate residents who died in the ACT<sup>c</sup></b>	28	28.0%
<b>Cases before the Coroner</b>	5	5.0%

<sup>a</sup> Figures do not sum; coronial cases appear in more than one category.

<sup>b</sup> Percentages are percentages of all infant (<1 year) deaths on the ACT death register (n=105).

<sup>c</sup> The Canberra Hospital is a regional hub for perinatal and infant medicine and services many high-risk pregnancies in the ACT and surrounding regions.

## ACT RESIDENT INFANT DEATHS BY AGE GROUP AND SEX, 2018–2022

Characteristics	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent
<b>Total ACT Resident Deaths<sup>b</sup></b>	72	
Neonatal deaths under 28 days	56	77.8%
Infant deaths 28–365 days	16	22.2%
<b>Sex</b>		
Female	32	44.4%
Male	40	55.6%
<b>Total Interstate Resident Deaths<sup>c</sup></b>	28	
Neonatal deaths under 28 days	25	89.3%
Infant deaths 28–365 days	●	●
<b>Sex</b>		
Female	13	46.4%
Male	15	53.6%

<sup>a</sup> Figures do not include open coronial cases.

<sup>b</sup> Figures include ACT residents only, regardless of place of death.

<sup>c</sup> Figures include non-ACT residents only, who died in the ACT.

## NUMBER OF ACT NOTIFICATION REPORTS OF CHILDREN AGED 0–17 YEARS WHO HAVE DIED, 2018–2022

Child notification	2018–2022 Deaths <sup>a</sup>	
	Number	Per cent <sup>b</sup>
Child concern report only	15	12.8%
Child protection report	●	●
Appraisal	●	●
Not known to CYPs	86	83.8%

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

<sup>b</sup> Percentage does not sum due to suppression of small cells.

**DATE-OF-DEATH REPORTING FOR THE REGISTER**

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

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

**FEWER THAN FIVE TOTAL DEATHS**

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

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

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

**POPULATION ESTIMATES AND RATES**

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

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

## APPENDIX C RESPONSE TO RECOMMENDATIONS

### RESPONSE TO RECOMMENDATIONS OF THE CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE THAT RELATE TO THE OFFICE FOR MENTAL HEALTH AND WELFARE

Recommendations/action	Current activities
<p>Involve young people with lived experiences</p> <p>The Committee recommends that any future design and delivery of suicide prevention services include young people and their families who have a lived experience of suicide (including within the analysis and co-design process in relation to the Office of Mental Health working group on the responses to the needs of children and young people with moderate to severe mental health support needs.</p>	<p>The Office for Mental Health and Wellbeing (the Office) has routinely involved young people in co-design initiatives to ensure the voices of lived experience are included and help to shape the outcome for the community. This included the <a href="#">Review of Children and Young People in the ACT in 2019</a>, that involved engaging with the ACT Youth Advisory Council, the headspace Youth Reference Group along with parents and carers. Following this review, the Office led the design, development and implementation of <a href="#">MindMap – ACT Youth Portal</a> which was achieved through a co-design process with young people along with parents/carers and service providers. This is an ongoing process and continues to engage with a dedicated group of young people working with the Office to support the ongoing enhancements of MindMap, including most recently recruiting a young person with lived experience to help the engagement of young people for this project and others.</p> <p>Following the <a href="#">Missing Middle</a> report that was completed in partnership with the Youth Coalition and the Capital Health Network in 2022, a key recommendation was the establishment of a Child and Youth Mental Health Services Network that will support collaboration and connection across the mental health sector. A key aspect of this network is the establishment of a dedicated Youth Reference Group that will support key initiatives across youth mental health, including suicide prevention initiatives where relevant. It is anticipated this group will be operational in the coming months.</p> <p>Most recently, the Office worked with the University of Sydney’s Brain and Mind Centre to design a youth systems modelling tool for the ACT youth mental health sector. This project involved co-designing the tool with young people with lived experience to ensure the experiences of young people were included in the landscape of the mental health sector.</p>

<p>Evaluate current youth mental health and suicide prevention programs</p> <p>The Committee recommends that the ACT Government evaluate current youth mental health and suicide prevention programs, to determine their effectiveness including in meeting demand.</p>	<p>LifeSpan evaluation</p> <p>The ACT Government commitment to suicide prevention commenced in the 2018-19 Budget with investment of \$1.545 million in the Black Dog Institute's (BDI) LifeSpan Integrated Suicide Prevention Framework over three years to June 2021. LifeSpan is an evidence-informed approach to integrated suicide prevention. The high-fidelity research trial of the Lifespan framework in the ACT with BDI concluded 30 June 2021.</p> <p>The Office is continuing its priority focus on multifaceted approaches to suicide prevention in the ACT and continues to have a suicide prevention team. The Office is continuing to implement many of the suicide prevention initiatives commenced through the trial, ensuring they align with the Final Advice of the National Suicide Prevention Advisor to the Prime Minister and the National Suicide Prevention Taskforce.</p> <p>The final ACT LifeSpan report will be prepared once data is finalised (hospital admissions data and coronial suicide data).</p> <p>Question, Persuade, Refer Question, Persuade, Refer (QPR) is a free online suicide prevention training program that has been available in the ACT since 2020. In 2022, the Office reviewed the qualitative and quantitative feedback from the ACT relating to QPR and found strong evidence for the continuation of similar gatekeeper training. The Office is currently determining next steps, including consideration of a locally developed and domestically managed program that: considers the ACT multicultural community in terms of language barriers and access to technology; the needs of the broad ACT community; and ensures accessibility standards are met.</p> <p>MindMap</p> <p>MindMap is an online youth navigation portal to support children and young people to navigate and access mental health supports and services in the ACT. MindMap has been operational since October 2021 and is currently in the process of an initial evaluation to measure the effectiveness of the portal for the community. Noting the timeframe of this portal, a more detailed evaluation will take place over the coming years.</p> <p>Youth Aware of Mental Health</p>
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	<p>ACTHD continues to implement Youth Aware of Mental Health (YAM), an evidence-based mental health and suicide prevention program for young people aged 14-16 years.</p> <p>ACTHD received the findings from the BDIs research evaluation of YAM in ACT schools In September 2022.</p> <p>Unfortunately, the rigour of the BDI evaluation was significantly limited by a small data set and there was insufficient data to reach any meaningful conclusions about program efficacy in the ACT. This was largely due to the unforeseeable and unprecedented circumstances from the COVID-19 pandemic leading to school closures during many months of the data collection phases of the trial. These school closures had a considerable impact on the ongoing participation of many schools involved in the evaluation of YAM, and BDI did not meet the required data thresholds to conduct reliable analyses of pre-post data by condition.</p> <p>This was a disappointing outcome for the ACT, however, the efficacy of YAM is well-supported by high quality research evaluation (i.e. The 'Saving and Empowering Young Lives' student undertaken in Europe with over 10,000 students found that YAM reduced suicidal ideation by 50% and new cases of depression by 30%, and an evaluation by BDI in NSW found similar results).</p> <p>There continues to be strong support for YAM in the ACT, and Mental Illness Education ACT, our ACT YAM delivery partner reports strong bookings by schools for 2023. ACTHD will continue to support the implementation of YAM during 2023, while also reviewing the ACT implementation model, and alternative programs to ascertain that we are offering a program that is truly fit for purpose in the ACT.</p>
<p>Implement information campaigns</p> <p>The Committee recommends that targeted information campaigns be implemented that target young people at risk and their families. Specific information should be provided on risk factors, warning signs and available services so that those closest to young people in distress can provide support.</p>	<p>Youth Aware of Mental Health (YAM)</p> <p>YAM is an evidence-based mental health and suicide prevention program for young people aged 14-16 years. This school-based program actively engages the ACT's year 9 students with the topic of mental health through role-play and student-led discussions supported by a trained YAM Instructor. YAM is run over 3 weeks and the topics covered are:</p> <ol style="list-style-type: none"> <li>1. What is mental health?</li> <li>2. Stress and crisis</li> <li>3. Self-help advice</li> <li>4. Depression and suicidal thoughts</li> </ol>

	<p>5. Helping a friend in need</p> <p>6. Who can I ask for advice?</p> <p>MindMap</p> <p>MindMap has an ongoing marketing campaign run by the lead community provider, Marymead. This involves ongoing marketing of MindMap both on social media but also within schools. MindMap has a range of resources and information on suicide prevention and links to appropriate services within the ACT.</p>
<p>Implement and evaluate the Connecting with People program</p> <p>The Committee supports the proposed implementation of the Connecting with People program within ACT clinical settings, as a model of person-centred assessment and safety planning that uses peer-reviewed clinical tools.</p> <p>Following the initial rollout, the Committee recommends that evaluation of the program's effectiveness be conducted, which includes consideration of establishing the program in education and non-government organisation settings.</p>	<p>Connecting with People (CwP) is an evidence-informed, compassion-based approach to suicide prevention and risk mitigation which aims to develop a shared language to improve understanding of suicidal distress.</p> <p>Since March 2021, the Office has been supporting the commencement of the CwP compassion-based suicide prevention training in the division of Mental Health, Justice Health, Alcohol and Drug Services (MHJHADS). Planning for commencement of training in the ACT Emergency Departments and community Non-Government Sector was also underway.</p> <p>A medium level of saturation of CwP within MHJHADS was achieved and a go live date of 1 March 2023 was set for the integration of the Connecting with People framework and tools in the service. In October 2022, due to the introduction of the Digital Health Record the Division of MHJHADS to postpone CwP training until mid 2023. In light of this, the Office is currently revising the 2023 CwP training program, with a focus on the NGO sector.</p>
Implement a support plan process in clinical settings	MHJHADS responsibility – suggest nil response from the Office

<p>The Committee recommends the implementation of a proactive support plan for all young people following a suicide attempt. Young people and caregivers should be supported to be involved in the development of a support plan before discharge from clinical settings. Continuity of care with clear timeframes and an identified key person who will follow up on service engagement should be identified. This plan should be shared with all individuals and organisations identified as a support to the young person.</p>	
<p>Implement assertive outreach guidelines</p> <p>The Committee recommends that assertive follow up occur for young people after a suicide attempt, which should include contact within the first 24 hours, frequent contact, face-to-face visits and support that includes intense case management. Where possible, contact with young people and their families should be flexible, with the preference for professionals to meet with young people in their own environments.</p> <p>The Committee recommends that the ACT Government monitor the effectiveness of the Suicide Prevention Outreach Teams in</p>	<p>Suggested MHJHADS lead this response</p> <p>Supporting people after a suicide attempt or self-harm is critically important and highlights the importance of viewing a suicide attempt within the person's broader psychosocial needs and responding with effective and empathic care. As part of the Bilateral Agreement, the Office is leading a project to expand the services available to people after a suicide attempt and creating options for people to access care and support sooner. The Office is collaborating on this project with the Commonwealth Department of Health, Beyond Blue, the CHN and other states and territories.</p>



NSW to inform future planning of ACT suicide prevention outreach programs.	
<p>Train staff on responsible information sharing</p> <p>The Committee recommends that people from organisations who are likely to encounter suicidal young people be trained on responsible information sharing. This training should be followed with a communication strategy that provides clear guidance to professionals on information sharing guidelines</p>	Suggest Education and MHJHADS (nil response from the Office)

## RESPONSE TO RECOMMENDATIONS OF THE CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE THAT RELATE TO THE COMMUNITY SERVICES DIRECTORATE

Information Sharing and Recording	
Recommendations 1	Response
<p>Improvements to information sharing and recording practices aimed at enabling:</p> <ul style="list-style-type: none"> <li>• Government and related services to improve the systems and culture for sharing information in the interests of protecting vulnerable children. <ul style="list-style-type: none"> <li>○ To operate effectively there is a need for organisational and professional cultures with strong governance and practice leadership, which observe and understand the guiding legislation.</li> <li>○ The ACT jurisdiction should consider providing training to relevant organisations concerning appropriate information sharing. This includes greater funding to improve education around rights and responsibilities.</li> </ul> </li> <li>• Service providers to use informal system for sharing of information, moving away from a penalty framework, including sharing information on health referrals, decisions and recommendations. Access by doctors to health notes during pre-court assessment period.</li> </ul>	<p>CYPS note that this recommendation was closed in the 2020 CYPDRC Annual Report. Since then CYPS has continued to deliver work on information sharing.</p> <p>Child and Youth Protection Services (CYPS) policies, processes and systems that support information sharing, and the recording of practices to prevent the death of a child or young person include:</p> <p>Health Passports</p> <ul style="list-style-type: none"> <li>• My Health Passports are provided to children and young people 0-14 years in Out of Home Care. My Health Passport is a small booklet specifically designed to allow health information to be stored in one location. My Health Passport can be easily inserted into the ACT Personal Health Record, also known as the Blue Book. The intent of the My Health Passport is that carers take it to appointments in order to capture a contemporary and detailed summary of a child or young person's health records. The My Health Passport and Blue Book are used to document all health appointments and therapies for a child.</li> <li>• Information relating to a child or young person's health can be entered into their Health Passport by their carer, CYPS, ACT Together and practitioners from ACT Health and Women, Youth and Children Community Health services. Information about a child or young person's health can be reviewed or updated by Child at Risk Health Unit (CARHU), Child Health Checks, Maternal and Child Health Nursing Service (MACH) and Kindergarten Health Checks. My Health Passports are issued prior to the first CARHU out of home care health and</li> </ul>

<ul style="list-style-type: none"> <li>• Better decision making and better outcomes for individuals to reduce avoidable deaths of children and young people.</li> <li>• The assessment of risks when families move between jurisdictions.</li> <li>• The Directorate to ensure clients' documents are complete, information is recorded fully and accurately and that assessments are documented in a manner that records the justification of decisions made by professionals in regard to the safety of the child.</li> <li>• Ongoing engagement with the Commonwealth and other states jurisdictions with regards to the making of nationally consistent legislation and administrative arrangements, including the development of a national database, to enable the sharing of information related to the safety and wellbeing of children.</li> <li>• The Family Safety Hub should also look to discern patterns, trends and risk that can inform system improvements, identify systematic issues and assist with better service provision.</li> <li>• That current complaint processes in CYPS and ACT Together are reviewed to ensure that information is provided in ways that allow non-English speaking clients and those with literacy difficulties access to information.</li> </ul>	<p>wellbeing screening, which generally occurs within a week of a child or young person entering care.</p> <ul style="list-style-type: none"> <li>• In addition to the above carers are also encouraged to ask other health personnel (e.g. doctors, dentists and therapists) to record information in the Health Passport.</li> </ul> <p>Implementation of the Child and Youth Record Information System</p> <ul style="list-style-type: none"> <li>• The Child and Youth Record Information System (CYRIS) for CYPS went live for case management services on 1 October 2019, and replaced the 20-year-old legacy system CHYPS. CYRIS will be extended to Bimberi Youth Justice Centre in November 2020 delivering one record keeping system for all children and young people involved with CYPS.</li> <li>• The ACT Government has committed to expanding the scope of the development of the new system to the Child and Family Centres (CFCs) and the Child Development Service (CDS), and to build capability to integrate with key stakeholders. This work is underway. An important aspect to consider for CFCs is the requirement of consent from families to exchange information with other agencies.</li> <li>• The CYRIS system reduces duplication of data entry, provides a genogram view of family relationships, has a powerful reporting capability, is designed to integrate with other systems relatively simply and has removed the need for paper files.</li> <li>• When extended to all of Children, Youth and Families it will provide those working with families in the CFCs and CDS, with improved access to effectively manage information to case manage children and young people and help keep them safe.</li> </ul> <p>Connect for Safety (C4S)</p> <ul style="list-style-type: none"> <li>• Children, Youth and Families have been working on a national project to share information about children known to the child protection system in each Australian jurisdiction. Connect for Safety (known as C4S) is a secure business system that allows each jurisdiction to check if a child or their family members are known to another child protection jurisdiction. Every jurisdiction has agreed to participate, and the Commonwealth has funded the initial set up. Only basic demographic information is matched, but this is sufficient to identify risk and direct case managers to jurisdictions to find out more information.</li> </ul>
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	<ul style="list-style-type: none"> <li>• The C4S system went live at the end of September 2020 with NSW, Queensland, Victoria and Western Australian data available. The remaining jurisdictions, including the ACT will be providing data over the coming months.</li> <li>• This is an innovative project which will significantly improve risk assessment for children who have recently moved to the ACT and have no known history.</li> </ul> <p>Co-locating staff from key partner agencies</p> <ul style="list-style-type: none"> <li>• Key partner agencies have entered into information sharing agreements to best support child, young people and their families. These agreements and/or contracts include services delivered by Onelink, DVCS and Functional Family Therapy – Child Welfare. These agencies have staff who are co-located within CYPS to provided assistance to staff, to support referrals to services.</li> </ul> <p>Interstate Transfers</p> <ul style="list-style-type: none"> <li>• When a child or young person engaged with Child Protection Services moves in or out of the ACT, an ‘Interstate Alert’ or ‘Interstate Notification’ is sent from their originating State/Territory to their destination State/Territory (if known). This prompts CYPS, or its interstate counterparts, to request a child protection history under Part 10 of the Interstate Child Protection Protocol. Information sharing occurs throughout these processes and procedures.</li> <li>• There are current projects being trialled between the ACT and NSW in respect of information sharing. These projects are aimed at creating a database accessible by either the ACT or NSW that will provide information as to whether a child or young person is known by that jurisdiction. These potential databases contain functions such as creating matches on the identification of a child or young person, and allow for an alert system to be set up so the alert-creator is notified when a child or young person becomes known to another jurisdiction, amongst other functions. The trial of this database has already proved beneficial in the early stages.</li> </ul> <p>Office of the Coordinator-General for Family Safety</p>
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	<ul style="list-style-type: none"> <li>• The Office of the Coordinator-General for Family Safety is currently progressing legislative reforms to allow and support improved sharing of information in order to identify risk of domestic and family violence. While this legislation is focussed on information sharing in relation to adult victims, improving the safety of adult victims of domestic violence will also improve the safety of their children.</li> <li>• A common dataset has been developed within the Community Services Directorate (CSD) to enable better analysis of client demographics and use of services. The dataset provides a guide for the collection of relevant service user data, including personal details, key characteristics, presenting needs and circumstances, service journey and service experience and outcomes.</li> </ul> <p>CYPS located at ACT Family Law Court</p> <ul style="list-style-type: none"> <li>• As part of an Australian Government pilot program, CYPS has commenced a liaison role with the Federal Circuit Court's Family Court. The intent of the pilot program is for CYPS to be co-located at the Court, but with COVID-19 restrictions this aspect is largely happening remotely for the time being. The aim of the pilot is to enhance and streamline information sharing between CYPS, the AFP and the Court to ensure the Court has all the necessary information to make timely and safe decisions for children. CYPS provide: <ul style="list-style-type: none"> <li>○ the Court timely information in response to notice of risk information requests and 69ZW orders</li> <li>○ the Court timely information to inform independent child and parenting assessments</li> <li>○ work in collaboration with AFP and Court on the identification and management of family safety risks</li> <li>○ assist with urgent applications to be heard by the Court on an <i>ex parte</i> basis (principally applications for recovery orders) and indicate if CYPS holds relevant information</li> <li>○ support referrals by CYPS to the Court</li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>○ support the development, evaluation and analysis of policies and procedures related to information sharing between CYPS, the AFP and the Court.</li> <li>• By providing a dedicated liaison role, CYPS are providing a practical way for CYPS, the AFP and the Court to work smarter together, minimising barriers and enabling relevant information to be shared early in proceedings to help keep children and young people safe. It also provides the opportunity to increase the knowledge and understanding of the Court and AFP of our CYPS risk assessments and processes.</li> <li>• The Children, Youth and Families Community Engagement and Client Services (CECS) Team, consider level two complaints, including those about Child and Youth Protection Services. CECS is about to enter a period of change to pivot the complaints process to one that takes a conciliation and restorative practice approach. One aspect of change will be to ensure boarder accessibility for all people to be able to contact CECS and make a complaint about services provided by Children, Youth and Families.</li> <li>• The governance structure of the ACT Government's Out of Home Care Strategy <i>A Step up for Our Kids 2015-2020 (Strategy)</i> provides various fora to raise policy, systems and operational issues that relate to the provision of services funded under the Strategy. It is governed by one Joint Governance Group, and four sub-committees that address issues under the auspices of Accountability, Performance and Evaluation; Carer Wellbeing; Policy and Operations; and Workforce Capability.</li> <li>• ACT Togethers internal complaints policy and procedures is an ongoing piece of work, the review is well progressed, but not yet complete.</li> </ul>
Addressing the risk factors in children's lives	
Recommendations 2	Response
<p>Improvements in responding to risk factors through:</p> <ul style="list-style-type: none"> <li>• Reviewing current practice models following prenatal reports to maximise early intervention strategies across ACT Health and Community Services Directorate before the birth of a child, including access to GPs and</li> </ul>	<p>The following activities, resources and roles continue to support improvements to responding to risk factors.</p> <p>Child and Youth Protection Services (CYPS) are undertaking a number of key pieces of work to respond to this recommendation, alongside the work to implement the Our Booris Our Way review.</p>

<p>prenatal health checks. Need to follow up non-attendance at appointments.</p> <ul style="list-style-type: none"> <li>○ The engagement of culturally appropriate services for Aboriginal and Torres Strait Islander and Culturally and Linguistically Diverse families.</li> <li>● Establishing a mechanism to identify and review children who have been reported to CYPS where four reports or more have been made and where the following co-existing risk factors have been identified: <ul style="list-style-type: none"> <li>○ domestic and family violence</li> <li>○ substance misuse</li> <li>○ unstable housing</li> <li>○ limited parental service engagement.</li> </ul> </li> <li>● Reviewing the capacity for current practices to identify and respond to cumulative harm through: <ul style="list-style-type: none"> <li>○ Review of the legislation to test whether it is sufficient in protecting children where risks do not meet current thresholds for intervention but where cumulative harm is identified.</li> <li>○ Training and mandatory refresher courses for workers raise awareness of the full extent of their powers under legislation. Training programs should be evaluated to assess their effectiveness.</li> </ul> </li> </ul>	<p>CYPS' Cultural Services Team has established a pre-natal pilot program. The pilot program will offer case management to women pregnant with an Aboriginal and/or Torres Strait Islander child who have been prenatally reported to CYPS. With consent from the mother, the pilot program will undertake an assessment using the North Carolina Family Assessment Scale (NCFAS) and the Wellbeing and Trauma Scale, to identify areas of support. The pilot program will then provide case management prenatal support to mothers with the view to the mother and child being supported postnatally within the community.</p> <p>Alongside the pre-natal pilot, CYPS are also currently establishing a team of dedicated and experienced case workers to work alongside Aboriginal and Torres Strait Islander families. The team will contribute to the development of a new practice framework. The team will be led by the Aboriginal and Torres Strait Islander Child Placement Principle as a base, and will be encouraged to test standardised and empirically-validated assessment tools like Structured Decision Making, Signs of Safety and the NCFAS. Learnings from this team will be used to support CYPS to move towards a family services approach.</p> <p>To build CYPS' capacity to respond to families and risk more immediately, CYPS continue to engage the Safe and Together Institute to deliver training in the Safe and Together model. The model ensures the CYPS workforce is domestic violence-informed, and promotes preservation of children with a protective parent. 40 staff have been trained in 2022, bringing the total number of staff trained in the model to over 100. Another 40 staff will be trained in 2023. CYPS continues to explore the option of participating in the Train the Trainer program and it is anticipated up to 5 staff will be trained in 2023. CYPS continues to consider approaches to embed the key learnings of the Safe and Together model, across all training and practice development initiatives.</p> <p>As part of the implementation of the Safe and Together model, CYPS are reconsidering the child protection intake model to ensure consistent and timely risk assessment. The changes will also enable earlier access to Family Group Conferencing, warm referrals to support, and enhanced connection to Child and Family Centres at Intake.</p> <p>CSD's Strategic Policy Division are currently reviewing the <i>Children and Young People Act 2008</i> to modernise the Act. This means ensuring it sufficiently enables CYPS to support children and families earlier, identify cumulative harm and empower staff to not only respond to instances of abuse and</p>
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	<p>neglect, but support families to engage with services that address root causes including domestic and family violence, substance misuse and unstable housing.</p> <p>CSD has also recently released a Domestic and Family Violence (DFV) Risk Assessment and Management Framework (the Framework). This framework outlines common understandings of DFV, risk indicators and appropriate responses. The framework includes a general section on children and young people and work is ongoing to develop this section with specific indicators of risk and appropriate children and young people focussed responses.</p>
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Enhanced supports for families under pressure	
Recommendations 3	Response
<p>Enhanced supports for families under pressure that address:</p> <ul style="list-style-type: none"> <li>• The need for access to and connection with services that can assist families to avert crisis, with a clear and trusted access point for families at points of crisis. <ul style="list-style-type: none"> <li>◦ Voluntary family support services should be provided by someone other than CYPS to avoid duality of roles.</li> </ul> </li> <li>• The provision of interim follow up support from caseworkers where they make referrals for vulnerable families but are waiting for services to commence.</li> </ul>	<p>CYPS note that this recommendation was closed in the 2020 CYPDRC Annual Report. Since then CYPS has continued to deliver work enhancing supports for families under pressure.</p> <p>Integrated Services and Programs</p> <ul style="list-style-type: none"> <li>• In July 2015, Child Protection Services and Youth Justice Services integrated to establish CYPS. A key feature of the integration of child protection and youth justice is a single case management model across both functions. This model focuses on the appointment of a single case manager across both custody and community, responding to both care and protection and youth justice matters, to provide consistency and seamless service delivery to young people throughout their involvement.</li> </ul> <p>OneLink</p> <ul style="list-style-type: none"> <li>• OneLink is a free phone and outreach-based service that provides information and referral for children, young people and their families seeking accommodation and family support. OneLink</li> </ul>



<ul style="list-style-type: none"> <li>• The need for services to be proactive in engaging parents to benefit from services, such as the National Disability Insurance Scheme, and the need for children and young people to be at the centre of decision making about services.</li> <li>• The need for a case planner to provide continuity of relationships and direction for family, as well as to facilitate communication between service providers. This applies in the health setting too.</li> <li>• The awareness of professionals to recognise and respond to stress in families and to better understand the impact that this has on children when other risk factors are evident.</li> <li>• The need for innovative and evidence-informed approaches to working with individuals who have experienced intergenerational trauma, particularly in relation to: <ul style="list-style-type: none"> <li>o children who are identified as experiencing cumulative harm</li> <li>o young parents who were engaged in statutory child protection services and/or corrective services</li> <li>o male and female perpetrators of family violence.</li> </ul> </li> <li>• The need for vulnerable families with an intergenerational history of abuse to be offered trauma-informed targeted parenting support prior to and following birth of their child in a non-stigmatising maternal health service.</li> </ul>	<p>brings together families, support services and community resources to help promote the safety and wellbeing of children, young people and families. OneLink can help all members of the community including people who are already or might become involved with statutory agencies like CYPS.</p> <ul style="list-style-type: none"> <li>• CYPS funds two part-time CYPS OneLink Liaison Officers. These OneLink staff co-locate two days a week with CYPS to facilitate improved referral pathways for families known to CYPS. The OneLink workers provide information about and referrals to services including child, youth and family services; tenancy support; support for people who are homeless including emergency accommodation; legal services; financial counselling; mental health services.</li> </ul> <p>Safer Families Collaboration Pilot</p> <ul style="list-style-type: none"> <li>• The Domestic Violence Crisis Service are working with CYPS under a <i>Safer Families Collaboration Pilot</i>, to provide expert family and domestic violence advice and support to CYPS in delivering child protection and youth justice services to the ACT community. This pilot program increases the capability of CYPS to respond to families impacted by Family and Domestic Violence.</li> </ul> <p>Functional Family Therapy – Child Welfare</p> <ul style="list-style-type: none"> <li>• Gugan Gulwan Youth Aboriginal Corporation, in partnership with OzChild, deliver Functional Family Therapy for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with the child protection system. The aim of the program is to reduce the number of Aboriginal and Torres Strait Islander children and young people entering, or remaining in out of home care, through interventions that strengthen families and communities. OzChild are co-located with CYPS staff one day each fortnight to support referrals to the program and to answer any questions CYPS staff may have about eligibility.</li> </ul> <p>Uniting</p> <ul style="list-style-type: none"> <li>• <i>Newpin</i> is primarily a group-focused centre-based program, with families and children attending 2 days per week for up to 18 months. Newpin provides parent therapeutic sessions, parenting education groups and therapeutic family play sessions. Parent education programs focus on attachment, safety and meeting the emotional needs of children. Occasional home visits are</li> </ul>
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<ul style="list-style-type: none"> <li>○ The ACT jurisdiction should consider the introduction of standardised empirically validated assessment tools to use in the pre and post- natal periods in order to identify vulnerable families requiring further support. This should include necessary training for practitioners.</li> </ul>	<p>made to assess progress with transference of new skills to the home environment, and preparedness for restoration.</p> <p>Australian Childhood Foundation – intensive support</p> <ul style="list-style-type: none"> <li>• The Australian Childhood Foundation, as part of the ACT Together consortia, provide therapeutic specialist support and advice specific to children and young people through the child or young person’s individual care team and professional meetings to collective work through the best approach to meeting the child or young person’s needs.</li> <li>• As part of this process, a therapeutic assessor will undertake an evaluation of all information on the child or young person including health screening, observation and analyses the information gathered. The therapeutic assessor presents the information and their assessment to the child or young person’s therapeutic care team.</li> <li>• Some strategies to reduce serious behaviours and mental health concerns can include 24-hour professional support, individually tailored behavioural support plans, mental health assessments and treatment and increased supervision.</li> </ul> <p><i>Family Group Conference</i> – divert families away from court process</p> <ul style="list-style-type: none"> <li>• During 2017-18, CYPS developed a Family Group Conferencing model for Aboriginal and Torres Strait Islander families at risk of ongoing involvement with the child protection service. The aim of Family Group Conferencing is to provide families with the opportunity to develop effective family plans that will keep their children safe. The priority is working with the family to keep children at home or planning for the successful restoration of children back to their families following some time in out of home care. Where children are not able to stay safely at home, the team works with and supports the families to identify the most appropriate kinship options to ensure the children remain connected to family and community. Family Group Conferencing ensures all members of a child’s extended family are contacted and encouraged to be involved in the decision-making process about their child’s situation. This process is considered in line with Aboriginal and Torres Strait Islander cultural values of family and community responsibility.</li> </ul> <p>Child and Family Centres</p> <ul style="list-style-type: none"> <li>• The CFCs are co located with Maternal and Child Health (MACH) services. MACH nurses refer clients identified as vulnerable to the CFC service on a regular basis. The CFC staff and</li> </ul>
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	<p>MACH staff share clients on occasion, the “warm referral” process on site is a very successful model of supporting these vulnerable clients. MACH nurses are able to complete “warm referrals” with identified vulnerable families by walking the clients to the CFC intake office and making introductions. With consent, the needs of the clients are then discussed, and the CFC will complete an assessment to link the family with supports and service either on site or in the wider community.</p> <ul style="list-style-type: none"> <li>• Evidence of the strong working relationships being of benefit to the community is seen in the flexibility of the MACH nurses on site weekly who will immunise CFC clients without appointments. This ensures that this barrier is removed for the families and the children receive this essential free service.</li> </ul> <p>Evidence based approaches</p> <p>Case Analysis Team</p> <ul style="list-style-type: none"> <li>• The Case Analysis team has developed a specific methodology which was informed by the recommendations of both the Glanfield and Muir reviews and has been endorsed by its oversight Committee comprising expert ‘critical friends’ from other jurisdictions. This methodology applies a consistent approach to reviewing each case but allows for individualised terms of reference in order to deliver to CYPS staff, appropriate and specific recommendations which relate to each child in the family, as well as the family as a whole.</li> <li>• The team is staffed by three full-time equivalent senior and experienced case analysis staff, all of whom have professional qualifications as well as review expertise and firsthand child protection experience. This has allowed the ACT to provide a professional and individualised response to each referred case, rather than relying on use of an empirical tool which is typically relied upon by larger jurisdictions with fewer professional staff and less capacity to provide a tailored response.</li> </ul> <p>IMPACT Program</p>
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	<ul style="list-style-type: none"> <li>• The IMPACT Program is a voluntary program based on client consent for full information sharing across agencies. The IMPACT team consists of two coordinators based at The Canberra Hospital (TCH) and three Liaison Officers who are located in their operational areas, consisting of the Alcohol and Drug Liaison at TCH, the Mental Health Liaison at Perinatal Infant Mental Health, Woden and the CYPS Liaison located within CYPS.</li> <li>• A major function of the program is a multiagency membership which consists of representatives from TCH Social Work, MACH nurses, Alcohol and Drug Service, Perinatal Infant Mental Health, CYPS IMPACT Liaison The Blue Star Clinic TCH, TCH and Calvary Maternity and Co-ordinators represent feedback from General Practitioners, NGOs and any other service providing support to families.</li> </ul>
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Child-focussed practice	
Recommendations 4	Response
<p>Changes to services to make them more focussed on children by:</p> <ul style="list-style-type: none"> <li>• Enabling access to comprehensive medico-psychosocial assessment for families with multiple and complex needs, with services prioritised to the child's assessed needs.</li> <li>• Moving the focus of services to the best interests of the child, in particular the child's safety and assessing whether the child's needs are being adequately addressed.</li> <li>• Shifting the focus to cumulative risk, rather than episodic risk, so that the family or child's</li> </ul>	<p>CYPS note that this recommendation was closed in the 2020 CYPDRC Annual Report. Since then CYPS has continued to deliver work to improve child-focussed practice.</p> <p>Melaleuca Place</p> <ul style="list-style-type: none"> <li>• Melaleuca Place is a specialised therapeutic service in the ACT focused on helping young children recover from the impacts of child abuse and neglect. The CYPS staff work with children aged 0 to 12 years old involved with child protection, and their carers. The specialised services help children to understand and work through the trauma that has happened, their emotions and to learn to trust again.</li> <li>• The CYPS staff at Melaleuca Place are a highly skilled team of clinical psychologists, social workers, a speech pathologist, an occupational therapist, and an operational support officer.</li> <li>• The team at Melaleuca Place provide multidisciplinary psychosocial assessments that outline the child's multiple and complex needs. These assessments guide treatment planning to meet the specific therapeutic needs of the child in a sequential, phase-based approach.</li> </ul>

<p>need can be addressed holistically, rather than in an ad-hoc piecemeal way, where the scale of the problem only becomes evident after an event.</p> <ul style="list-style-type: none"> <li>• Organisations and professionals working with young children need to be supported to recognise that all children, including very young children, have rights as set out in the <i>United Nations Convention on the Rights of the Child (1989)</i>. Professionals need to be supported to build capacity, skills and knowledge to work, think and act in a way that supports the implementation of children's rights.</li> <li>• Building organisational and workplace cultures within the ACT that embrace a range of practices and attitudes that aim to keep the 'child in mind'. Further work is required to develop and support all professionals and adult services, such as Corrective Services, to be aware of and to act with the best interests of the child as a primary consideration.</li> </ul>	<ul style="list-style-type: none"> <li>• Melaleuca Place works from a child-centred, strengths-based framework, respecting the child's wishes and best interests. The staff at Melaleuca Place are trained in various evidence-based treatment modalities to match the child's changing needs.</li> <li>• Melaleuca Place will also work with the child's declared care team to establish a therapeutic care environment, prioritising safety and stability, and helping the care team respond to the child in a trauma-informed manner.</li> </ul> <p>Establishment of the Case Analysis Team</p> <ul style="list-style-type: none"> <li>• The Case Analysis team undertakes case analysis of identified cases of children and young people with extensive involvement with the child protection service, or those considered at high risk. The team provides independent advice and quality assurance to caseworkers and team leaders. The team assists CYPS to further develop consolidated histories which identify historic and current risks, impact, and risk of cumulative harm, identified vulnerabilities to children's safety and protective factors which mitigate the vulnerabilities.</li> </ul> <p>Embedding the Human Rights of Children and Young People</p> <ul style="list-style-type: none"> <li>• The ACT was the first jurisdiction to enact the <i>Human Rights Act 2008</i> in which the rights of children are included. The <i>Human Rights Act 2004</i> provides the statutory basis for respecting, protecting and promoting civil and political rights in the ACT. This means that every Directorate embeds the principles and rights of the <i>Human Rights Act 2004</i> in the development and implementation of all strategic and organisational policies and documents including contracts with the NGO sector.</li> <li>• To support ongoing efforts to embed best practice and promote a human rights culture in policy implementation, CYPS ensure staff are appropriately trained in policy and legislation, including the <i>Children and Young People Act 2008</i> and the <i>Human Rights Act 2004</i> to fulfil obligations in supporting children and young people and their families who are involved in the child protection system.</li> </ul>
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	<ul style="list-style-type: none"> <li>Decision making in the ACT is subject to unique and complex oversight obligations to six separate statutory office holders (across several legislations) including; the Public Advocate of the ACT, the ACT Children's Commissioner, the Senior Practitioner, the ACT Ombudsman, the Official Visitors (including an Aboriginal and/or Torres Strait Islander Official Visitor) and the Human Services Registrar. Amongst other things, these agencies receive copies of all abuse in care reports which proceed to an investigation, as well as copies of all applications for new or amendments to Care Orders, Emergency Action, Youth Justice Orders, copies of Annual Reports pertaining to all children in care and Case Plans (including Cultural Plans, Transition Plans, Care Plans and Youth Justice Case Plans).</li> <li>CYPS welcomes the introduction of an external review of decisions process to streamline these obligations and eliminate the current duplication in reporting, as well as current lack of legal harmony between these legislations. The internal review process, which will commence in 2021 will create a suitable platform for consistent recording of all key child protection and youth justice decisions.</li> </ul>
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Assessment of parenting capacity	
Recommendations 5	Response
<p>To enable CYPS to better assess parenting capacity:</p> <ul style="list-style-type: none"> <li>The ACT jurisdiction should consider the introduction of standardised empirically validated assessment tools to use in the pre and post-natal periods in order to identify vulnerable families requiring further support.</li> </ul>	<p>Functional Family Therapy – Child Welfare</p> <ul style="list-style-type: none"> <li>Gugan Gulwan Youth Aboriginal Corporation, in partnership with OzChild, continue to deliver <i>Functional Family Therapy – Child Welfare</i> in the ACT. Functional Family Therapy – Child Welfare works specifically with Aboriginal and Torres Strait Islander families with children and young people aged from birth to 17 years who are facing vulnerable times in their lives and are at risk of entering the out of home care system.</li> <li>Functional Family Therapy aims to support families to keep child and young people at home safely, reducing or eliminating the need for ongoing involvement of the child protection system and creating positive family experiences.</li> </ul>

<p>This should include necessary training for practitioners</p> <ul style="list-style-type: none"> <li>• The ACT jurisdiction should consider establishing a high-quality parenting capacity assessment service and support for parents with children where four reports have been received about a child by CYPS, including any prenatal reports.</li> <li>• All information and reports from parents provided to services need to be tested through accessing information from other services, particularly in regard to reports of parental drug and alcohol use or instances of domestic violence.</li> </ul>	<ul style="list-style-type: none"> <li>• Since implementation of the Pilot Program in November 2018 to 30 June 2020, Oz Child and Gugan Gulwan Youth Aboriginal Corporation, have engaged with a total of 40 families involving 116 children and young people. Of this, 25 families, made up of 82 children and young people, have successfully completed the Functional Family Therapy (FFT-CW program) with no subsequent entries of children and young people in the out of home care system.</li> <li>• For Aboriginal and Torres Strait Islander families at risk of involvement with the child protection system, the ACT Government is currently supporting a trial of Functional Family Therapy being delivered by Gugan Gulwan Youth Aboriginal Corporation in partnership with OzChild.</li> </ul> <p>Child and Family Centres and Child Development Service (CDS)</p> <ul style="list-style-type: none"> <li>• Parents who require less intensive parenting support can access to a range of programs and services through the CFCs in Gungahlin, Tuggeranong and West Belconnen, and through community organisations funded under the Child, Youth and Family Support Program. These programs may include family support or counselling services. CFCs also partner with other community organisations to offer parenting programs.</li> <li>• The new <i>Child and Young People Record Information System</i> (CYPS) is in the process of implementing a new client management system (CYRIS), which will allow for improved information sharing and data matching between agencies and mandatory reporters. The Government has committed to expanding the scope of the new system to include CFCs and the CDS, and to build capacity to integrate with key stakeholders.</li> <li>• The project will build connections with key government partners, commencing with ACT Policing and the Education Directorate, and will allow automated real time information exchange of risk, safety and wellbeing information about children and young people. The system will provide CYPS staff, and those working with families in the CFCs and CDS, with improved access to effectively manage information to case manage children and young people and help keep them safe.</li> </ul>
Staff training and development of decision making capacity	

Recommendations 6	Response
<p>Enhanced training and development for staff working with families to ensure:</p> <ul style="list-style-type: none"> <li>• Improved interpretation of drug screen results to assess the impact of the drug use on the capacity to provide safety and care. This could be through training or practice directions.</li> <li>• That supervision of staff assists in critical reflection of casework, decision and practice and professional development. <ul style="list-style-type: none"> <li>○ Professional development opportunities such as supervision and in-service staff training should be provided in organisations working with vulnerable families to ensure that workers utilise current knowledge of the impact of gender in assessment and interventions and incorporate gender sensitive strategies into routine practice, particularly in relation to client experiences of trauma, domestic violence and service utilisation.</li> </ul> </li> <li>• The use of evidence-based decision making in relation to the restoration of children to their parents. Need for clarification around when restoration is no longer considered in the best interests of the child.</li> <li>• Improvements to the way CYPS make judgements about the veracity of reports and comprehensiveness of reports, including need for comprehensive assessment of cumulative</li> </ul>	<p>CYPS note that this recommendation was closed in the 2020 CYPDRC Annual Report. Since then CYPS has continued to deliver work to improve training and development for staff working with families.</p> <p>CYPS Training and Development</p> <ul style="list-style-type: none"> <li>• The CYPS Training and Workforce Development team provides specialist support to CYPS staff by delivering face-to-face and eLearning training; and assisting to increase the knowledge capacity and skills of staff within the child protection system. The team has developed, implemented and maintained a significant number of training programs since its establishment.</li> <li>• An e-Learning package on cumulative harm has been developed for CYPS staff. Key learnings from the training include understanding the impacts of cumulative harm; identifying the indicators of cumulative harm; being able to take appropriate action when you believe you have identified when cumulative harm is present; and knowing where to find more information and support to assist in developing your knowledge of cumulative harm.</li> <li>• CYPS provides intensive training to staff in relation to family and domestic violence, which focuses on supporting the protective parent where family safety is identified as a significant risk. A key component of this training also includes engaging fathers, through a whole family approach to safety.</li> <li>• In early 2021, CYPS will engage the Safe and Together Institute to undertake an organisational assessment and to deliver training to CYPS staff, including CYPS executive, the CYPS Leadership team and case managers. This will ensure the Safe and Together principles are imbedded in both practice and policy development across the organisation.</li> <li>• Housing ACT has also recognised the importance of frontline staff being aware of the issues impacting children and young persons that may be impacted by trauma. Modules on 'Keeping Children and Young People Safe' and the 'Reportable Conduct' have been included amongst the core competency training that Client Service Branch staff are required to complete. As at 2 October 2020, 75% of Client Service Branch staff have completed the Keeping Children Safe</li> </ul>



<p>harm, particularly for older children where imminent risk may not be present.</p> <ul style="list-style-type: none"> <li>• The presumption of the mother as the ‘protective parent’ as observed in records and applied by workers is critically reviewed. The participation of both parents/caregivers in assessments and interventions should be required where it is evident that both parents/caregivers are involved in the care of the child.</li> <li>• Good data is used to support judgements about weighting decisions with regards to the capacity of the parents as opposed to the vulnerabilities of the child.</li> <li>• That any internal merits review process implemented by CYPS: <ul style="list-style-type: none"> <li>○ Is underpinned by the key values of the best interest’s principal, timeliness of decision making, participation and transparency;</li> <li>○ Is codified by amending the Children and Young People Act 2008.</li> </ul> </li> <li>• The ACT jurisdiction should consider establishing an external merits review mechanism that would hear matters not</li> </ul>	<p>module and 78% of staff have completed the Reportable Conduct training. Housing ACT is seeking to have all frontline staff complete these modules by the end of 2020.</p> <p>Role of CYPS Principle and Senior Practitioners</p> <ul style="list-style-type: none"> <li>• The Senior Practitioners are responsible for providing expert case practice advice and leadership, supporting and developing case managers in the integration of theory and practice while demonstrating expertise through case management. The Principal Practitioner’s roles are focussed on driving excellence in service delivery through a range of interventions including co-working on case management, strategically working to improve practice and through direct case management of complex and/or sensitive cases, as well as: <ul style="list-style-type: none"> <li>○ Develop and share professional knowledge to facilitate and promote best practice service delivery. Including developing knowledge, understanding and ability to articulate a cohesive practice framework regarding child development, attachment, and trauma theories.</li> <li>○ Build a positive culture of feedback, reflective practice and learning by fostering a collaborative learning environment.</li> <li>○ Build knowledge across CYPS of the legislative and policy drivers for trauma informed case management practices.</li> <li>○ Actively participate in reflection sessions and other review opportunities to improve delivery of child, young people and family focussed outcomes.</li> <li>○ Coach and mentor other staff (including team leaders) in case management to continuously improve engagement and service delivery.</li> </ul> </li> <li>• Work with and support the Practice Leaders, other Principal and Senior Practitioners, Team Leaders and Operations Managers in their roles as coaches and mentors.</li> </ul> <p>Children and Young People Act 2008 – Best Interests Principle</p> <ul style="list-style-type: none"> <li>• Decisions about the long-term placement of children are complex ones and are guided by the Children and Young People Act 2008 (the Act) and often in the context of the ACT Children’s Court through a Case Management Conference negotiation. The Act requires that when</li> </ul>
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adjudicated by a court and that were not resolved through internal review.	decisions are made in relation to a particular child, the decision maker must regard the best interests of the child as the paramount consideration. These decisions are typically discussed in the context of declared care teams and recorded in a transparent and easily reviewable format.
Safe sleeping	
Recommendations 7	Response
<p>Provide families with information on safe sleeping through:</p> <ul style="list-style-type: none"> <li>• Consistent guidelines agreed across the directorates and delivered through the continuum of services. <ul style="list-style-type: none"> <li>○ Cross-directorate agreement is established about safe sleeping guidelines.</li> <li>○ Professionals and providers have access to evidence-based training and resources on safe sleeping.</li> </ul> </li> <li>• The provision of safe infant sleeping promotion, co-sleeping and bed- sharing messages to all caregivers prior to and after the birth of the child by health and social welfare professionals.</li> <li>• Ensuring vulnerable families are provided with the necessary support to obtain appropriate bedding for the child prior to leaving hospital.</li> </ul>	<p>CYPS note that this recommendation was closed in the 2020 CYPDRC Annual Report.</p>

Blind Cords	
Recommendation 8	Response
The Committee wrote to the Director-General of Community Services in 2014, following the deaths of two young children in NSW as a result of blind cord injuries. The Committee recommended that ACT Housing perform inspections of blind and curtain cords for safety and compliance with standards as part of the housing inspection process. The Committee also recommended that ACT Housing introduce methods to increase the safety of corded internal window coverings in public housing, such as the installation of safety devices.	Housing ACT note that this recommendation was closed in the 2020 CYPDRC Annual Report.

## RESPONSE TO RECOMMENDATIONS OF THE CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE THAT RELATE TO THE ENVIRONMENT, PLANNING AND SUSTAINABLE DEVELOPMENT DIRECTORATE

The ACT Government is committed to preventing death and serious injuries from drownings and near drownings in home swimming pools. Regulatory reforms will be introduced in 2023 that will require all home swimming pools to have a barrier compliant with modern safety standards. The reforms will apply to all ACT home swimming pools and spa pools that are capable of containing water to a depth greater than 30cm (with exemptions available in specified circumstances). Home swimming pools means pools associated with a residential building such as a house, unit, townhouse or block of apartments. This includes in-ground and above-ground pools, both temporary and permanent pools. It includes wading pools, splash pools, inflatable pools, demountable pools, concrete pools, portable pools, kids' pools and spa pools. The reforms will not apply to swimming pools in tourist and visitor accommodation such as hotels, motels and caravan parks.

The reforms will:

- require all home swimming pool barriers to comply with modern safety standards
- require ongoing maintenance of home swimming pools and barriers with a penalty for non-compliance
- require disclosure of a pool's compliance status when the property is sold or leased
- establish a compliance framework to support the enforcement of the above.

The reforms will not include a registration system for pools or require CPR training or signage. A registration system was not considered necessary to support the enforcement of these reforms due to existing data held by government on building approvals for swimming pools. existing government processes.

Improvements to compliance will be achieved through several initiatives, including:

- a disclosure scheme at the time of sale or lease of a property requiring disclosure of the property's pool fencing compliance status
- ongoing maintenance requirements
- an increased inspection and compliance program.

The ACT Government will continue to promote the importance of CPR training and CPR signage at swimming pools through its Backyard Lifeguard campaign and website.

Public consultation for the reforms ran from 1 February to 15 March 2023, with the outcomes of the consultation informing the final design of the reforms. The reforms will be introduced in 2023, with a specified transition period for pool owners to meet the new requirements.

[Subject to when this input is required for publication, we can potentially provide further information on the final design of the reforms]

## RESPONSE TO RECOMMENDATIONS OF THE CHILDREN AND YOUNG PEOPLE DEATH REVIEW COMMITTEE THAT RELATE TO CANBERRA HEALTH SERVICES



**ACT**  
Government

**Canberra Health  
Services**

Ms Margaret Carmody  
Chair  
ACT Children and Young People Death Review Committee  
[childdeathcommittee@act.gov.au](mailto:childdeathcommittee@act.gov.au)

Dear Ms Carmody

Thank you for your letter of 13 September 2021 regarding an update on a recommendation made by the Committee in 2015 to develop a protocol for managing the treatment of button battery ingestion.

I am pleased to advise that Canberra Health Services (CHS) has developed the *Suspected Foreign Body and Button Battery Ingestion Practice Guideline – Paediatrics (Infants, Children and Adolescents)*.

The Practice Guideline provides clinicians with guidance on the management of paediatric patients with suspected or actual ingestion of a foreign body. I have attached a copy of the Practice Guideline for your information at Attachment A.

The guideline was prepared for the Sydney Children's Hospitals Network and has been endorsed for use at CHS.

Thank you for writing to me about this matter.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Dave Pepper'.

Dave Pepper  
Interim Chief Executive Officer  
Canberra Health Services

18 October  
September 2021

## GLOSSARY

Aboriginal and/or Torres Strait Islander	<p>In the Children and Young People Act 2008 (ACT):</p> <p>Aboriginal or Torres Strait Islander person means a person who –</p> <ul style="list-style-type: none"> <li>a) is a descendant of an Aboriginal person or Torres Strait Islander person; and</li> <li>b) identifies as an Aboriginal person or Torres Strait Islander person; and</li> <li>c) is accepted as an Aboriginal person or Torres Strait Islander person by an Aboriginal community or Torres Strait islander community.</li> </ul>
Certain conditions originating in the perinatal period	<p>Refers to deaths whose cause originates in that period, even though death may occur later. According to the World Health Organisation (WHO), the perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500g) and ends seven completed days after birth (WHO, 2011). The ACT definition differs in that the perinatal period begins from 20 weeks gestation and 400 grams in birthweight.</p>
Child	<p>In the Children and Young People Act 2008 (ACT):</p> <p><i>child</i> means a person who is under 12 years old.</p> <p>The <i>Children and Young People Act 2008</i> (ACT) does not provide guidance on when an individual becomes a ‘child’. In accordance with common law, a child is a person who has been born alive, which means the child must be living outside its mother’s body by virtue of the functioning of its own organs and indicated by breathing, beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. The term ‘a child born alive’ does not include stillbirths or other foetal deaths.</p>
Child concern report	<p>Refers to a report made to Care and Protection Services in accordance with s. 359 of the Children and Young People Act 2008 (ACT) and can be made by either a voluntary or a mandated reporter. A Child Concern Report is a record of information regarding the needs of a child or young person or is about a child or young person’s safety or wellbeing.</p>
Child protection report/ report under s. 360(5) of the act	<p>If the Director-General suspects, on reasonable grounds, that a child or young person subject to a Child Concern Report may need care and protection, the Director-General must decide that the Child Concern Report is a Child Protection Report. Section 345 of the Children and Young People Act 2008 (ACT) defines that a child or young person is in need of care and protection if the child or young person has been abused or neglected, is being abused or neglected, or is at risk of abuse and neglect AND no-one with parental responsibility for the child or young person is willing and able to protect the child or young person from the abuse or neglect or risk of abuse or neglect.</p>
Congenital Abnormalities	<p>Includes deformities and chromosomal abnormalities and refer to physical and mental conditions present at birth that were either hereditary or caused</p>

by environmental factors and where there is no indication that they were acquired after birth.

Coroner	Refers to a coroner for the ACT appointed under the Coroners Act 1997.
Infant	In this report, refers to the period from 28 days to one year of age.
National Coronial Information System	Refers to the initiative of the Australasian Coroners Society that is managed by the Victorian Department of Justice on behalf of the Australian Government and the states and territories. Information about every death subject to a coronial inquiry in Australia is stored in the system, providing a valuable hazard identification and death prevention tool for researchers, including state and territory death review committees (definition from the National Cancer Institute).
Neonatal period	Refers to the period from birth to 28 days of age.
Neoplasm	An abnormal mass of tissue that results when cells divide more than they should or do not die when they should. Neoplasms may be benign (not cancer) or malignant (cancer). Also called tumours (definition from the National Cancer Institute).
Parent	Refers to a birth, step, de facto or adoptive parent of a child or young person as identified by the committee from information obtained as part of its functions.
Perinatal	Refers to the period from 20 weeks gestation to 28 days of age.
Register	Refers to the register of all deaths of children and young people in the ACT that is used by the Committee.
Review by the ACT	Refers to reviews undertaken in the ACT which may include: a coronial inquest into the manner and cause of death of a person who dies in circumstances set out in the Coroners Act 1997; a Clinical Health Review Committee; an internal review by the Office for Children, Youth and Family Support; or a joint ACT Health and Office for Children, Youth and Family Support review.
Sibling	Refers to all biological, half, step and adoptive siblings as identified by the Committee from information obtained as part of its functions.
SIDS	Refers to Sudden Infant Death Syndrome. SIDS is a category of SUDI (see below) that has four categories: 1a, 1b, 2 and unclassified. <ul style="list-style-type: none"> <li>SIDS 1a <ul style="list-style-type: none"> <li>An infant aged over 21 days but under 9 months of age.</li> <li>Gestational age equal to or over 37 weeks.</li> </ul> </li> </ul>

- Normal clinical history, including during pregnancy.
- Normal growth and development.
- No similar deaths among siblings, close relatives or other infants in the custody of the carer.
- The scene where the incident leading to the death occurred does not provide an explanation of the death.
- Absence of potentially fatal pathological findings.
- No evidence of unexplained trauma, abuse, neglect or unintentional injury.
- No evidence of substantial thymic stress effect and
- Negative result in other tests (e.g., toxicology).

SIDS 1b

As with SIDS 1a but:

- an investigation of the scene where the incident leading to the death occurred was not performed, or
- one of the following tests/screens was not performed:
  - toxicology
  - radiologic
  - microbiologic
  - vitreous chemistry, or
  - metabolic screening studies.

SIDS 2

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

- age outside of range
- similar deaths among siblings, close relatives or other children cared for by the carer not considered infanticide or a recognised genetic disorder
- neonatal or perinatal conditions that have resolved at the time of death
- mechanical asphyxia or suffocation caused by overlaying not determined with certainty
- abnormal growth and development not thought to have contributed to the death, and/or
- marked inflammatory changes/abnormalities not sufficient to be unequivocal (certain) cause of death.

SIDS

Unclassified

- Did not meet the criteria for SIDS 1 or 2, and



- Alternative diagnosis or natural or unnatural conditions are equivocal (uncertain), including cases for which an autopsy was not performed.

SUDI                      Refers to Sudden Unexpected Death in Infancy, meaning the death of an infant aged less than 12 months that is sudden and unexpected and where the cause was not immediately apparent at the time of death.

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



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

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