ACT Children & Young People
Death Review Committee
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ACT Remuneration Tribunal 2019 Spring Annual Review

1. Functions of the Committee

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

Established in 2012, the Committee reports to the Minister for Children, Youth and Families. The Act sets out the requirement of the Committee to:

- keep a register of deaths of children and young people;
- identify patterns and trends in relation to the deaths of children and young people;
- undertake research that aims to help prevent or reduce the likelihood of the death of children and young people;
- identify areas requiring further research, by the committee or another entity, that arise from the identified patterns and trends in relation to the deaths of children and young people;
- make recommendations about legislation, policies, practices and services for implementation by the Territory and non-government bodies to help prevent or reduce the likelihood of the death of children and young people;
- monitor the implementation of the committee's recommendations.

In order to undertake this work, the Act stipulates that relevant entities which include the Chief Police Officer, the Registrar General and the ACT Heath, Community Services and Education Director Generals are required to provide information to the Committee concerning:

- the cause of the death of the child or young person;
- the age and sex of the child or young person;
- whether the child or young person is an Aboriginal or Torres Strait Islander person;
- whether, within 3 years before his or her death, the child or young person, or a sibling of the child or young person, was the subject of a report the director-general decided, under section 360 (5), was a child protection report.

In addition, the Committee holds powers to request information from individuals where the Committee believes on reasonable grounds that a person can give

information or produce a document or something else that the Committee considers necessary to allow it to exercise its functions.

2. ACT Children and Young People Death Review Committee Membership

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

Chair:

- Ms Margaret Carmody – Chair of a local Not-For-Profit and Director in small business. Area of expertise: National social services policy development and implementation, governance and large-scale operational service delivery.

Committee Members:

- Mr Eric Chalmers – Retired CEO, Kidsafe ACT, Deputy Chair, ACT Children and Young People Death Review Committee. Area of expertise: Engineering, child safety products and systems.
- Ms Barbara Causon PSM – Retired public servant with experience in Indigenous affairs and service delivery. Area of expertise: Working with Aboriginal and Torres Strait islander children and young people.
- Ms Louise Freebairn – Manager, Knowledge Translation and Health Outcomes, Epidemiology Section ACT Health. Area of expertise: epidemiology.
- Dr Sue Packer AO – Retired ACT Health Paediatrician. Area of expertise: Extensive paediatrics, adolescent mental health and child protection experience since 1972. Board member of NAPCAN, community paediatrician.
- Dr Catherine Sansum – Clinical Forensics ACT and Child at Risk Health Unit. Area of expertise: Child Forensic Medicine.
- Professor Morag McArthur: Retired social work academic with in the School of Allied Health, Australian Catholic University. Area of expertise: Social work and child protection.
- Dr Judith Bragg - Senior Career Medical Officer at the Child at Risk Health Unit and clinical lecturer at ANU Medical School. Area of expertise: Paediatrics.
- Sergeant Dennis Gellatly – OIC Judicial Operations, ACT Policing. Area of expertise: policing in the community.
- Dr Amanda Dyson- Consultant Neonatologist ACT Health. Area of Expertise: Neonatology and Paediatrics.
- Ms Rebecca Cross – Director General Community Services Directorate. Area of expertise: Public policy
- Ms Jodie Griffiths-Cook – ACT Children and Young People Commissioner. Area of expertise: Children and young people policy, adolescent mental health.

In addition to the key tasks of the Committee, two sub-committees have been established by the Chair, the Data sub-committee and the Communications sub-committee. These appointments directly reflect the Committee's commitment to obtaining the necessary skill and expertise concerning data collection and analysis and all aspects related to the development and dissemination of the Committee's work.

Currently Dr Catherine Sansum, Dr Judith Bragg, Ms Louise Freebairn and Dr Amanda Dyson are members of the Committee's data sub-committee. Mr Eric Chalmers, Ms Barbara Causon and Dr Sue Packer AO are members of the Committee's Communication sub-committee.

3. Role and Scope of work, extent of advisory or decision-making powers and where known budget

In accordance with the Act, the Committee is required to meet at least once a year. Since 2013, the Committee has met formally as a committee four times a year. However, the Chair, deputy chair and subcommittee members provide significant time to Committee activities across the year.

The ACT Children and Young People Death Register is currently operational and holds the records of 532 children and young people who have died since 2004. The register is a critical tool for analysis to inform recommendations to improve systems that prevent and reduce risk of harm to children. For each calendar year, the Committee must report to the Minister about the deaths of children and young people included on the children and young people deaths register during the year. Other analysis includes the development of individual reviews, contributions to interstate projects. Committee members represent the ACT jurisdiction at relevant national forums and with international delegations.

The Committee's success is reflected in the systemic change recommended and adopted by Government and by the local community. The Committee has contributed to enhanced knowledge, policy recommendations and workforce development so as to prevent of child deaths in the ACT community. Independence and objectivity are critical to ensuring systemic issues are identified and recommendations identified.

The Committee makes recommendations for systemic change and these recommendations are tabled in the ACT Assembly. The Committee makes decisions to request specific information and to publish reports.

The Committee receives ongoing funding from the ACT government. The budget for this financial year is $219,000 and for 2020-21 $222,000.

What members are responsible for and what work they do

Members contribute their expertise at meetings and in sub-committees. The Chair is expected to be independent of the current service system and is responsible for working with the Committee to resolve the agreed work program and ensure the necessary agreements and processes are in place to enable the register and the Committees work to be progressed.

The following matters are just some of the ACT community issues that have been addressed by the Committee:

- Asthma
- Blind cords
- Brain tumours
- Button batteries
- Co-sleeping
- Recording of cause of deaths
- Domestic violence
- Family safety and family law
- Information sharing
- Suicide prevention
- Swimming pool safety

Reports finalised in the past two years include:

Changing the Narrative for Vulnerable Children: Strengthening ACT Systems	This report was based on the lives of 11 children aged 0-3 years who died prior to 2014 and who were subject to a closed coronial inquiry. The Committee analysed the sociological risk factors that the children and their families experienced, and which potentially contributed to the death of an infant. The report was tabled in the Legislative Assembly by the Minister for Children, Youth and Families.
2017 and 2018 Annual Reports	The Annual report provides information on changes in the death rates in the ACT for each calendar period compared with earlier periods. The report details the incidence of child and youth deaths from the previous year, highlighting key trends, systemic improvements and reporting on particular population groups. The most recent report provided details on progress made with previous recommendations. The 2018 Annual report provides information on the recommendations made by the Committee since establishment and makes comment

Other work progressed by the Committee includes:

Translation	An active agenda of communication to widely distribute the body of knowledge arising from the committee's work, ensuring that professionals and citizens with responsibility for Children and Young People have access to local and current

	evidence. For example, the Committee has made a number of press releases at relevant times to raise the profile of certain risks to child safety.
Register Maintenance	The way we come to learn about and understand child and youth mortality in a social context is evolving. This means updating the register to ensure that it provides current and relevant evidence which informs policy, programs and systems. Identified data gaps include Disadvantage and Diversity indicators. The data includes a range of contextual data relating relevant to each child, their family and carers. A number of new agreements have been initiated by the Committee to ensure the most relevant information is included in the register to inform recommendations
Contribution to consultations	In the past year the Committee has responded to discussion papers on Domestic Violence and the Review of Child Protection Decisions.
Monitoring	The Committee monitors what action has been taken as a result of reports, recommendations and information provided by the Committee. This information was reported for the first time in the 2018 Annual report.
National Collaborations	By attending national conferences and forums and responding to information requests from other jurisdictions the Committee aims to develop an Australia wide understanding of and response to child mortality. It also involves monitoring international and national data sources for relevant strategies to reduce the risk of harm.

At the current time the Committee is undertaking a review to improve effectiveness and identify areas for improvement. It also has a thematic review underway focused on intentional fatal self-harm.

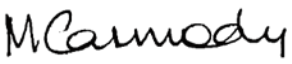
4. Remuneration

Similar Review Committees are evident in the following State and Territories:

- NSW – Child Death Review Team, NSW Ombudsman's Office
- Victoria - Consultative Council on Obstetric and Paediatric Mortality and Morbidity
- Queensland - Queensland Child Death Case Review Committee, Commissioner for Children and Young People and Child Guardian
- South Australia – Child Death and Serious Injury Review Committee, Government of South Australia
- Northern Territory – Northern Territory Child Deaths Review and Prevention Committee, the Office of the Coroner, Northern Territory

- Tasmania – Child Death Review Committee, Tasmanian Department of Health and Human Services
- Tasmania - Council of Obstetric & Paediatric Mortality & Morbidity

It is the Committee's submission that the ongoing work value described in this submission, warrants the continuation of the Committee Chair and Member remuneration that was decided in Determination 15 of 2018.



Margaret Carmody PSM

Chair, Children and Young People Death Review Committee

17 September 2019