



ACT Children & Young People Death Review Committee

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Ms Cahill Lambert AM
Chair
ACT Remuneration Tribunal
PO Box 964
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Sent by email: remtrib@act.gov.au

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Dear Ms Cahill Lambert,

ACT Remuneration Tribunal 2017 Spring Annual Review

Thank you for the opportunity to provide comments on the annual review into the remuneration and allowances to be paid, and other entitlements to be granted to Part-time Holders of Public Office on boards, tribunals and committees, referred under section 10(1) of the Remuneration Tribunal Act 1995.

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* to work towards reducing the number of deaths of ACT children and young people. The Committee is funded by the ACT government and in the 2017-18 Budget announcement, the Committee secured \$883,000 over the next four years. This is the first time that the Committee has received continuing funding of this length. This has greatly assisted with the future work plan of the Committee.

Established in 2012, the Committee reports to the Minister for Disability, Children and Youth. The legislation 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 legislation stipulates that relevant entities which include the Chief Police Officer, the Registrar General and the ACT Health, 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 legislation 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:

- Eric Chalmers – CEO, Kidsafe ACT, Deputy Chair, ACT Children and Young People Death Review Committee. Area of expertise: Engineering, child safety products and systems.
- Samantha Page - CEO, Early Childhood Australia Board Member of PANDA. Area of expertise: psychology.
- Dr Michael Rosier – Paediatrician. Area of expertise: paediatrics.
- Louise Freebairn – Senior epidemiologist and researcher within ACT Health Directorate. Area of expertise: epidemiology.
- Prof. Alison Kent - Consultant Neonatologist. Area of expertise: Paediatrician and neonatologist, previous chair of ACT Perinatal Mortality Committee, member of the Perinatal Society of Australia and New Zealand Perinatal Mortality group.
- Dr Sue Packer – 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.
- Julie Tongs – CEO, Winnunga Nimmityjah Aboriginal Health Service. Area of expertise: Working with Aboriginal and Torres Strait Islander people and Health service delivery.

- Sgt Robert Rose – OIC Judicial Operations, ACT Policing. Area of expertise: policing in the community.
- Jacinta Evans – Director Student Engagement. Area of expertise: education
- Michael De'Ath – Director General Community Services Directorate. Area of expertise: public policy
- 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, Ms Louise Freebairn and Dr Michael Rosier are members of the Committee's data sub-committee. Mr Eric Chalmers, Ms Samantha Page and Dr Sue Packer are members of the Committee's Communication sub-committee.

3. Role and impact of the Committee in the ACT Community

In accordance with the Act, the Committee is required to meet at least once a year. Since 2013, the Committee meets 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, as of October 2017, of 466 children and young people who have died. 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 and contributions to interstate projects. Committee members represent the ACT jurisdiction at relevant national forums and with international delegations.

In accordance with the Act, the Committee was also required to report on the deaths of children and young people in the ACT for the period from 1 January 2004 to 17 September 2011 (Section 727U). The Retrospective Report has been completed this year and was submitted to the operational Minister on 28 January 2017. Under the legislation, the Minister must table the report in the Assembly within six (6) sitting days of receipt.

The Committee's success is presently measured by its adherence to current legislative requirements. Yet the work of the Committee has contributed to enhanced knowledge, policy recommendations and improved workforce

development regarding the prevention 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 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

At the most recent committee meeting, the Committee agreed to a two year strategic plan further establishing clarity and direction of the Committee's research agenda. The current work program is as follows:

Group Review: 0-3 yrs	A review of the sociological risk factors that surround and potentially contribute to the death of an infant. This review is close to completion and will be provided to the Minister in the current quarter.
Annual Report	A report on changes in the death rates in the ACT for the period of 2017 compared with earlier periods. A report on the incidence of child and youth deaths from the previous year, highlighting issues of concern, systemic improvements and reporting on particular population groups.
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 developed a Safe Sleeping information sheet and contributed to the ACT Health child safety methadone brochure.
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.

Monitoring	The Committee monitors what action has been taken as a result of reports, recommendations and information provided by the CYPDRC. A critical project in the Committees research agenda will be to review recommendations of the Committee and appraise performance.
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.

4. Remuneration

All states and territories within Australia have child death review mechanisms in various forms and stages of development. 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 Children's Commissioner, Northern Territory
- Tasmania – Child Death Review Committee, Tasmanian Department of Health and Human Services
- Tasmania - Council of Obstetric & Paediatric Mortality & Morbidity

Future directions for the Committee are informed by its ongoing priority to become one of the leading bodies in the ACT in helping to prevent or reduce the likelihood of the death of children and young people. To achieve this, the Committee requires the engagement and expertise of Committee members who can assist the Committee in its strategic objectives and to work collaboratively to develop nationally comparable data and promote prevention messages across jurisdictions.

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 established in Amended Determination 12 of 2016.



Margaret Carmody PSM

Chair