



NORTHERN TERRITORY OF AUSTRALIA

Office of the Coroner

Secretary
Legislative Scrutiny Committee
GPO Box 3721
DARWIN NT 0801
By email: LSC@nt.gov.au

Dear Secretary

RE: Submission on Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026 amending the *Care and Protection of Children Act 2007* with the effect of abolishing the Child Deaths Review and Prevention Committee.

This proposed amendment is not supported.

On 15 May 2026 at 3.27 pm the Legislative Scrutiny Committee wrote to the Coroner's Office by email inviting the Territory Coroner to make a submission to its inquiry into the Attorney-General Legislation Amendment (Boards, Committees and Statutory Offices) Bill 2026, with any submission due by Friday 22 May 2026.

This submission concerns the proposed amendment to the *Care and Protection of Children Act 2007* (**the Act**) to abolish the Child Deaths Review and Prevention Committee (**CDRPC**) and transfer functions to relevant Government agencies.

The Territory Coroner does not support this proposed amendment.

The Northern Territory has the worst child mortality outcomes of all Australian jurisdictions.

The Australian Institute of Health and Welfare (AIHW) reported that the national infant mortality rate fell from 5.7 deaths per 1,000 live births in 1999 to 3.3 deaths per 1,000 in 2017. Shamefully, the infant mortality rate remains significantly higher in the Northern Territory than even the national average 25 years ago, with 7.3 deaths per

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1,000 live births in 2023. Aboriginal infant and child mortality continues to be of significant concern. The Queensland Family & Child Commission in the Australian Death Statistics 2023 report found that Aboriginal and Torres Strait Islander children constituted 6.8% of the national child population but accounted for 18.1% of child deaths, with Aboriginal child mortality rate being between 1.0 to 4.0 times higher than that of non-Aboriginal children.¹

The Northern Territory CDRPC is an independent statutory body established in 2008 in response to the recommendations arising from the landmark Territorian inquiry into the protection of Aboriginal children from sexual abuse, the Little Children are Sacred report. That report highlighted that child death review processes are integral to improving outcomes for children and, similarly to other jurisdictions across Australia, the Northern Territory established the CDRPC to understand the drivers of our death rates and to recommend measures to reduce those rates and prevent deaths. In 2007 the CLP recognised the need for and supported the establishment of the NT CDRPC.

Legislative independence allows the CDRPC to critically examine systemic failures (including in Government departments and agencies), identify gaps in services or policy, and make recommendations that may be controversial or uncomfortable for government departments to address internally. It also allows the CDRPC to engage in review, where review is otherwise not legislatively available, such as in the instance of deaths that are not reportable to the Coroner under the *Coroners Act 1993*. The CDRPC's independence promotes public confidence that child deaths will be reviewed objectively and with transparency, and with the sole focus on prevention, detached from government or agencies policies, priorities or sentiment.

The cross sectional makeup of the CDRPC ensure that it provides a collective expert response to child deaths and does not represent a single perspective, cause or interest. The diverse membership ensures the CDRPC is informed by legal, policy, policing, child protection, and health experts. This provides an opportunity for all relevant Government departments in conjunction with independent, not-for-profit, and private sector agencies responsible for child health and wellbeing, to work together to review each child death and to ensure all facets of expertise actively contribute to formulating death prevention strategies and recommendations.

The benefits of this independent, expert, and collaborative approach would be lost if the functions are devolved and dispersed to Government agencies as is proposed. This collective expert response cannot be replicated by a single department or agency alone, and to absorb the CDRPC's function into a singular, pre-existing entity for the purpose of governmental coordination and efficiency would be to the detriment of Territorian children.

¹ <https://www.aihw.gov.au/reports/children-youth/australias-children/contents/health/infant-child-deaths>

Of concern, although the basis for this amendment is said to reduce overlap² and duplication,³ there has been no identification or clarification as to the nature, occurrence or extent of the asserted overlap and duplication.

Although the CDRPC is said to be formally abolished effective 1 July 2026,⁴ there has been a failure to appoint and re-appoint committee members since 2024 and the CDRPC last met on 10 October 2024. Without a quorum it has been unable to continue its work since that date.

Between October 2024 and April 2026, 144 child deaths have been registered at Births, Deaths and Marriages. There are seven further child deaths that have not yet been registered at Births, Deaths and Marriages, bringing the total number of child deaths to 151. Even though it has been asserted that death review, prevention and analysis can be more effectively reviewed within Government departments, with responsibility for transitional arrangements and continuity of critical functions resting with the AGD,⁵ it is understood that none of these 151 child deaths have had the benefit of a child death review.

During the same period there have been 30 child deaths reported to the Coroner's Office. This does not represent an 'overlap' or 'duplication.' The CDRPC and the Coroner's Office are complementary. The expertise of the broad committee membership of the CDRPC is shared with the Coroner's Office and informs its investigations, identifying concerns and avenues for evidential gathering and enquiry. Similarly, the Coroner's powers can progress the work of the CDRPC. A recent example of this complementary nature can be found in the *Inquest into the Deaths of Baby K, Baby B and Baby S* [2026] NTCC 06.

Even if there were an 'overlap' or 'duplication' between the CDRPC, any so called overlap is in the order of 20 percent. 80 percent of the outstanding child deaths which would normally be considered by the CDRPC are deaths from disease or other morbid condition which are not reported to the Coroner's Office and are not subject to coronial oversight or scrutiny. Given the overrepresentation of the Northern Territory in the child death statistics, it must be understood that this overrepresentation likely comprises preventable, natural causes, deaths. It is these preventable deaths that benefit from the independent expert scrutiny provided by the CDRPC as it endeavours to identify patterns and causes, with the aim of identifying effective responses to prevent these deaths in the future. Indeed, given the appalling child death statistics in the Northern Territory, the vital work of the CDRPC should be promoted and enhanced with additional resourcing.

² Explanatory Statement Notes on Clauses, Clause 6.

³ Letter from the Attorney-General to the Deputy Coroner dated 4 February 2026.

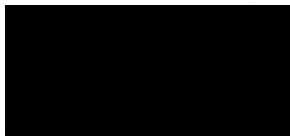
⁴ Letter from the Attorney-General to the Deputy Coroner dated 4 February 2026.

⁵ Letter from the Attorney-General to the Deputy Coroner dated 4 February 2026.

The Coroner's Office currently receives and considers between 350-400 reportable deaths each year. The Coroner's Office is comprised of the Territory Coroner, the Deputy Coroner, a Legal Officer, a Grief Counsellor and three Coroners Clerks with investigations undertaken by Coroner's Constables and allocated police investigators. If the Coroner's Office were to take on the additional workload of registered child deaths that are not otherwise reportable to the Coroner (presently 111 child deaths from October 2024 – April 2026) that would equate to a roughly 25-30 percent increase in deaths to be investigated and considered by the Coroner's Office. Significant additional resourcing would be required to manage such an increase in volume. The Coroner's Office would likely be undertaking these investigations without the support of police investigators and so would require additional staff to undertake the investigative component of any review. The Coroner's Office would also require resources to access paediatric related expertise, in areas including oncology, cardiology, neurology, maternal-foetal medicine and neonatology. Without sufficient additional resources the Coroner's Office would not be able to complete child death reviews within relevant and meaningful time frames or at all.

The Coroner's Office would be happy to provide any further information that would be of assistance to the Legislative Scrutiny Committee.

Yours sincerely



Elisabeth Armitage
Territory Coroner

20 May 2026