

NSW Child Death Review Team Annual Report 2024–25

The NSW Child Death Review Team (CDRT) acknowledges the Gadigal people of the Eora nation, who are the traditional custodians of the land on which the CDRT meet and work. The CDRT also respectfully acknowledge the traditional custodians of the land and waters across NSW and their contributing cultural, spiritual customs and practices, and celebrate the diversity of Aboriginal and Torres Strait Islander people throughout NSW.

The CDRT pays respect to all First Nations Elders past and present, and to the children of today who are the Elders of the future.

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NSW Ombudsman

Level 24, 580 George Street
Sydney NSW 2000

Phone: (02) 9286 1000

Toll free (outside Sydney Metro Area): 1800 451 524

Website: ombo.nsw.gov.au

Email: info@ombo.nsw.gov.au

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30 October 2025

The Hon. Ben Franklin MLC
President
Legislative Council
Parliament House
Sydney NSW 2000

The Hon. Greg Piper MP
Speaker
Legislative Assembly
Parliament House
Sydney NSW 2000

Dear Mr President and Mr Speaker

NSW Child Death Review Team Annual Report 2024-25

As Convenor of the NSW Child Death Review Team (CDRT), I present the NSW Child Death Review Team Annual Report 2024-25 for tabling in Parliament.

This report is made under section 34F of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. It details the activities of the CDRT and progress of its recommendations.

I recommend that this report be made public immediately.

Yours sincerely



Paul Miller

Convenor, NSW Child Death Review Team
NSW Ombudsman

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About this report

This annual report describes the operations of the NSW Child Death Review Team (**CDRT**) during the period 1 July 2024 to 30 June 2025.

The report has been prepared pursuant to section 34F of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (**the Act**). The Act requires the CDRT to prepare an annual report of its operations during the preceding financial year. The report must be provided to the Presiding Officer of each house of Parliament, and must include:

- a description of the CDRT's activities in relation to each of its functions
- details of the extent to which its previous recommendations have been accepted
- whether any information has been authorised to be disclosed by the Convenor in connection with research undertaken for the purpose of helping to prevent or reduce the likelihood of deaths of children in NSW, and
- if the CDRT has not presented a report to Parliament in relation to its research functions within the past three years, the reasons why this is the case.

The report is arranged in the following chapters:

- Chapters 1 and 2: The NSW Child Death Review Team – outlines the constitution of the CDRT, its members, and the functions of the CDRT.
- Chapter 3: Reporting of child deaths – information about the *Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament*.
- Chapter 4: Research to help reduce child deaths – details CDRT research projects.
- Chapter 5: Other activities – notes other work of the CDRT.
- Chapter 6: Disclosure of information – details information disclosures as prescribed in the Act.
- Chapter 7: CDRT recommendations – summarises responses by agencies to CDRT recommendations, and their progress towards implementation.
- Appendices: progress in relation to current strategic priorities and member meeting attendance.

CDRT information

At the time of tabling, all CDRT information, publications and reports are available on the NSW Ombudsman website (www.ombo.nsw.gov.au). The CDRT will be launching its own website in early November 2025, and following this, some CDRT documents will only be available on the CDRT's website (www.cdrt.ombo.nsw.gov.au).

1. The NSW Child Death Review Team

1.1 The CDRT's role, purpose and membership

Since 1996, the NSW Child Death Review Team (**CDRT**) has been responsible for registering, classifying, analysing, and reporting to the NSW Parliament on data and trends relating to all deaths of children aged 0-17 years in NSW. The CDRT's purpose is to prevent or reduce the likelihood of deaths of children in NSW through the exercise of its functions under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (**the Act**).

CDRT membership is prescribed by the Act. Members are:

- the NSW Ombudsman, who is the Convenor of the CDRT
- the Community Services Commissioner (**the Commissioner**)
- the NSW Advocate for Children and Young People (**the Advocate**)
- 2 Aboriginal persons
- representatives from the following NSW Government agencies:
 - NSW Health
 - NSW Police Force
 - Department of Communities and Justice (**DCJ**): one from staff involved in administering the *Children and Young Persons (Care and Protection) Act 1998*, one from staff involved in administering the *Disability Inclusion Act 2014*, and one from the part of DCJ that formerly comprised the Department of Justice
 - Department of Education
 - Office of the NSW State Coroner
- experts in health care, research methodology, child development or child protection, or persons who because of their qualifications or experience are likely to make a valuable contribution to the CDRT.

The Ombudsman, the Commissioner and the Advocate are ex officio appointments. Other members are appointed by the Minister administering the Act and may be appointed for a period of up to 3 years, with capacity for re-appointment.

The CDRT must have at least 17 and no more than 23 members. The CDRT must elect one member to be the Deputy Convenor, who may undertake some of the roles of the Convenor in his or her absence, including chairing of meetings.

All members of the CDRT, even if nominated because they are employed in a particular agency, are members as individuals and not as spokespeople for their agency.

1.2 CDRT members at 30 June 2025

Ex officio members



Mr Paul Miller PSM (Convenor)
NSW Ombudsman



Mr Chris Clayton¹
Senior Deputy Ombudsman, Systems Oversight & Reviews,
Community Services Commissioner



Ms Zoë Robinson
NSW Advocate for Children and Young People

Agency representatives



Ms Sarah Bramwell
Director Practice Learning, Office of the Senior Practitioner
Department of Communities and Justice



Ms Vanessa Chan (on leave)
Director, Criminal Law Specialist, Policy and Reform Branch
Department of Communities and Justice



Dr Helen Goodwin
Chief Paediatrician/Senior Clinical Advisor Paediatrics
NSW Health
Senior Staff Specialist Paediatrician
Royal North Shore Hospital



Ms Anne Reddie
Director Child Wellbeing and Mental Health Services, Student Support
and Specialist Programs
Department of Education



Ms Alison Sweep
Director, Inclusive Practice
Department of Communities and Justice

¹ Mr Chris Clayton was appointed as Community Services Commissioner effective 30 June 2025. Ms Monica Wolf was formerly the Chief Deputy Ombudsman and Community Services Commissioner in the period 1 July 2024 to 27 June 2025.



Ms Amy Vincent-Pennisi (on leave)
Coronial Information Support Program Coordinator
NSW State Coroners Court

Representative of the NSW Police Force (vacant)²

Independent members



Dr Susan Adams
Senior Staff Specialist, General Paediatric Surgeon
and Head of Vascular Birthmarks Service
Sydney Children's Hospital
Associate Professor, School of Women's and Children's Health
University of New South Wales



Dr Susan Arbuckle
Paediatric/Perinatal pathologist
The Children's Hospital at Westmead



Ms Jennifer Black
Commissioner
Mental Health Commission of NSW



Professor Ngiare Brown
Chancellor, James Cook University
Chair, National Mental Health Commission Advisory Board
Director and Program Manager, Ngaoara Child and Adolescent Wellbeing
Executive Manager Research and Senior Public Health Medical Officer, National
Aboriginal Community Controlled Health Organisation
Professor of Indigenous Health and Education, University of Wollongong



Professor Kathleen Clapham AM (Deputy Convenor)³
Honorary Professor
Ngarruwan Ngadju First Peoples Health and Wellbeing Research Centre
School of Medical, Indigenous and Health Sciences
University of Wollongong

² Detective Superintendent Joseph Doueihy, Commander Homicide Squad, State Crime Command, NSW Police Force was appointed as the NSW Police representative on 1 July 2025. Prior to his appointment, Mr Doueihy was appointed as an expert adviser.

³ Professor Clapham has stepped aside from the position of Deputy Convenor until the conclusion of the Review of the suicide deaths of Aboriginal children and young people.



Dr Luciano Dalla-Pozza

Head of Department (Cancer Centre for Children)
Senior Staff Specialist (Paediatric Oncology)
The Children's Hospital at Westmead



Dr Bronwyn Gould AM

General Practitioner



Professor Ilan Katz

Professor Social Policy Research Centre
University of New South Wales



Dr Matthew O'Meara

Senior Staff Specialist Paediatric Emergency Medicine
Sydney Children's Hospital Randwick



Dr Lorraine du Toit-Prinsloo

Chief Forensic Pathologist and Clinical Director
Forensic Medicine Newcastle
Forensic and Analytical Science Services
NSW Health Pathology

1.3 Previous members (1 July 2024 to 30 June 2025)

Ms Monica Wolf (to 27 June 2025)

Chief Deputy Ombudsman, Community Services Commissioner

Detective Superintendent Danny Doherty (to 10 April 2025)

Commander Homicide Squad, State Crime Command
NSW Police Force

1.4 Expert advisers

The Act provides for the Convenor to appoint persons with relevant qualifications and experience to advise the CDRT in the exercise of its functions. Expert advisers who assisted the CDRT in its work and/or who undertook research on behalf of the CDRT during 2024-25 include:

- Ms Intan Bailey, Acting Coordinator, Coronial Information and Support Program, Office of the NSW State Coroner
- Ms Jennifer Black, Commissioner, Mental Health Commission of NSW
- Detective Superintendent Joseph Doueihi, Commander Homicide Squad, State Crime Command, NSW Police Force
- Dr Helen Goodwin, Chief Paediatrician/Senior Clinical Advisor Paediatrics, NSW Health; Senior Staff Specialist Paediatrician, Royal North Shore Hospital
- Professor Philip Hazell, Honorary Professor, The University of Sydney School of Medicine; locum psychiatrist, Hunter New England Local Health District
- Dr Marlene Longbottom, Associate Professor, Indigenous Education and Research Centre, James Cook University
- Dr Matthew O'Meara, Senior Staff Specialist Paediatric Emergency Medicine, Sydney Children's Hospital Randwick
- Ms Amy Vincent-Pennisi, Coordinator, Coronial Information and Support Program, Office of the NSW State Coroner
- Ms Lisa Robinson, Acting Director, Criminal Law Specialist, NSW Department of Communities and Justice
- Emeritus Professor Les White AM, former NSW Chief Paediatrician
- Ms Maryann Wood, Lecturer, School of Public Health and Social Work, Queensland University of Technology

2. CDRT functions

Under Part 5A of the Act, the CDRT's functions⁴ are to:

- maintain a register of child deaths occurring in NSW
- classify those deaths according to cause, demographic criteria and other relevant factors, and to identify trends and patterns relating to those deaths
- undertake, alone or with others, research that aims to help prevent or reduce the likelihood of child deaths and to identify areas requiring further research
- identify areas requiring further research by the Team or other agencies or persons, and
- make recommendations to prevent or reduce the likelihood of child deaths.

2.1 Reporting to NSW Parliament

The CDRT reports directly to the NSW Parliament, with oversight by the Parliamentary Committee on the Ombudsman, the Law Enforcement Conduct Commission and the Crime Commission.

There are three provisions in the Act under which the CDRT is required to report to Parliament:

- The **annual report** (section 34F), which details the activities of the CDRT and progress of its recommendations. This is the annual report for 2024-25.
- The **biennial child death review report** (section 34G), which consists of data collected and analysed in relation to child deaths. The CDRT's biennial report, covering deaths of children in NSW in 2022 and 2023, will be tabled in Parliament in November 2025.
- **Other reports** (section 34H), which provide information on the results of research undertaken in the exercise of the CDRT's research functions. The CDRT may report to Parliament at any time and is expected to report on its research at least once every three years. Details of recent and current research are provided in Chapter 4.

All reports are available on the NSW Ombudsman website: www.ombo.nsw.gov.au. From early November, all CDRT reporting will be available on the CDRT's new website: www.cdrt.ombo.nsw.gov.au.

2.2 CDRT Charter and Code of Conduct

Members of the CDRT adhere to a Charter and Code of Conduct that outlines the CDRT's scope, purpose and values, requirements of members, and other matters such as conflict of interest, confidentiality, and privacy.⁵

The Charter identifies the CDRT's vision and purpose as well as detailing its specific legislative powers and authority, its values, strategic priorities, and operational imperatives.

⁴ Under Part 6 of the Act, the NSW Ombudsman also has a separate function to review the deaths of children in circumstances of (or suspicious of) abuse and neglect, and the deaths of children in care or detention (known as 'reviewable' child deaths). Further information about the Ombudsman's reviewable deaths function is available on the [NSW Ombudsman website](http://www.ombo.nsw.gov.au) and in the [NSW Ombudsman's Annual Reports](#).

⁵ These documents can be accessed at: <https://www.ombo.nsw.gov.au/about-us/what-we-do/our-statutory-functions/child-death-review-team-cdrt>.

The CDRT's vision is:

A society that values and protects the lives of all children, and in which preventable child deaths are eliminated.

The CDRT's purpose is:

To eliminate preventable child deaths in New South Wales by working collaboratively to drive systemic change based on evidence.

The CDRT's vision and purpose are further expressed through its strategic priorities.

2.3 CDRT Strategic Priorities

2022-2025 Strategic Priorities

The CDRT's 2022-2025 Strategic Priorities identified its main priorities for this three-year period and initiatives to achieve them. These priorities, and progress against the initiatives that sit underneath the priorities during the reporting year, are included at Appendix 1.

Highlights over the three-year Plan include:

- Improved stakeholder engagement and collaboration
To further the CDRT's first strategic priority (nurturing strategic relationships and collaboration with key partners and stakeholders to optimise its influence and reach), the CDRT targeted 3 key stakeholders for engagement on the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*. The CDRT prepared a fact sheet for the NSW State Coroner's Office, and presented to Senior Coroners on the CDRT's functions. The Coroner's Office routinely requests information about individual child deaths to inform their inquests and there has been a significant increase in information requested and provided. The CDRT have also strengthened engagement with agencies to whom the CDRT has made recommendations, through holding meetings to discuss progress with agencies prior to issuing formal monitoring correspondence. This strengthened engagement has improved our reporting of issues and monitoring of recommendations, facilitated relationship building, and provided a forum for the sharing of information relevant to other areas of our work that the CDRT may not otherwise have access to.
- Strengthening the CDRT's research function
Three strategic priorities included initiatives related to the CDRT's research function, including improved data quality and sharing, collaboration with research and community partners and the alignment of CDRT research projects with its goals and objectives. A research framework to guide the prioritisation, delivery and communication of research projects was developed, as well as an internal procedure for responding to external requests for data from the Register of Child Deaths.

- Revised biennial reporting to improve the visibility of its work and data
Initiatives under two strategic priorities sought to improve the CDRT's public reporting in respect of the visibility of its work and data. A revised format was developed for CDRT biennial child death review reports that focused on the visual presentation of data and enhanced highlighting of key emerging issues. This revised format will be used in the *Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament*, to be tabled in November 2025.
- Improved data collection and analysis
Two strategic priorities sought to enhance the CDRT's data and reporting through considering societal stressors (such as COVID-19) and inequitable child mortality outcomes. Societal stressor data is now collected in the Register of Child Deaths, and considered in the Research Framework. The *Biennial report of the deaths of children in New South Wales: 2020 and 2021* introduced reporting on LGBTIQ+ children in the context of suicide, and the upcoming *Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament* will incorporate reporting on children with a child protection history as a distinct cohort.
- Improved recommendations
To support the initiative to deliver powerful and influential evidence-based recommendations that bring about change, the CDRT completed a review of the impact of recommendations from 2017-2022 to identify learnings for future recommendations. This review highlighted the critical importance of earlier and deeper engagement and consultation with agencies about CDRT recommendations, which has been incorporated into standard practice.

2025-2030 Strategic Priorities

To support development of the new CDRT Strategic Priorities for 2025-2030, the NSW Ombudsman convened a planning day for CDRT members (25 February 2025) and presented the proposed priorities and enablers for discussion and endorsement (27 May 2025).

Strategic areas explored in those discussions include effective collaboration between the CDRT and NSW Ombudsman's Office staff supporting the CDRT, ways that the CDRT can build relationships and influence the ecosystem it sits within, collecting and sharing data for the greater good, amplifying the impact of issues identified and recommendations made, and testing the currency of the CDRT's legislative model and its fit with the future needs of society. These issues have been translated into five strategic priorities and two key enablers that will sit above initiatives to implement those priorities in the same way as the previous plan.

On 9 September 2025, the CDRT endorsed its *Strategic Priorities 2025-2030* and initiatives to implement these priorities. This will be available on the new CDRT website in early November 2025.

2.4 Meetings of the CDRT

The CDRT met formally on four occasions in 2024-25: September 2024, November 2024, February 2025, and May 2025. Two meetings were held in person and two via an online platform. An attendance table is at Appendix 2.

2.5 CDRT Member survey

In December 2024, the NSW Ombudsman conducted an annual governance survey of CDRT members and expert advisers. The confidential survey sought feedback about their views and experiences of CDRT meetings, NSW Ombudsman secretariat support and the CDRT composition over the calendar year. The 2024 survey introduced questions about possible improvements, risks, threats and challenges. This was the third annual member survey. Responses across the period have been largely consistent.

Consolidated results of the survey were shared with the Convenor and with the CDRT in the February 2025 workshop. Survey results indicated that while secretariat support is a continuing strength, some members had a desire and capacity for increased involvement with CDRT projects.

Suggested improvements included seeking to raise the profile of the CDRT and the Register of Child Deaths, and growing collaboration with external entities through information exchange and project and research partnerships to achieve increased positive impact. These goals informed the development of the CDRT's new strategic priorities for 2025-2030 and are reflected across the priorities, in particular to promote awareness of the CDRT to extend its reach, and to enhance open and constructive relationships with key agencies.

2.6 CDRT Secretariat

The CDRT's day-to-day work is supported by staff of the Child Death Reviews Unit in the NSW Ombudsman's Office. The unit is also responsible for the Ombudsman's reviewable child death function.⁶ At the end of the 2024-25 period, this unit comprised 19 staff.

Work undertaken by staff to assist the CDRT includes:

- registration of individual deaths (on average, approximately 450-500 children die in NSW each year)
- gathering relevant information and records from stakeholders and service providers
- recording information in the Register of Child Deaths and analysing and reviewing that information
- identifying systemic issues and providing strategic advice to the CDRT
- coordinating, overseeing, and completing research and other projects to support the work of the CDRT
- preparing statutory reports (annual, biennial, research)
- monitoring recommendations from previous reporting periods
- performing secretariat functions for the CDRT.

Some CDRT members receive sitting fees in accordance with the NSW Government Boards and Committees Guidelines⁷ and the Act.

⁶ See note 4 above.

⁷ [NSW Government, NSW Government Boards and Committees Guidelines, September 2015](#)

3. Reporting of child deaths

3.1 Biennial report

The CDRT is required to table a report of data collected and analysed in relation to child deaths every two years.

The CDRT's *Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament* will be tabled in November 2025. Following tabling, the report will be accessible on the CDRT's new website which will be launched on the same day.

3.2 Recommendations

Chapter 7 of this report includes detailed information from agencies about their actions to implement two recommendations currently being monitored by the CDRT. These two recommendations relate to Sudden Unexpected Death in Infancy (**SUDI**) prevention (1) and suicide prevention (1).

4. Research to help reduce child deaths

Research is an important way of examining causes and trends in child deaths, and to identify measures that can assist in preventing or reducing the likelihood of child deaths.

The Act anticipates that the CDRT will table a research report in Parliament on a triennial basis, with reasons required to be given if such a report has not been presented within the previous 3 years. Most recently, the CDRT published *Infant deaths from severe perinatal brain injury in NSW, 2016-2019: key thematic observations* on 27 November 2023.⁸

4.1 CDRT Research Framework

In September 2024, the CDRT published a framework to support its research functions. The framework guides the prioritisation, delivery and communication of research projects; ensures the CDRT's approach to research is consistent, equitable and inclusive; supports collaboration with stakeholders; and aligns research projects with the latest CDRT Strategic Priorities and the NSW Ombudsman's Strategic Plan. The Framework has been used to guide the CDRT's current research (see Section 4.2), including establishing the governance arrangements for each project and considering the particular issues referred to in the appended Schedule for externally commissioned research in the appointment of external research organisations.

A copy of the Research Framework is available on the NSW Ombudsman's website: www.ombo.nsw.gov.au.

4.2 Research planned or underway in 2024-25

Review of the suicide deaths of Aboriginal children and young people

Aboriginal and Torres Strait Islander children and young people are over-represented in suicide deaths of children and young people aged 10-17 years. Over the ten-year period 2011-2020, the NSW Register of Child Deaths recorded the deaths by suicide of 238 children and young people aged 10-17 years, of whom 43 were identified as being of First Nations background.

The primary aim of the project is to identify opportunities for preventing and reducing the likelihood of suicide deaths of Aboriginal and Torres Strait Islander children. The CDRT has engaged the Ngarruwan Ngadju First People Health and Wellbeing Research Centre to conduct the research. Aboriginal members of the CDRT are acting as project sponsors overseeing the key findings and outcomes of this work.

The project includes:

- detailed case reviews of Aboriginal and Torres Strait Islander children and young people who died by suicide in the ten-year period (completed by Ombudsman review staff and expert advisers connected to the project),
- oversight by a newly established Aboriginal Suicide Prevention First Nations Advisory Group,

⁸ This research report was tabled together as an annexure with the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*. See NSW Ombudsman, Annexure B to the [Biennial report of the deaths of children in New South Wales: 2020 and 2021](#), 27 November 2023, p. 219.

- consultation with stakeholders in regional forums (including representatives from Aboriginal community-controlled organisations) and a metropolitan policy workshop, and
- an updated literature and policy review and service mapping (building on preliminary unpublished work commissioned by the CDRT from the Sax Institute completed in 2021).

The research report, *Holding Hope: Preventing Suicide among Aboriginal and Torres Strait Islander Young people in New South Wales*, will be tabled in NSW Parliament with an accompanying community report in November 2025.

Follow-up review of perinatal deaths from severe brain injury in NSW, 2020-2023

The follow-up review of perinatal deaths from severe brain injury in 2020-2023 builds on the preliminary review of deaths in 2016-2019, which reviewed neonatal deaths associated with asphyxia-related causes such as hypoxic ischemic encephalopathy over the 4-year period. The preliminary review considered a range of factors such as infant characteristics; maternal characteristics; risk factors for fetal/newborn compromise; pregnancy, labour, and birth characteristics; maternal and newborn care; and pregnancy, pre- and post-death investigations. It found key thematic areas, with strong validity and consistency with the evidence-base, of fetal intrauterine growth restriction, decreased fetal movements, fetal heart rate monitoring, post-birth/newborn onset of deterioration, use of oxytocin to induce labour, instrumental vaginal birth and critical incident investigation.⁹

The objectives of this follow-up research are to understand the key contributory factors in infant deaths from severe perinatal brain injury in NSW; identify opportunities, and make recommendations, for the prevention of future deaths; and identify and assess the adequacy of clinical practice guidelines and policies, adherence to these guidelines and policies, and any changes made since the preliminary study.

In 2024-25, the follow-up review was approved by the CDRT, funding was allocated and a procurement process led to the selection of the University of Sydney as the research partner to undertake all elements of the research. The research is expected to be completed by late 2026.

Review of suicide-related deaths among LGBTIQ+ young people

The review of suicide-related deaths from 2018-2023 among young people aged 10-17 years who identified as LGBTIQ+ aims to:

- understand the specific risk factors that may have contributed to the deaths of the young people who died
- understand the social contexts of the young people who died (where possible)
- identify protective factors and effective approaches to address suicide risks among the cohort
- identify current support measures available for LGBTIQ+ young people as well as any gaps in the support provided
- make recommendations on ways to prevent future deaths among young people who identify as LGBTIQ+, where supported by the evidence.

⁹ See note 8 above.

The methodology includes a cohort review, a literature review of effective preventative measures, and a desktop review of countermeasures currently in place in NSW to support LGBTIQ+ young people.

In 2024-25, the project plan was approved by the CDRT, funding was allocated and a procurement process led to the selection of a research partner to undertake the literature and desktop reviews. The research is expected to be completed by mid-2026.

5. Other activities and information

In addition to the CDRT's review and research work it is also involved in other activities, including making submissions to Parliament and government, and engaging with similar functions across Australia to share knowledge and promote efforts to prevent future deaths of children.

5.1 National child death review group

The Australia and New Zealand Child Death Review and Prevention Group involves member representatives from every state and territory in Australia and New Zealand. The group meets every year to share information, knowledge, and ideas about child death-related work to assist members to meet their common goal of preventing deaths of children. The role of convening the group rotates among jurisdictions, and is currently held by the Queensland Family and Child Commission (**QFCC**).

The group's fifth 'virtual' annual conference was held on 20 May 2025. The conference offers a professional development opportunity for people working in child death prevention, registration, review, policy and research. Presentations included:

- Suicide risks and prevention
 - Multifactorial approaches to understanding and addressing youth suicidality (Grace Scholl, student at Griffith University, sociologist and lived experience advocate)
 - A study that examines childhood experiences of domestic and family violence among young people who died by suicide (Professor Silke Meyer, Leneen Forde Chair in Child & Family Research at Griffith University, and Maria Atienzar-Prieto, School of Health Sciences and Social Work Griffith University)
- Filicides and domestic and family violence
 - A study of filicides in a domestic and family violence context from 2010 to 2018 (Dr Holly Blackmore, Research Manager, Death Review Australia's National Research Organisation for Women's Safety, and Anna Butler, Co-Chair of the Australia's National Research Organisation for Women's Safety and Manager, Domestic Violence Review Team)
- Child death review
 - Development of a model for Aboriginal child death review (Judith Lovegrove, Oversight and Advocacy Authority for Aboriginal Infants, Children and Young People)
 - Findings from a review of historical inquiries into the safety and wellbeing of vulnerable children from 2010 to 2022 (Commissioner Anne Hollonds, National Children's Commissioner Australian Human Rights Commission)
- Drowning and water safety
 - Using coronial data to inform the Australian Water Safety Strategy 2030 (Stacey Pidgeon, Royal Life Saving Society Australia)
- Road safety
 - Restraint practices among fatally injured child passengers and the general child passenger population (Professor Julie Brown, Co-Director, Transurban Road Safety Centre at NeuRA Injury Prevention Research Centre at The George Institute)

- SUDI
 - Findings from the review of Queensland Sudden Unexpected Death in Infancy cases between 2013 and 2016 (Dr Julie McEniery, Queensland Paediatric Quality Council)

The group's annual Secretariat meeting was held on 29 May 2025, attended by the group's jurisdictional representatives. The meeting included updates on the National Child Death Data Collection, research projects, staff wellbeing, presentations about emerging trends and focus topics (suicide prevention, management of children with disabilities and complex medical needs, multicultural backgrounds, e-scooters, bikes and personal mobility devices) and group priorities over the next 12 months.

5.2 Submissions

The CDRT sent 4 submissions (or other correspondence providing information from CDRT reports and the Register of Child Deaths) to various inquiries and NSW Government Ministers over the year:

- To the NSW Parliamentary Inquiry examining prevalence, causes, and impacts of loneliness in NSW on 25 October 2024.
- To the Head of the National Suicide Prevention Office on 25 October 2024 providing information and feedback on the National Suicide Prevention Strategy.
- To the NSW Minister for Health on 26 March 2025 related to the identification and response of hospitals and primary care to ill children, for the NSW Government's roundtable on strengthening the REACH (Recognise, Engage, Act, Call, Help) program.
- To the NSW Premier on 15 April 2025 providing information relevant to the Government's response to recommendations arising from the NSW Parliamentary Inquiry on use of e-scooters, e-bikes, and related mobility options, and supporting 5 recommendations in the report.

6. Disclosure of information

6.1 Disclosures under s 34L(1)(a)

Section 34L(1)(a) of the Act allows the disclosure of information in good faith for the purpose of exercising a function under Part 5A of the Act. Under this provision, the CDRT provided the following information:

- In August 2024, the CDRT provided the Department of Education data on children who had died after being unintentionally left in vehicles, from January 2018 to December 2023.

6.2 Disclosures under s 34L(1)(b)

The CDRT is required to include in this annual report whether any information has been disclosed by the Convenor under section 34L(1)(b) of the Act. The section allows the Convenor to authorise the release of information acquired by the CDRT in connection with research 'that is undertaken for the purpose of helping to prevent or reduce the likelihood of deaths of children in NSW.' Under this provision, the following information was provided:

- In September 2024, the CDRT provided the NSW Coroner's Court with data on all deaths from 1 January 2018 – 31 December 2022 where the death has been notified to the Coroner, to support an external research project.
- In May 2025, the CDRT provided the Australian Institute of Health and Welfare (**AIHW**) with de-identified unit record data from the Register of Child Deaths for all deaths from 1 January 2020 – 31 December 2021, as part of a data sharing agreement for a Proof of Concept to support the national child death data collection project.

6.3 Disclosures under s 34L(1)(c)

Section 34L(1)(c) of the Act allows the disclosure of information to certain entities for specified purposes, in relation to deaths within their jurisdiction. Under this provision, the CDRT provided the following information:

- In 2024-25, the CDRT provided the Coroner's Court of NSW with information from the Register of Child Deaths about the circumstances of the deaths of individual children.
- The CDRT provided the NSW Ombudsman with information to inform correspondence to DCJ sent on 10 February 2025 as part of DCJ's review of the Sibling Safety Policy.

Section 34L(1)(c)(vi) provides for disclosure for the purpose of 'giving effect to any agreement or other arrangement entered into under section 34D(3)'. Section 34D(3) allows the Convenor to enter into an agreement or other arrangement for the exchange of information between the CDRT and a person or body having functions under the law of another State or Territory that are substantially like the functions of the CDRT.

The CDRT currently has formal agreements in place with similar bodies in the Australian Capital Territory and Western Australia and provides information to bodies in other States and Territories on a case-by-case basis. The CDRT also put in place a one-off data sharing agreement with AIHW in March 2025 to support the exchange of data for the purpose of the national child death data collection project.

In this context, information was provided to the following agencies between 1 July 2024 and 30 June 2025 in response to requests received:

- In July 2024 the CDRT provided the NT Child Deaths Review and Prevention Committee with data on the deaths of children in New South Wales during the period 1 January 2019 – 31 December 2023 who were normally resident in the Northern Territory.
- In October 2024 the CDRT provided the Queensland Family and Child Commission with 2022 Australia and New Zealand child death data for inclusion in the *Australian child death statistics 2022* report, prepared by the QFCC on behalf of the Australia and New Zealand Child Death Review and Prevention Group.
- In February 2025 the CDRT provided the ACT Child & Young People Death Review Committee with data on the deaths of children in New South Wales during the period 1 January – 31 December 2024 who were normally resident in the Australian Capital Territory.

7. CDRT recommendations

The CDRT can make recommendations aimed at preventing or reducing the likelihood of child deaths.

Recommendations can be for new or amended legislation, policies, practices, and services. They can be directed to government and non-government agencies, or to the community.

Under sections 34F(2)(b) and (3) of the Act, the CDRT annual report:

- a. must include details of the extent to which its previous recommendations have been accepted, and
- b. may comment on the extent to which those recommendations have been implemented in practice.

The CDRT recognises that in some cases it can take time for agencies to implement recommendations fully, and some recommended changes may be made incrementally.

Accordingly, as well as reporting on any new recommendations made during the reporting year, the CDRT also looks at any open recommendation from previous years, and decides and reports on whether:

- to **close** the recommendation on the basis that it is satisfied the recommendation has been substantially implemented or that the intent of the recommendation has otherwise been met
- to **continue monitoring** the recommendation, or
- to **vary** the recommendation or make a **new** recommendation to take account of progress to date or to reflect other developments since the original recommendation was made.

At the beginning of this reporting period there were two open CDRT recommendations. These relate to SUDI prevention and suicide prevention. These recommendations are detailed below, along with a report on the status of each recommendation.

7.1 Summary of recommendations

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation (2025)
SUDI – Policy Directive review NSW Health should review PD2019_035 Management of Sudden Unexpected Death in Infancy, having regard to the results of its audit of compliance with the revised SUDI medical history protocol completed in October 2023. As part of this review, NSW Health should consult with relevant stakeholders referred to in the Policy and the CDRT.	October 2024	NSW Health	Supported	To be closed - implemented
Suicide – targeted prevention measures The NSW Government should include in any suicide prevention plan specific measures targeted to school-aged children and young people across the spectrum of need. In particular, this should include: (element met and closed in 2021-22) (element met and closed in 2022-23) - The provision of targeted, sustained, and intensive therapeutic support to young people at high risk – including strategies for reaching those who are hard to engage.	June 2019	NSW Health	Supported	Continue monitoring

7.2 Progress on recommendations

Recommendation: SUDI – Policy Directive review

Recommendation 1, NSW Child Death Review Team Annual Report 2023-24 **(published October 2024)**

NSW Health should review PD2019_035 Management of Sudden Unexpected Death in Infancy, having regard to the results of its audit of compliance with the revised SUDI medical history protocol completed in October 2023. As part of this review, NSW Health should consult with relevant stakeholders referred to in the Policy and the CDRT.

Why the recommendation was made

Following the introduction in 2019 of a revised guide for taking an infant's medical history after a SUDI death (the *Medical History Guide – Sudden Unexpected Death in Infancy*, part of the NSW Health Policy Directive PD2019_035 *Management of Sudden Unexpected Death in Infancy (SUDI)*), the CDRT made a recommendation to NSW Health in 2021 to audit use of the updated Guide.

In October 2023, NSW Health advised that it had completed the audit, and provided formal advice on the audit findings and outcomes to the CDRT. The audit found that compliance with the Medical History Guide was below expectations. The SUDI cross-agency working group¹⁰ considered the audit findings and agreed to review the Policy Directive.

Given the review of the Policy Directive had not yet commenced, and to ensure relevant stakeholders were consulted, the CDRT made the above recommendation in October 2024. NSW Health advised its acceptance of the new recommendation in December 2024.

Agency progress updates in relation to implementation

NSW Health advised that the review of the Policy Directive consisted of a desktop review and the development and finalisation of a draft SUDI response model and draft SUDI policy. Throughout the review process, NSW Health consulted with Ministry of Health and agency advisers (Prevention and Response to Violence, Abuse and Neglect, Senior Clinical Advisor workforce, Chief Paediatrician, Senior Clinical Advisor Child and Family Health, Centre for Aboriginal Health, Health Chief Executives), agency representatives (NSW Ambulance, NSW Health Pathology Forensic Medicine, Red Nose, NSW Police, NSW Department of Communities and Justice, Office of the NSW State Coroner), and clinicians (Local Health District/clinician representatives, paediatricians/paediatric clinical nursing consultants, emergency physicians, rural GPs and visiting medical officers, social workers). NSW Health advised that they took a holistic approach to the review, incorporating consideration of how agencies interact, how services wrap around families, and any revisions required in light of international research in addition to the audit findings.

¹⁰ The SUDI Cross Agency Working Group (**CAWG**) was established in response to a previous CDRT recommendation, Recommendation 3 in the Child Death Review Report 2015 (published November 2016). NSW Health has had responsibility for the management of the CAWG since July 2019; [NSW Child Death Review Team Annual Report 2020-21](#) p 17.

The audit findings indicated that while paediatricians usually completed the medical history interviews, they recorded the interviews differently. Some staff used the 2019 Medical History Guide, while others used a previous template or recorded additional information in other ways. In some cases, an interview or record was not provided to Forensic Medicine as required and when the information was provided, the level of detail varied. P79A forms (Report of Death to Coroner) were found to be important sources of information. Reasons why a medical history was not completed were generally not documented, but those that were cited high levels of family distress, or that the interview had already been or would be conducted by Police.

NSW Health met with NSW Ombudsman staff in November 2024 and March 2025, and then the CDRT in May 2025, with the CDRT providing both oral and written feedback on the revised Policy Directive.

NSW Health advised in August 2025 that consultation on the draft revised policy review had been completed and the Policy Directive review is expected to be completed by early 2026. All stakeholders will be advised of the revised Policy's publication.

Has the intent of the recommendation been met?

NSW Health's review of PD2019_035 *Management of Sudden Unexpected Death in Infancy* has considered the results of its audit of compliance with the revised SUDI medical history protocol completed in October 2023 and has involved consultation with relevant stakeholders referred to in the Policy, including the CDRT. Therefore, the recommendation will be closed as met.

Recommendation: suicide – targeted prevention measures

Recommendation 10, Biennial report of the deaths of children in NSW: 2016 and 2017 (published June 2019)

The NSW Government should include in any suicide prevention plan specific measures targeted to school-aged children and young people across the spectrum of need. In particular, this should include:

- a. (element met and closed)
- b. (element met and closed)
- c. The provision of targeted, sustained and intensive therapeutic support to young people at high risk – including strategies for reaching those who are hard to engage.

Why the recommendation was made

At the time the recommendation was made, the suicide rate for young people aged 10-17 years had increased over the prior decade, and the CDRT observed school-age young people to have particular vulnerabilities and needs that should be considered in suicide prevention strategies. It observed that NSW generally had good systems for identifying young people who are at risk of suicide or who are dealing with mental health problems, but that intervention – once a problem is identified – could be episodic and fragmented. Identification of suicide risk must be supported by effective strategies to manage and contain risk to prevent suicide.

The CDRT also observed that, in NSW, demand for access to developmentally appropriate specialist mental health services for children and young people regularly outstripped the capacity to supply timely services. The *Strategic Framework for Suicide Prevention in NSW 2018-2023 (the Framework)*¹¹ supported whole of government suicide prevention activity across all NSW communities and was identified as a foundation for targeted youth mental health services.

Agency progress updates in relation to implementation

The NSW Government supported the recommendation, and delegated responsibility for providing its updates to NSW Health.

Between 2021 and 2023 NSW Health provided information on a range of Child and Adolescent Mental Health Services (**CAMHS**), Towards Zero Suicides and National Mental Health and Suicide Prevention Agreement suicide prevention initiatives, including the Getting on Track in Time – Got it! programs, Safeguards Teams, the Youth Aftercare Pilot (**YAP**) program (branded “i.am”), Zero Suicides in Care, Suicide Prevention Outreach Teams (**SPOT**), Safe Havens, Project Air Schools initiative, Head to Health Kids Hubs, the Enhancement and Integration of Youth Mental Health Services Initiative, Youth Community Living Support Services, and an out of home care (**OOHC**) mental health framework being developed in partnership with DCJ.

In June 2024, in the context of reported shortages of beds and psychiatrists and increasing presentations, NSW Health provided advice about initiatives including a gap analysis on community mental health services conducted by the NSW Mental Health Minister in December 2023,¹² and a revised psychiatry workforce plan. They highlighted the role of Safeguards Teams in assessing and linking young at-risk patients with appropriate longer term care services provided by CAMHS, private practice clinicians, psychosocial support services, and housing and education services.

In May 2025 representatives from the NSW Ombudsman met with NSW Health staff to discuss the recommendation. NSW Health provided updates on the community mental health services gap analysis, evaluation of the Safeguards Teams and their flexible service delivery models, and Kids Hubs (formerly Head to Health Kids Hubs). NSW Health also advised about its management of the impact of the industrial action involving NSW public health psychiatrists.

In August 2025 NSW Health advised that following the gap analysis paper, a report of the findings of service mapping using service planning and simulation (modelling) tools will be made available in 2025-26. They noted that they are modelling demand for CAMHS, adult and older adult services, both inpatient and community ambulatory, and that Local Health Districts will be consulted about the findings to provide further context.

NSW Health advised that the joint framework with DCJ to guide the provision of mental health care for children in OOHC, the Mind My Wellbeing framework, would soon be published.

NSW Health provided interim evaluations of the Safeguards Teams, conducted in 2023 and 2024, that found the Teams fill an important gap in responding to children in mental health crisis. The 2024 evaluation found consumers had fewer mental-health related ED presentations and hospital readmissions, and improved clinical outcomes, following contact with Safeguards. It made 11 recommendations for improvement of the program, including in relation to the extension of care beyond 6 weeks, and workforce and culture.

¹¹ Since replaced by the [Strategic Framework for Suicide Prevention in NSW 2022-2027](#).

¹² NSW Ministry of Health (2023) [NSW Community Mental Health Services Priority Issues Paper](#), published December 2023.

The evaluation's findings support the CDRT's observations regarding the importance of accessible long-term mental health services, and the workforce challenges currently experienced by the sector. Notably, the Safeguards model of care recommends a 6-week period of care in the program. While the average length of care was 4 weeks and 4 days, the evaluation observed that 1 in 10 consumers engaged with Safeguards for 12 weeks or more. This was due to the time needed to build trust and rapport, as well as holding consumers during a transition period or gap in service support. Consumers reported that the transition from Safeguards to longer-term care was sometimes fragmented, leading to these gaps in support. Identified challenges for the program included workforce recruitment and limited long-term service availability, due to demand outpacing supply.

NSW Health advised that CAMHS teams were provided with support in managing the impacts of the industrial action involving NSW public health psychiatrists. They advised that there were no temporary service reductions within CAMHS, and the Ministry monitors all reportable incidents.

NSW Health noted that the Suicide Prevention Bill 2025¹³ would establish a whole-of-government approach to suicide prevention with cross-portfolio delivery of suicide prevention programs. The Bill proposes a Suicide Prevention Council and Aboriginal Suicide Prevention Council to advise the Mental Health Commission in the preparation of a statewide suicide prevention plan and statewide Aboriginal suicide prevention plan, both to be reviewed at least every 5 years. The Councils can also provide advice to the Mental Health Commission about improvements to suicide prevention, and the Aboriginal Suicide Prevention Council can make recommendations to the Mental Health Commission regarding the Aboriginal suicide prevention plan. The statewide suicide prevention plans are to have regard to the needs of priority population groups among other considerations. Departments, the NSW Police Force and other prescribed agencies will also be required to have agency suicide plans.

The Mental Health Commission can report on the implementation of suicide plans, and must annually report on advice or recommendations received from the Councils, and whether that advice or those recommendations were accepted and implemented. The Secretary¹⁴ may keep a register of suicide deaths with the purpose of monitoring and reporting on suicide deaths, identifying risk factors or patterns, and enabling the identification and monitoring of suicide prevention and response strategies.

NSW Health also provided advice on funding to 6 men's mental health organisations providing wellbeing and support services to young men (aged 10-25 years), suicide bereavement support for children and young people, and the NSW Suicide Monitoring System.

¹³ The Suicide Prevention Bill 2025 passed New South Wales Parliament on 11 September 2025. A commencement date for the Act has not yet been proclaimed.

¹⁴ The Bill provides that this refers to the Secretary of the Department in which the Act will be administered on behalf of the Minister.

Has the intent of the recommendation been met?

The CDRT acknowledges NSW Health's continued endeavours to enhance child and adolescent mental health services and that its programs and initiatives provide a foundation for targeted, sustained and intensive therapeutic support to young people at high risk of suicide. The CDRT notes the findings of the Industrial Relations Commission (IRC) on 3 October that "(t)here is an acute shortage of psychiatry staff specialists, distinguishable from other staff specialists, which is causing a deterioration in the quality of mental health care delivered in the public health system in New South Wales and a deterioration in the working conditions of psychiatrists."¹⁵

The CDRT notes the shortfalls in the provision of targeted, sustained and intensive therapeutic support, partially due to ongoing challenges in recruiting and maintaining an adequate workforce. The CDRT acknowledges that some of these challenges require long-term, systemic change, and there are efforts to map some of these required changes in the service modelling underway. In relation to the impact on children and young people at risk of suicide as a priority group, the CDRT will monitor the implementation of the NSW Suicide Prevention Act, and the Mind My Wellbeing framework for children in OOHHC. Therefore, the CDRT will continue to monitor this recommendation.

7.3 New recommendations

The CDRT made one recommendation during the 2024-25 reporting year, see section 7.2.

¹⁵ [Health Secretary, Ministry of Health v Australian Salaried Medical Officers' Federation \(New South Wales\) \(No 2\) \[2025\] NSWIRComm 27](#)

Appendix 1: CDRT Strategic Priorities 2022-2025

The CDRT agreed upon its Strategic Priorities 2022-2025 in February 2022 and developed an Action Plan setting out actions and associated tasks for the three-year period against the strategic priorities identified.

Updates against in progress actions as of 30 June 2025 are set out in the table below.

Meeting our strategic outcomes

Priority	Status	Comments
1. Nurture strategic relationships and collaboration with key partners and stakeholders to optimise our influence and reach		
Revise and refine our list of stakeholders <i>Focus initiative: stakeholder network mapping</i>	In progress	In 2023-24 the CDRT completed an initial review which identified three priority stakeholders for engagement on the CDRT's <i>Biennial report of the deaths of children in New South Wales: 2020 and 2021</i>.¹⁶ NSW Ombudsman staff have met with two of those three stakeholders, the NSW Coroner and the Sydney Children's Hospital Network/The Children's Hospital at Westmead. Most recently, in August 2024 NSW Ombudsman staff presented on the <i>Biennial report of the deaths of children in New South Wales: 2020 and 2021</i> and deaths due to neoplasms to the Children's Hospital at Westmead. Identifying opportunities to deepen our engagement with stakeholders is part of the CDRT's 'business-as-usual' processes. An updated, comprehensive stakeholder mapping exercise is one of the first initiatives under the new CDRT Strategic Priorities for 2025-2030.
Leverage the expertise of CDRT members, and collaborate with research and community partners (such as universities and institutes) to bring further authority and academic expertise to our work	Completed in prior year (ongoing)	The CDRT has engaged an external research organisation to conduct literature and desktop reviews as part of the CDRT's review of suicide-related deaths among LGBTIQ+ young people, and another external research organisation to conduct a cohort review of relevant deaths, and assess the adequacy of (and adherence with) clinical practice guidelines, as part of the follow-up review of perinatal deaths from severe brain injury in 2020-2023. Closer involvement of CDRT members and external research partners is now part of our Research Framework and other 'business-as-usual' practices.

¹⁶ Accessible at: <https://cmsassets.ombo.nsw.gov.au/assets/Reports/Biennial-report-of-the-deaths-of-children-in-NSW-2020-and-2021.pdf>

Priority	Status	Comments
Embed a collaborative approach in our work and ways the CDRT do business	Completed in prior year (ongoing)	The NSW Ombudsman sought feedback from CDRT stakeholders through its annual stakeholder survey, which includes questions about whether its staff took the time to listen and were professional and respectful.
Proactively engage with stakeholders to ensure our recommendations are well-targeted, understood, and attainable	Completed in prior year (ongoing)	Three stakeholder meetings were held with relevant program areas within NSW Health to discuss Health's progress towards implementing CDRT recommendations. The CDRT will continue to meet with agencies to discuss recommendations as part of 'business-as-usual' practices.
Develop strategies to improve the visibility of our work with stakeholders and community partners <i>Focus initiative: promoting our work</i>	Completed in prior year (ongoing)	A new standalone website for the CDRT is under development, which will improve the accessibility and visibility of the CDRT's data and insights, CDRT reporting and research, and information on the CDRT's membership, functions and the Register of Child Deaths.
Share information and data from the Register of Child Deaths to support stakeholders in research and other work related to the prevention of child deaths	Substantially completed	A procedure for responding to external requests for Register data has been finalised. Information and contact details for those seeking access to information from the Register will be included on the new CDRT website.
2. Identify and generate current data that provides insight into the effect of society-wide stressors such as COVID-19		
Identify relevant data to be captured and address any gaps <i>Focus initiative: identifying data to be captured</i>	Completed in prior year (ongoing)	The CDRT continues to capture societal stressor data in the Register of Child Deaths and to report on this data as relevant. The CDRT also considers the impact of societal stressor data in its Research Framework.
Extract information from case records for inclusion in the Register of Child Deaths	Completed in prior year (ongoing)	Matters associated with COVID-19 will be reported on in the <i>Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament</i> .
Analyse captured information to provide insight into the impact of societal stressors, including partnering with relevant agencies where required <i>Focus initiative: analysis and insight</i>	Completed in prior year (ongoing)	Discussion of how COVID-19 related societal stressors may have impacted children who died by suicide will be included in the <i>Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament</i> .

Priority	Status	Comments
3. Undertake meaningful and well-targeted projects, and make the most of existing data		
Complete and publish reports for each of our current projects:		The status of current research projects is as follows:
Preventing the suicide deaths of Aboriginal children and young people	In progress	A final draft of the report for this project was completed in 2024-2025. The CDRT anticipates the final public report of this research, accompanied by a community report, will be tabled in November 2025.
Report on agency responses to any recommendations made in these reports, together with their progress in implementing recommendations	Pending	When a research report with recommendations is published, the CDRT will report on the implementation of any recommendations made in the report.
Track, to the extent this is practicable, the direct and indirect impacts of our project work and recommendations <i>Focus initiative: measuring our impact</i>	Pending	This action will be carried forward into the strategic priorities for 2025-2030 through a survey of key stakeholders following every CDRT report to measure trust and impact.
Select, plan, and resource at least one new project or piece of research that can be achieved and delivered during the 3-year period. Shortlisted topics should support CDRT strategic priorities, build on/consolidate previous recommendations, and actively leverage current work and projects.	Completed (ongoing)	Under the Act, the CDRT is expected to publish at least one research project in any three-year period, and otherwise must provide reasons why it has not done so. During the 2022-25 period, we: - finalised research on the effects of perinatal conditions and local area socioeconomic status on early childhood mortality in NSW using linked data analysis (reported December 2022) - finalised research on key thematic observations from infant deaths from severe perinatal injury in NSW, 2026-2019 (reported November 2023) - finalised research on the suicide deaths of Aboriginal children and young people (report to be published late 2025). Two new research projects are underway: - suicide deaths of young people aged 10-17 who identified as LGBTIQ+ (2018-2023) - follow up review of perinatal deaths from severe brain injury (2010-2023).

Priority	Status	Comments
		Members were consulted on a list of other potential research projects and topics which may be pursued in future, and NSW Ombudsman staff continue to record new emerging issues for consideration as they are identified.
Explore further opportunities for additional person-centred datasets that link numerical and qualitative data to deepen our understanding of the context of child deaths <i>Focus initiative: exploring opportunities</i>	Pending	This action will be carried forward into the strategic priorities for 2025-2030 through mapping relevant external data to contextualise data in the Register of Child Deaths.
Develop recommendations that are both systems level and specific	In progress	Internal guidance on making recommendations will be finalised in 2025-26.
4. Apply an equity lens to our work as core business		
Define an 'equity lens', and how to apply it in our work, considering the specific role of the CDRT and how/where the CDRT might lead work in this area	Completed in prior year (ongoing)	The CDRT continued to apply an equity lens to our work in relation to identified priority populations, including through the Research Framework which: • is guided by a key principle of conducting research that can contribute to reducing inequities (including by focusing where appropriate and possible on over-represented groups), particularly where the inequity highlights potentially preventable deaths, • embeds a commitment to equity at all stages of research processes including planning, design and sharing of findings, and • provides criteria to prioritise and select research projects that include consideration of whether there is an issue that disproportionately impacts an over-represented group.
Focus on equity aspects of preventable mortality – including access to resources and services. The CDRT will consider any unresolved and/or worsening trends in the post-COVID environment, as	Completed in prior year (ongoing)	The <i>Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament</i> will include different presentation of data to identify any over-representation of children with a child protection history.

Priority	Status	Comments
well as inequitable distribution of serious injury and morbidity		
Identify any groups which should be the focus of targeted work, and consider opportunities to collaborate with associated stakeholders	Completed in prior year (ongoing)	The CDRT continued to consider opportunities for collaboration with identified priority populations.
Identify and consider how to obtain/generate relevant equity-related data <i>Focus initiative: data generation</i>	Completed (ongoing)	The CDRT continued to obtain and generate equity-related data, through the Register of Child Deaths and our research projects.
Consider commitments in the NSW Implementation Plan for achieving the National Agreement on Closing the Gap to improve the lives of Aboriginal and Torres Strait Islander people in relevant child death cases <i>Focus initiative: Closing the Gap</i>	Completed in prior year (ongoing)	Aboriginal and Torres Strait Islander families were identified as a priority population. The <i>Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament</i> will discuss commitments in the National Agreement on Closing the Gap. In 2024-25, the CDRT considered the NSW Government commitments in the Closing the Gap 2022-24 Implementation Plan. ¹⁷
5. Deliver powerful and influential evidence-based recommendations that bring about change		
Develop evidence-based recommendations that incorporate lessons from previous strategies, such as the use of smaller inter/intra-agency working groups to workshop actions needed to bring about change <i>Focus initiative: review of unsuccessful recommendations</i>	Completed (ongoing)	The findings of the recommendation review have continued to inform the CDRT's recommendations making practice.
Explore ways of communicating and targeting our messaging to incentivise agencies to act on our recommendations – whether they are directly or	Completed in prior year (ongoing)	The CDRT continued to enhance its engagement processes with stakeholders about recommendations.

¹⁷ [Closing the Gap 2022-24 Implementation Plan | NSW Government](#)

Priority	Status	Comments
indirectly impacted – and align with our broader purpose to prevent deaths <i>Focus initiative: broadening our reach</i>		
Develop strategies to track the impact of our recommendations in future data, including beyond 2025	Pending	This action will be carried forward into the strategic priorities for 2025-2030 through a survey of key stakeholders following every CDRT report to measure trust and impact.
Review our public reporting <i>Focus initiative: review of public reporting</i>	Completed in prior year	The <i>Child Deaths in NSW 2022 and 2023 Biennial Report to Parliament</i> will use a revised simplified format, and the Ombudsman's reporting on reviewable deaths during the period will be a separately tabled report.

Appendix 2: Member meeting attendance

Individuals marked 'N/A' were not CDRT members at the time of the meeting in question.

Member	3 September 2024	26 November 2024	25 February 2025	27 May 2025
Mr Paul Miller (Convenor)	Y	Y	Y	On leave
Prof Kathleen Clapham (Deputy Convenor) ¹⁸	Y	Y	Y	N
Ms Monica Wolf ¹⁹	Y	Y	Y	Y
Ms Zoë Robinson	N	N	N	N
Ms Sarah Bramwell	Y	N	N	Y
Ms Vanessa Chan ²⁰	Y	Y	Y	On leave
Det Super Danny Doherty ²¹	N	Y	Y	N/A
Dr Helen Goodwin ²²	N/A	N/A	Y	Y
Ms Anne Reddie	Y	Y	N	Y
Ms Amy Vincent- Pennisi ²³	Y	Y	On leave	On leave
Ms Alison Sweep	Y	N	Y	Y
Dr Susan Adams	Y	Y	Y	N
Dr Susan Arbuckle	Y	Y	Y	N
Prof Ngiare Brown	N	Y	N	N
Dr Luciano Dalla-Pozza	Part attend	Part attend	Y	Part attend
Dr Bronwyn Gould	Y	Y	Y	Y
Prof Ilan Katz	N	Y	Part attend	Y
Dr Lorraine du Toit-Prinsloo	Y	Y	Y	Part attend
Dr Matthew O'Meara	Y	Y	Y	Y
Ms Jennifer Black ²⁴	N/A	N/A	Y	Y

¹⁸ Professor Clapham has stepped aside from the position of Deputy Convenor until the conclusion of the Review of the suicide deaths of Aboriginal children and young people.

¹⁹ Ms Monica Wolf's membership ceased on 27 June 2025.

²⁰ Ms Vanessa Chan commenced leave from CDRT under clause 5(1)(d) of Schedule 2 to the *Community Services (Complaints, Reviews and Monitoring) Act 1993* in March 2025.

²¹ Det. Superintendent Danny Doherty's CDRT membership ceased in April 2025.

²² Dr Helen Goodwin's CDRT membership commenced in January 2025.

²³ Ms Amy Vincent-Pennisi commenced leave from the CDRT under clause 5(1)(d) of Schedule 2 to the *Community Services (Complaints, Reviews and Monitoring) Act 1993* in January 2025.

²⁴ Ms Jennifer Black's CDRT membership commenced in December 2024.



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NSW Ombudsman

Level 24, 580 George Street

Sydney NSW 2000

Phone: (02) 9286 1000

Toll free (outside Sydney Metro Area): 1800 451 524

Website: ombo.nsw.gov.au

Email: info@ombo.nsw.gov.au

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