Ombudsman
New South Wales

NSW Child Death Review Team Annual Report 2019–20

nsw cdrt
child death review team

27 October 2020

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27 October 2020

The Hon John Ajaka MLC
President
Legislative Council
Parliament House
SYDNEY NSW 2000

The Hon Jonathan O'Dea MP
Speaker
Legislative Assembly
Parliament House
SYDNEY NSW 2000

Dear Mr President and Mr Speaker

NSW Child Death Review Team Annual Report 2019–20

As Convenor of the NSW Child Death Review Team (CDRT), I am pleased to present the NSW Child Death Review Team Annual Report 2019–20 for tabling in Parliament.

This report is made under s 34F of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

I request that you now make the report public forthwith.

Yours sincerely

Paul Miller
Convenor, NSW Child Death Review Team
Acting Ombudsman

Ombudsman
New South Wales

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Contents

About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during the period 1 July 2019 to 30 June 2020.

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:

- Chapter 1 and 2: The NSW Child Death Review Team – outlines the constitution of the CDRT, its members, and the functions of the Team.
- Chapter 3: Reporting of child deaths – provides advice about our upcoming report of child deaths in 2018 and 2019.
- Chapter 4: Research to help reduce child deaths – details research and projects to meet our purpose and functions.
- Chapter 5: Other activities – a summary of some of the other work we are engaged in.
- Chapter 6: Our plans – progress against our strategic priorities.
- Chapter 7: Disclosure of information – details information disclosures as prescribed in the Act.
- Chapter 8: Our recommendations – documents responses by agencies to CDRT recommendations, and their progress towards implementation.
- Appendix: copies of agency advice in relation to recommendations.

Chapter 1. The NSW Child Death Review Team

Who we are

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 (being persons under the age of 18 years) in NSW. Our purpose is to prevent or reduce the deaths of children in NSW through the exercise of our functions under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.

CDRT membership is prescribed by the Act. Members are:

- The NSW Ombudsman, who is the Convenor of the CDRT
- The NSW Advocate for Children and Young People
- The Community and Disability Services Commissioner (Deputy Ombudsman)
- Two persons who are Aboriginal persons
- Representatives from NSW Government agencies:
  - NSW Health
  - NSW Police Force
  - Department of Communities and Justice[1] (two representatives, one in respect of the *Children and Young Persons (Care and Protection) Act 1998*, and one in relation to the *Disability Inclusion Act 2014*)
  - Department of Education
  - Department of Justice[2]
  - 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 Advocate and the Commissioner are ex officio appointments. Other members may be appointed for a period of up to three years, with capacity for re-appointment.

The CDRT must have at least 14 members, in addition to the Convenor and ex officio members. The members also elect a Deputy Convenor, who may undertake some of the roles of the Convenor in his or her absence, including chairing of meetings.

1. On 1 July 2019, the former Departments of Family and Community Services and Attorney General and Justice merged to form the Department of Communities and Justice.
2. Ibid.

CDRT members in 2019–20

Ex officio members

Mr Michael Barnes (Convenor)
NSW Ombudsman

Mr Paul Miller
Community and Disability Services Commissioner
Deputy Ombudsman

Mr Andrew Johnson (to December 2019)
NSW Advocate for Children and Young People

Ms Zoe Robinson (from January 2020)
Acting NSW Advocate for Children and Young People

Agency representatives

Assistant Commissioner Scott Cook
Police Prosecutions and Licensing Enforcement Command, NSW Police Force

Ms Eloise Sheldrick
Coordinator and Assistant Coroner,
Coronial Information and Support Program
Office of NSW State Coroner

Ms Kate Alexander (to July 2019)
Executive Director,
Office of the Senior Practitioner
Department of Communities and Justice

A/Prof Gabrielle Drake (October to December 2019)
Director Child Safety and Review,
Office of the Senior Practitioner
Department of Communities and Justice

Ms Sarah Bramwell (from April 2020)
Director Practice Learning,
Office of the Senior Practitioner
Department of Communities and Justice

Ms Robyn Bale (to September 2019)
Director, Student Engagement and Interagency Partnerships, Department of Education

Ms Lisa Alonso Love (from November 2019)
Executive Director Learning and Wellbeing,
Educational Services, Department of Education

Mr Ben Spence (from October 2019)
Executive District Director, Hunter & Central Coast District, Child Protection & Permanency,
District and Youth Justice Services,
Department of Communities and Justice

Dr Matthew O'Meara (from October 2019)
Chief Paediatrician, NSW Ministry of Health
Staff Specialist Paediatric Emergency Medicine,
Sydney Children's Hospital

Ms Larisa Michalko (to June 2020)
Director, Criminal Law Specialist,
Policy and Reform Branch
Department of Communities and Justice

Independent experts

Professor Ngiare Brown[3]
Director and Program Manager
Ngaoara Child and Adolescent Wellbeing

Professor Kathleen Clapham[4] (Deputy Convenor)
Professor Indigenous Health,
Australian Health Services Research Institute
University of Wollongong

Dr Susan Adams
Senior Staff Specialist, General Paediatric Surgeon and Head of Vascular Birthmarks Service
Sydney Children's Hospital

Dr Susan Arbuckle
Paediatric and perinatal pathologist
The Children's Hospital at Westmead

Dr Isabel Brouwer
Statewide Clinical Director
Department of Forensic Medicine

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
General Practitioner

Professor Philip Hazell
Child and Adolescent Psychiatrist, Sydney Local Health District, Conjoint Professor of Child and Adolescent Psychiatry, The University of Sydney School of Medicine

Professor Heather Jeffery (Honorary)
International Maternal and Child Health
University of Sydney/Royal Prince Alfred Hospital

Professor Ilan Katz
Professor, Social Policy Research Centre
University of NSW

3. Appointed by the Minister under section 34C (7) as an Aboriginal person within the meaning of the *Aboriginal Land Rights Act 1983*.
4. Ibid.

Expert advisers

Our legislation 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 2019-20 include:

- Professor Les White, former NSW Chief Paediatrician and CDRT member for NSW Health
- Dr Lorraine du Toit-Prinsloo, Senior Staff Specialist, Clinical Training Coordinator, Forensic Medicine Newcastle
- Dr Julie Brown, Senior Research Scientist, Neuroscience Research Australia
- Dr Daniel Challis, Executive Medical Advisor Obstetrics, NSW Perinatal Services Network; Director Women's and Children's Health, South East Sydney Local Health District; Conjoint Associate Professor, University of NSW

Researchers undertaking projects on our behalf may also be appointed as expert advisers. Chapter 4 provides details of any researchers who have undertaken projects for the CDRT.

Chapter 2. Our functions

Under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, our functions 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, and
- Make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.

CDRT reports of child deaths are available at: https://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/nsw-child-death-review

The NSW Ombudsman also has a separate responsibility for reviewing the deaths of children in circumstances of abuse or neglect, and the deaths of children in care or detention. Under Part 6 of the Act, the Ombudsman's functions are to:

- Maintain a register of reviewable deaths
- Monitor and review 'reviewable' deaths
- Undertake, alone or with others, research that aims to help prevent or reduce, or remove risk factors associated with reviewable deaths that are preventable.
- Make recommendations as to policies and practices for implementation by government and non-government service providers to prevent or reduce the likelihood of reviewable 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** (s 34F), which details the activities of the CDRT and progress of its recommendations. This is the annual report for 2019-20.
- The **biennial child death review report** (s 34G), which consists of data collected and analysed in relation to child deaths. Until 2016, this report was prepared and tabled on an annual basis. The first biennial report – which covered deaths of children that occurred in 2016 and 2017 – was tabled in Parliament in June 2019. The next biennial child death review report is due to be tabled in mid-2021.
- **Other reports** (s 34H), which provide information on the results of research undertaken in the exercise of our 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.

Reports by the Ombudsman of reviewable deaths of children prior to 2019 are available at: www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths

From 2019, the CDRT biennial report and the Ombudsman's report of reviewable child deaths have been combined in the one report. The focus of both functions is to help prevent the deaths of children. The combined report brings together the work and findings of both statutory functions, and provides for a holistic and contextual approach to the analysis and consideration of trends and issues.

The most recently tabled biennial report (June 2019) is available at: www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths/biennial-report-of-the-deaths-of-children-in-new-south-wales-2016-and-2017

2.2. Meetings of the CDRT

The CDRT met formally on four occasions in 2019-20: September 2019; December 2019; March 2020 (via teleconference); and June 2020 (via online meeting platform). Minutes of meetings record information about topics and issues discussed, any decisions made, and action items.

2.3. CDRT Secretariat

The CDRT's day-to-day work is supported by staff of the Death Reviews Unit in the NSW Ombudsman's Office. That Unit is led by Assistant Ombudsman, Monica Wolf, and comprises 11 staff. The Unit is also responsible for the Ombudsman's child death review functions, as well as the Ombudsman's separate functions of reviewing certain deaths of people with a disability who were living in supported accommodation. Work undertaken by staff to assist the CDRT includes:

- Identifying, registration and triage of individual death notifications. 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 for trends and patterns.
- Identifying of key issues and matters that require further action, and providing strategic advice to the CDRT.
- Coordinating, oversight and completion of research and other projects to support the work of the CDRT.
- Drafting statutory reports (annual, biennial, and research).
- Monitoring recommendations from previous reporting periods.
- Managing appointments and operation of the CDRT membership and meetings.

2.3.1. The CDRT and COVID-19

In March 2020, the World Health Organization declared the Novel Coronavirus (COVID-19) a global pandemic. Extraordinary actions have been, and continue to be, taken in NSW, nationally and globally, in order to limit the spread of the disease and to protect public health.

In the reporting period to end June 2020, we have not identified any COVID-19 related deaths of children under the age of 18 years in NSW. We will continue to monitor child deaths, and will actively consider whether there may be any possible direct or indirect association with COVID-19 or actions taken in response to it. We will report any insights or emerging trends in our next annual report.

The members of the CDRT would also like to take the opportunity to acknowledge those families and other loved ones who have had to deal with the death of a child or young person during these particularly difficult times, aware that recent circumstances, including limits on the number of mourners at funerals and restricted visiting in hospitals, will add to their stress and grief.

Chapter 3. Reporting of child deaths

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

The CDRT's most recently published child death review report, the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*, was tabled in June 2019. An overview of this report was included in our 2018-19 annual report.

We are aiming to table the next biennial child death report by mid-2021; work on this report commenced in 2019-20. This report will examine the deaths of children in NSW that occurred in 2018 and 2019, within the context of child deaths over the past 10-15 years.

3.1. Recommendations

The CDRT is currently monitoring 19 recommendations in relation to SUDI (5), drowning (1), transport-related fatalities (7), and suicide (6). Detailed information from agencies about actions they are taking to implement these recommendations is included later in this report in Chapter 8.

Chapter 4. Research to help reduce child deaths

Our research is an important way of examining causes and trends in child deaths in some detail, and to consider measures that go to preventing or reducing the likelihood of child deaths. Information from research assists us to identify and target recommendations for prevention.

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.

In 2019-20, we did not table any reports from research projects; however, a number of research projects are currently underway. Two of these projects are discussed below.

4.1. Research in progress

Social determinants in child deaths

In June 2019, the Team agreed its next major research project would examine the nature of links between socio-economic disadvantage and child death.

Previous work commissioned by the CDRT and the Australian Institute of Health and Welfare (AIHW) – *Spatial analysis of child deaths in New South Wales* (April 2018) – identified the increased likelihood of a child dying in NSW if they live in a disadvantaged area, and specifically, if they live in an area characterised by high poverty, low school engagement, overcrowded housing and childhood developmental vulnerability. While the general link between socio-economic status and the risk of child death has been well established, questions remain about the factors underpinning this relationship.

The research project will aim to deliver a more in-depth analysis using linked individual-level data to model the effect of individual and area-level characteristics on the risk of child death.

The project is currently still in the planning stage. We aim to complete this work in 2022.

Perinatal asphyxia

Our work to review infant deaths related to perinatal asphyxia is continuing.

The project involves examining infant deaths associated with perinatal asphyxia over the four-year period from 2016 to 2019, in order to identify opportunities to improve practice and prevent similar deaths in future. The review also has the potential to benefit infants who survive a perinatal asphyxia-related incident, but with disability of varying severity. CDRT member Dr Bronwyn Gould, with the assistance of Dr Daniel Challis (an expert advisor to the CDRT) and staff, is leading this work.

The project is considering a range of issues, such as: level of monitoring for women in labour; recognition of abnormal traces via monitoring; and timeliness and appropriateness of decision-making in relation to women at risk.

We aim to complete this work in 2021-22.

Chapter 5. Other activities

In addition to our review and research work, we are also involved in a range of other activities that ensure we engage in discussions with other similar teams across Australia, keep our knowledge current, and help with our efforts to prevent future deaths of children. Two of these activities are discussed below.

5.1. Consistent classification of Sudden Unexpected Death in Infancy (SUDI)

In 2019-20, the CDRT continued its work to improve investigation and understanding of factors that may contribute to SUDI, in order to identify strategies that may help to prevent sudden and unexpected infant deaths.

In 2016, the CDRT developed a classification system for SUDI deaths that identified levels of post death investigation and factors present at the time of death. This classification system was adopted for use within the CDRT and has been piloted by NSW Health Pathology, Forensic Medicine.

We submitted our proposed classification for SUDI to the World Health Organization's (WHO) International Classification of Diseases (ICD) revision taskforce of the 11th edition of the ICD (ICD-11).[5] It is anticipated that the WHO will endorse the ICD-11 before 1 January 2022 and countries around the world will be able to adopt ICD-11 for use after this. In 2019, our proposal had progressed to the ICD-11 Mortality Reference Group for further consideration.

The CDRT will continue to apply the revised classification, along with the final outcomes of the ICD-11.

5.2. National child death review group

NSW currently has the responsibility of convening the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG). The group involves member representatives from every state and territory in Australia, as well as New Zealand. The group meets every year for a two-day conference to share information, knowledge and ideas about child death-related work.

In late 2019 and early 2020, we undertook extensive planning activities in preparation to host the annual conference in Sydney on 30 April-1 May 2020. However, national concerns about the COVID-19 pandemic and increasing travel restrictions meant that we had to cancel the planned meeting.

Although we initially considered rescheduling the meeting for late 2020, given ongoing uncertainties about the fluctuating national situation and impact of the pandemic in Australia, and the limited capacity of some jurisdictions to participate, we made the decision to concentrate on preparing for the 2021 meeting, which will again be hosted by NSW.

5.3. Injury prevention group

A number of CDRT members are also members of the NSW Children and Young People Injury Prevention Working Group (CYPIP), which was formed in 2018 to facilitate the reduction of risk, severity and frequency of injury to children and young people in NSW by:

- Providing a forum for the discussion of children and young people injury prevention priorities in NSW
- Facilitating member collaboration on children and young people injury prevention projects
- Identifying priority areas for action on unintentional injury to children and young people, and

5. https://www.who.int/classifications/icd/en/ accessed 15 July 2020

- Guiding the direction of children and young people injury prevention planning, research and policy in NSW.

The group is supported by the Office of the NSW Advocate for Children and Young People. Members of the CYPIP are drawn from a cross section of academia, government and non-government organisations.

The CYPIP seeks to build on work already done and to utilise recent research into the prevalence of unintentional injury to children and young people in NSW. The CYPIP are planning to release a desk review report later this year which will provide a broad overview of existing research and best practice with respect to unintentional childhood injury prevention in a local and international context. A key aim of this work is to identify priorities for child and young person injury prevention in NSW and to outline opportunities to address gaps in order to improve injury prevention efforts in the state.

In June 2020, the CDRT provided comments to the National Injury Prevention Strategy Draft for Consultation, focusing on our work and previous research.

Chapter 6. Our strategic priorities

The CDRT's practice is to develop a triennial plan of strategic priorities to guide our work and prioritise our resources. This year, we started work on actions agreed in our new Strategic Priorities Plan 2019-22.

6.1. Meeting our priorities

The figure below details progress against the key strategic priorities 2019-22.

Figure 1. Progress report for CDRT strategic priorities 2019-22 (at June 2020)

Priority	Status	Comments
Building on our work		
Using our data, between July 2019 and June 2022 we will:		
• Identify relevant external datasets and strategies to link with our data	In progress	A data linkage project is in an advanced planning stage. The Team is engaging with NSW Health and the Australian Institute of Health and Welfare to access linked data.
• Use data linkage in a major project	Pending	
• Build dashboards to provide timely and relevant data		A high-level dashboard has been built to provide quarterly data about child deaths. Planning is underway to build additional dashboards showing more detailed information and data.
• Work with external stakeholders to promote the Register and patterns and trends identified	Pending	
Between July 2019 and June 2022, our priorities will be to actively monitor:		
• Outcomes from the Cross Agency Working Group (SUDI) towards achieving improved investigation and response to sudden and unexpected deaths of infants	Progressed	Each issue nominated for active monitoring is subject to a current recommendation. Chapter 8 details the current status of these recommendations, and actions taken by agencies to progress them.
• The development and implementation of strategies to improve the correct use of child restraints and seatbelts in NSW, particularly how strategies are targeted to vulnerable communities	Progressed	As above
• The development of a suicide prevention plan which includes specific measures targeted to preventing suicide in school-aged children	Progressed	As above
• The implementation of measures in public, Catholic and Independent schools to ensure suicide deaths are subject to review to inform practice and postvention	Progressed	As above

Priority	Status	Comments
Research and projects		
Over the three-year period, we will produce reports on our work and table these in Parliament:		
• CDRT Annual Report 2018-19	Completed 2019	Tabled 31 October 2019
• CDRT Annual Report 2019-20	In progress	To be tabled 27 October 2020
• CDRT Annual Report 2020-21		
• Biennial child death review report – deaths in 2018 and 2019	In progress	To be tabled in 2021
• Biennial child death review report – deaths in 2020 and 2021		
Between July 2019 and June 2022, we will:		
• Undertake at least one major research project and table this in Parliament. The research will focus on analysis of the effects of social determinants on early childhood mortality / risk of child death.	In progress	As detailed in 4.1, the Team will focus on a project that examines the relationship between socio-economic factors and child death.
• Undertake and report on at least three detailed group reviews, which will examine data held in the Register of Child Deaths relating to: – Asphyxia-related deaths of newborn infants – Deaths of Aboriginal and Torres Strait Islander children – The role of young drivers in motor vehicle crash deaths	In progress	The review of asphyxia deaths of newborns is continuing, with an anticipated completion date of 2021-22. Planning has commenced for a detailed review of suicide deaths of Aboriginal children and young people. Work in relation to the young driver project is pending.
Engagement and promotion		
Between July 2019 and June 2022, our priorities will be to:		
• Develop a communications plan for the CDRT	In progress	The Team held a workshop in June 2020 to begin the process of developing a plan. Further work is underway to progress this action.
• Prepare and promote fact sheets to highlight potentially avoidable child deaths and share evidence-based prevention strategies	Pending	
• Work with the State Coroner's office, NSW Health Pathology Forensic Medicine, and other key stakeholders to promote a revised SUDI classification	Pending	
• Work with stakeholders to promote the findings and recommendations arising from our report *'The role of child restraints and seatbelts in passenger deaths of children aged 0-12 years in NSW'*	In progress	We are actively monitoring a number of recommendations made to Transport for NSW arising from this report. See Chapter 8 for details. We are also considering other ways to work with stakeholders.

Priority	Status	Comments
• Lead the Australia and New Zealand Child Death Review and Prevention Group, with a focus on engaging all jurisdictions in determining forward priorities and working with states to implement a future work agenda	In progress	The group's annual conference was cancelled due to national COVID-related travel and group meeting restrictions. Work will commence later this year to prepare for the 2021 conference.
Exploring new opportunities		
Between July 2019 and June 2022, our priorities will be to:		
• Include data linkage in one major project, to shift our work towards predictive analysis	Pending	We are in the process of engaging with NSW Health and the Australian Institute of Health and Welfare to access linked data.
• Include analysis of injury data in our review of young driver deaths	Pending	
• Include analysis of injury data (intentional self-harm) in our review of suicide deaths of Aboriginal children and young people	Pending	Planning has commenced for a detailed review of suicide deaths of Aboriginal children and young people, including analysis of intentional self-harm injury data.
• Review progress of recommendations from the Senate Select Committee Inquiry into Stillbirths in Australia (finalised in December 2018). The CDRT will consider the need for further work in linking perinatal deaths and stillbirths	Pending	The CDRT plans to review progress in August 2020, and will determine any actions at this time.

Chapter 7. Disclosure of information

7.1. Disclosure under s 34L (1) (b)

We are required to include in our annual report to Parliament whether any information has been disclosed by the Convenor under s 34L (1) (b) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. This provision 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'.

During 2019-20, we made the following disclosures under s 34L (1) (b):

- In July 2019, we provided information in relation to medical histories taken following the sudden and unexpected death of an infant less than one year of age over the period 2016-2018, to the Australian Paediatric Surveillance Unit (APSU) for its study into NSW paediatricians' experience with management of SUDI.
- In October 2019, we provided information in relation to pedestrian deaths of children aged 5-17 years over the 10 year period 2009-2018, to a member of the NSW Parliament to assist drafting of a Bill in relation to child safety in and around school zones in NSW.
- In October 2019, we provided information in relation to the deaths of children and young people by suicide in 2016 and 2017 to the North Coast Primary Health Network (NCPHN) to assist the NSW/ACT Primary Health Data and Information Network (of which NCPHN is a member) to identify health needs and service gaps in the PHN regions.

7.2. Other information disclosures

Under section 34D of the Act, any function of the Team with respect to child deaths in NSW may also be exercised by the Team in connection with the death of a child dying outside the State while ordinarily resident in NSW. The Act also 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 similar to the functions of the CDRT, relevant to the exercise of the CDRT's functions and those of the interstate body. The CDRT has reciprocal arrangements in place with all Australian states and territories.

In this context, we provided information to agencies in Victoria and the Australian Capital Territory (ACT):

- In September 2019, we provided the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) with de-identified data relating to the deaths of children who died in NSW in 2018, but were residents of Victoria.
- The ACT child death register includes children who normally live in the ACT, but whose death occurs outside of the ACT. In February 2020, we provided the ACT Children and Young People Death Review Committee (CYPDRC) with information about the deaths of ACT resident children who died in NSW in 2019.

Under separate provisions – section 34L (1) (c) – we also provided information to the State Coroner and other agencies as prescribed by our legislation:

- The *Coroners Act 2009* (section 24) outlines the Coroner's jurisdiction concerning the deaths of children and disabled persons. In June 2020, we provided information to the Coroner in relation to child deaths under section 34L (1) (c) (iii) of CS CRAMA for inclusion in the Chief Magistrates Annual Report 2019. The State Coroner also sought, and we provided, individual case reviews for five child death matters in accordance with section 34L.
- The Department of Communities and Justice (DCJ) publishes an annual report of child deaths known to DCJ.[6] In June 2020, we provided DCJ with information about gestational age for infants under one year who died during the period 2016-18 whose families were known to DCJ to inform their review of infant deaths resulting from prematurity.

6. https://www.facs.nsw.gov.au/download?file=770647 accessed 17 July 2020

Chapter 8. Our recommendations

One of the functions of the CDRT, as outlined in s 34D (1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, is to make recommendations arising from our work as to legislation, policies, practices and services that could be implemented by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.

Sections 34F(2)(b) and (3) of the Act require that our annual report to Parliament include details of the extent to which our previous recommendations have been accepted, and comment on the extent to which those recommendations have been implemented in practice.

In monitoring recommendations, we recognise that agencies may take time to fully implement those that are accepted, and may make changes incrementally. In that context, we decide each year whether to:

- close a recommendation on the basis that we are satisfied the intent of our proposal has been met
- continue monitoring the recommendation
- amend the recommendation to take account of progress to date, or
- amend the recommendation to reflect other developments that change the need for the proposal in its original form.

As present, we have 19 open recommendations relating to Sudden Unexpected Death in Infancy (SUDI), private swimming pools, road safety (safer vehicle choices, child seatbelt and restraint practices, crash surveillance, low speed run-over incidents, and quad bikes), and suicide prevention.[7] These recommendations are detailed below, along with a report on the current status of each recommendation.

Agency correspondence is provided in full at appendix 1.

8.1. Progress on recommendations

8.1.1. Sudden Unexpected Death in Infancy (SUDI)

Our recommendations: SUDI investigation

Recommendations 2 and 3, Child Death Review Report 2015 (published November 2016)

We recommended that the NSW Government, in the context of previous CDRT recommendations and the work of Garstang et al:[8]

> **Consider a centralised model for SUDI response and investigation in NSW. This would be staffed by specialist health professionals to work with police, the family, pathologists and the Coroner to respond immediately and consistently to SUDI.**
>
> **Devise a joint agency policy and procedure governing the individual and coordinated roles and responsibilities of NSW Health, the NSW Police Force and the NSW Coroner in SUDI investigation. The policy and procedure should incorporate all elements of a joint agency response to SUDI:**
>
> **(a) Expert paediatric assistance in death scene investigation and interviews with the family (noting that investigation of any suspicious deaths would be the responsibility of police).**
>
> **(b) Specialised training and development of resources for police in SUDI investigation.**

7. In addition to the 19 recommendations monitored by the CDRT, the Ombudsman is monitoring a small number of recommendations (2) that relate to reviewable child deaths.
8. Garstang J., Ellis C., & Sidebotham P. (2015). Reporting to Sudden Unexpected Death in Infancy (SUDI): A review of the evidence. Research compiled for NSW Kids and Families, through the Sax Institute.

(c) **Identified specialists to take the SUDI medical history, and review of the SUDI medical history form and the immediate post-mortem findings to enable further specific history taking where necessary.**

(d) **Application and monitoring of standardised protocols for SUDI pathology, with specific requirements for standard screens in sudden unexpected infant death.**

(e) **The conduct of SUDI post-mortems by specialist paediatric pathologists. Minimally, where post-mortems are not conducted by paediatric pathologists, there should be consultation with paediatric specialists.**

(f) **Multi-disciplinary review following post-mortem. The review should be chaired by an informed paediatrician, and involve relevant health providers to review the case. Review should consider all available information and provide advice to assist the Coroner in determining cause of death, to advise on possible genetic issues and necessary investigations for surviving children and parents, and prevention strategies for the family in the context of identified risks.**

(g) **The introduction of clear procedures to ensure families are provided with:**

i. **Appropriate advice and referral, particularly where genetic causes are indicated or suspected, and**

ii. **Ongoing contact, including for provision of grief counselling.**

Why we made the recommendations

Each year in NSW, around 40-50 infants under the age of 12 months die suddenly and unexpectedly. Identifying a cause of death for SUDI is important for a number of reasons, including for parents and carers to understand their loss; to provide information about possible medical or genetic implications for the family; and to learn from untimely deaths and to help prevent future deaths.

Identifying a cause of death after the sudden and unexpected death of an infant requires a timely, expert-led and comprehensive investigation involving police, NSW Health (emergency departments and NSW Heath Pathology Forensic Medicine services) and the Coroner's office. The CDRT has consistently identified gaps in investigation of SUDI in NSW.

The NSW Government supported our recommendations, and established a cross-agency working group (CAWG) under the lead of the Department of Premier and Cabinet (DPC) to develop a more coordinated approach to SUDI responses.

To what extent have the recommendations been implemented?

We acknowledge that the NSW government did not pursue a centralised model of SUDI investigation, but rather sought to improve the cross-agency response. The CAWG was established in 2017, originally led by DPC, with the lead role being taken on by NSW Health in July 2019. Over the three years, there have been a number of changes to the investigation of and response to SUDI:

- In addition to on-call services provided by the Duty Forensic Pathologist, police and medical practitioners have access to Clinical Nurse Consultants based at the State Coroner's office in Sydney and Forensic Medicine, Newcastle. The consultants provide advice on SUDI death referrals to the Coroner, and are involved in following up to SUDI medical history and other medical information from hospitals and general practitioners.
- NSW Police has updated its Police Handbook to better support SUDI investigations, as well as its Forensic Evidence and Technical Services protocols to ensure appropriate forensic examination at death scenes.
- A multi-disciplinary review process was established in December 2017 to consider all available information, including initial post mortem results and SUDI medical histories, in order to provide advice to assist the Coroner in determining cause of death and other relevant issues.
- Policy directives across NSW Police, NSW Ambulance and NSW Health have been updated and aligned to clarify interagency roles and responsibilities, and provide clear instruction for frontline police and ambulance staff about the requirement to transfer all infants who die suddenly and unexpectedly to their nearest emergency department.

- NSW Health has published a revised policy directive relating to the management of SUDI, which includes a revised SUDI medical history protocol.[9] Completion of the infant medical history is mandatory, along with a requirement that a copy of the infant's health care record be forwarded to NSW Health Pathology Forensic Medicine within 24 hours of the infant's death.
- NSW Ambulance's protocol and clinical guidelines for paramedics on how best to observe the environment at the scene of death have been updated.
- Forensic Medicine is developing a new SUDI post-mortem protocol. The CAWG has determined that genetic testing will be conducted in SUDI cases at the discretion of clinical paediatric specialists and/or the forensic pathologist involved in a specific investigation.

The Appendix provides NSW Health's full response, which includes details of planned work (pg 31-82).

Our assessment of progress

While a centralised model for investigation of SUDI has not been adopted, there has been notable progress in achieving a more coordinated cross-agency response to SUDI, driven by the CAWG.

In addition, NSW Health's policy directive relating to the management of SUDI has been revised, and includes information about the role of NSW Health, the NSW Coroner, and NSW Police in the context of the NSW Government's response to SUDI.

Noting the progress made in a number of key areas, we will no longer monitor recommendation 3 (a), (b) (d) (f) and (g). We are satisfied that the intent of these recommendations has been met. Through our work, we will continue to have close regard to how agencies work together in response to SUDI, and we will maintain vision of further developments in these important aspects of the SUDI response.

We will, however, continue to directly monitor (c) and (e) of the recommendation.

In regard to:

(c) Identified specialists to take the SUDI medical history, and review of the SUDI medical history form and the immediate post-mortem findings to enable further specific history taking where necessary.

NSW Health has acknowledged that further work is required to ensure the SUDI medical history is completed fully in order to provide the required information to Forensic Medicine. NSW Health has also advised it will undertake further work to determine the possibility of an early multi-disciplinary meeting attended by all agencies involved in the first two weeks following an autopsy to assist ongoing monitoring of the information provided to Forensic Medicine following a sudden and unexpected infant death.

Our work in reviewing SUDI matters has shown there continues to be a significant number of SUDI cases where a medical history is not taken – in either the previous 12-page template format or via the new topics-to-cover guide – and/or the infant's health record containing this and other relevant information is not forwarded to Forensic Medicine within 24 hours of the infant's death, as required by policy. We are also aware that the processes in place within Forensic Medicine for timely expert review of the SUDI medical history and immediate post mortem findings are still being trialled and evaluated.

In regard to:

(e) The conduct of SUDI post-mortems by specialist paediatric pathologists. Minimally, where post-mortems are not conducted by paediatric pathologists, there should be consultation with paediatric specialists.

There does not appear to have been any progress in relation to this recommendation since DPC's update in December 2018 which noted that, against a background of national and international workforce shortages and training issues regarding paediatric pathologists, 'Forensic Medicine is working with NSW Health Pathology on ways to consult with paediatric pathologists' when conducting SUDI post mortems.

9. NSW Health PD2019_035, Management of Sudden Unexpected Death in Infancy (SUDI), published 30 July 2019. This policy replaces PD2008_070.

Our recommendation: unintentional bed sharing

Recommendation 6, Child Death Review Report 2015 (published November 2016)

Noting observations from our work about risks arising from unintentional bed sharing, we recommended that NSW Health, in consultation with Red Nose, should:

Review current advice and educational strategies with a view to the inclusion of:

- **Advice and preventative strategies to parents and carers in relation to unintentional bed sharing as part of NSW Health education and advice programs, and the Red Nose 'Safe Sleep My Baby' public health program.**
- **Strategies targeted to young mothers, including use of alternative avenues of advice through social media and parenting blogs, and targeting grandmothers for safe sleep education.**

Why we made the recommendation

Our work has identified a risk of overlaying in circumstances where an adult carer has fallen asleep while feeding or settling an infant on a bed or lounge. Safe sleep advice and education should promote strategies to help parents and carers to avoid this situation.

It is also critical that clear messages about safe sleeping and safe environments be developed and delivered to specific high risk populations.

NSW Health and Red Nose supported this recommendation.

To what extent has the recommendation been implemented?

Over the past three years, there have been a number of initiatives and updates to reinforce safe sleeping and address risks associated with unintentional bed sharing, including:

- development of a cot card for use in NSW Health maternity facilities.
- revision of key documents such as the child Personal Health Record (Blue Book), and Aboriginal Maternal and Infant Health Service and Building Strong Foundations *Safe sleeping for your baby* brochure.
- development of a safe sleeping e-learning module
- revision of NSW Health's Safe Sleeping Practices policy directive and clinical practice guideline to include information about risks associated with unintentionally falling asleep with a baby, and an assessment to identify vulnerable families who may require additional support. The policy recommends safe sleeping messaging be provided to all caregivers, and that safe sleeping messages are reiterated at each opportunity during the first 12 months of an infant's life. NSW Health maintains a risk elimination approach and takes the position that an adult bed cannot be made safe for a baby.
- creation of a *Co-Sleeping Tool* by Red Nose to support parents who co-sleep, both intentionally and unintentionally.

Our assessment of progress

Noting the actions taken since 2017, we are satisfied that the substance of this recommendation has been met, and will no longer monitor this recommendation.

Our recommendation: safe sleeping in vulnerable families

Recommendation 1, Biennial report of the deaths of children in NSW: 2016 and 2017 (published June 2019)

We recommended that:

NSW Health should develop and implement strategies to promote safe infant sleep practices to vulnerable families. In particular, NSW Health should target:

- **In consultation with the Department of Family and Community Services, families known to child protection services**
- **Families living in remote areas of the state, and**
- **Families living in areas of greatest socio-economic disadvantage.**

Why we made the recommendation

A disproportionate number of infants who die suddenly and unexpectedly live in in disadvantaged families – including Aboriginal families, families with a child protection background, families from areas of greater socio-economic disadvantage, and families living in more remote locations. In this context, we consider SUDI prevention initiatives should target high-risk populations, and that NSW government agencies should take specific actions to directly address risk issues.

NSW Health supported the recommendation.

To what extent has the recommendation been implemented?

In 2019, NSW Health introduced the *Baby Bundle* – a bag containing items to reduce the risk of SUDI (a baby safe sleeping bag, a room thermometer) and safe sleep information – which is given to parents and caregivers of every baby born from 1 January 2019 when discharged from hospital.

NSW Health also published its revised Safe Sleeping Practices policy and Clinical Practice Guideline,[10] which contains information about strategies to support families.

Our assessment of progress

In November 2019, NSW Health met separately with the Department of Communities and Justice (DCJ) and Red Nose, and facilitated a meeting to connect these two agencies to discuss opportunities to work together to support vulnerable families. Subsequent meetings planned for March 2020 have been delayed and will be rescheduled.

We will therefore continue to monitor this recommendation.

10. NSW Health, PD2019_038, Babies – Safe Sleeping Practices, published 20 August 2019. This policy replaces GL2005_063 and PD2012_062.

Our recommendation: identification of illness in infants

Recommendation 2, Biennial report of the deaths of children in NSW: 2016-2017 (published June 2019)

We recommended that:

> **NSW Health should undertake a campaign to promote resources (including fact sheets, websites, apps and phone lines) that aim to assist parents and carers to identify illness in infants. The campaign should focus on resources that are evidence-based and have been subject to evaluation.**

Why we made the recommendation

In 2016 and 2017 preceding infectious illness was present for more than half the infants who died suddenly and unexpectedly. For some infants, undiagnosed illness was fatal. Signs of serious illness in infants can be subtle and difficult to recognise, and hard to differentiate from those of a relatively minor illness. Infants can also develop an acute illness very quickly and can deteriorate very rapidly.

There are a number of resources available to assist parents, primarily website based, that provide guidance on illness in infancy. We considered more could be done to actively support carers to identify and respond to illness in infants.

NSW Health supported this recommendation.

To what extent has the recommendation been implemented?

In August 2019, NSW Health provided initial advice that it was in the process of contacting Red Nose to work collaboratively to promote evidence-based and evaluated resources for parents and carers.

Our assessment of progress

No new work or initiatives were included in NSW Health's July 2020 update, which provided a summary of existing resources available, such as the Health Direct website, and information and linkages to resources available via the Blue Book.

Our recommendation has not been implemented and we will continue to monitor this recommendation.

8.1.2. Drowning: private swimming pools

Our recommendation: publication of annual data from the swimming pool register

Recommendation 10, Child Death Review Report 2015 (published November 2016)

We recommended that the Office of Local Government should:

> **Publish annual data from its analysis of the swimming pool register, including but not limited to:**
>
> **(a) the number of pools registered**
>
> **(b) the number of pools that have been inspected**
>
> **(c) the proportion of inspected swimming pools that were deemed non-compliant with the Act at the time of inspection**
>
> **(d) the main defects identified at the time of inspection, and**
>
> **(e) whether or not owners have rectified defects within a reasonable period of time.**

Why we made the recommendation

There is little publicly available data on the outcomes of the regulatory regime for swimming pool safety and inspection. We consider there should be open and regular reporting on key aspects of swimming pool regulation.

The Office of Local Government (OLG) supported the recommendation in principle.

In January 2018, responsibility for the administration of the Swimming Pool Register transferred from the OLG to the Department of Finance, Services & Innovation (DFSI). In 2019, DFSI was incorporated into the new Department of Customer Service (DCS).

To what extent has the recommendation been implemented?

Some information about swimming pool safety and inspection is published in annual reports of local councils and the Building Professionals Board:

- the *Swimming Pools Regulation 2018*[11] requires councils to report the number of inspections they carried out that resulted in the council issuing certificates of compliance and non-compliance. Details about non-compliance must be entered on the Swimming Pool Register (the Register).
- the Building Professionals Board publishes information about the number of pools registered, the number of pools inspected, and the number of pools found compliant/non-compliant in NSW. The Board's Annual Report 2018-19 provides high level amalgamated data about the number of pools and spas inspected (25,958). The report notes that of these, the majority (21,120) were compliant with the *Swimming Pools Act 1992*. However, almost one in five (4,838) of the pools or spas inspected were non-compliant with the standards.

DCS has advised that the Register cannot currently provide an amalgamated report of the reasons pool barriers fail inspections, and whether non-compliances were rectified by owners within reasonable timeframes. Upgrades to the Register are required, and will not be available until 2021. The Appendix provides DCS's full response, which includes further details about upgrades (pg 83-84).

Our assessment of progress

To date, our recommendation has not been implemented.

The information that is currently published is not comprehensive or consistently provided by each council. We believe it should be. We will therefore seek further advice from DCS about its actions to ensure Councils comply with their obligations.

With regard to local council reporting requirements, we reviewed Council annual reports in June 2020 and found:

- A small improvement in compliance with reporting requirements – 62% of councils reported all required information about swimming pool inspections in 2018-19 (up from 56% in 2017-18).
- There has been a decrease in the number of councils which did not comply with legislative requirements – 18% of councils did not report any information about swimming pool inspections (down from 30% in 2017-18).
- The remaining councils provided some, but not all, required information.
- Little information is available about the number of pools inspected as a proportion of the number of pools registered.

11. The *Swimming Pools Regulation 2018* came into effect in September 2018. https://www.legislation.nsw.gov.au/#/view/regulation/2018/503/full accessed 6 August 2020

8.1.3. Transport-related fatalities

Our recommendation: safer vehicle choices

Recommendation 3, Biennial report of the deaths of children in NSW: 2016-17 (published June 2019)

We recommended that:

> **Transport for NSW (Centre for Road Safety) should include, as part of the *Safer Vehicle Choices Save Lives* campaign website, a page targeted at young drivers purchasing a vehicle. This should detail the features and vehicles to consider when purchasing the safest car in a range of price brackets – similar to the *'how safe is your first car?'* website (Victorian Transport Accident Commission).**

Why we made the recommendation

Our work has identified the majority of transport-related deaths of children and young drivers involved older, less safe vehicles that did not have advanced safety technologies.

Promoting the purchase of a safe vehicle is therefore an important initiative, and more can be done to provide education on safety for young drivers and their families when buying a new or used vehicle, such having information which compares the safety features of vehicles to assist young people buy the safest vehicle they can afford.

Transport for NSW (TfNSW) supported the recommendation.

To what extent has the recommendation been implemented?

Steps to implement this recommendation are underway. TfNSW has advised that:

- NSW consumers are directed to the Towards Zero website from advertising associated with the *Safer Vehicle Choices Save Lives* campaign.
- additional content aimed at younger drivers is being developed for publication on the Towards Zero website.
- in future, the ANCAP website will enable price range car searches, similar to the *'how safe is your car'* website.

The Appendix provides TfNSW's full response (pg 85-87).

Our assessment of progress

This recommendation has not been implemented.

As at 4 August 2020, we have not been able to identify a specific page or additional content aimed at younger drivers on either the Towards Zero website,[12] TfNSW's Centre for Road Safety webpage,[13] or ANCAP's *Safer Vehicle Choices Save Lives* campaign website.[14]

We will seek further advice from TfNSW about action being taken to implement the recommendation.

12. https://towardszero.nsw.gov.au/campaigns accessed 3 August 2020
13. https://roadsafety.transport.nsw.gov.au/campaigns/towards-zero/index.html accessed 3 August 2020
14. https://www.ancap.com.au/safervehiclescampaign accessed 4 August 2020

Our recommendations: child restraints and seatbelts

Recommendations 4, 5, 6 and 7, Biennial report of the deaths of children in NSW: 2016-17 (published June 2019)

In the context of the findings a 10-year review of the role of seatbelts and child restraints in the deaths of 66 child passengers aged 0-12 years in vehicle crashes, we recommended that:

> **Transport for NSW should undertake a study of child restraint practices in NSW. The study should have a particular focus on areas of socio-economic disadvantage and those outside major cities** (recommendation 4).
>
> **NSW Health and Transport for NSW should use their data linkage system for regular surveillance and monitoring of crash injuries and fatalities of children under the age of 13** (recommendation 5).
>
> **Transport for NSW (Centre for Road Safety) should actively promote information on best practice for restraining children over the age of seven years. Promotion activities should particularly target culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander communities, and areas of low socio-economic status** (recommendation 6).
>
> **Transport for NSW should fund a comprehensive and ongoing program to increase the correct and age-appropriate use of motor vehicle child restraints in NSW. The program should draw on the learnings of the Buckle-Up Safely program and incorporate a range of settings. It should provide education about safe travel for children, access to appropriate restraints (including subsidies for low-income families), and expert fitting of child restraints** (recommendation 7).

Why we made the recommendations

In 2019, we released a report detailing our findings from a review of the deaths of 66 children who died as passengers in NSW during the period 2007-2016.[15]

The review found that just over half (35) of the 66 children who died in crashes over the 10-year period were not properly restrained in the vehicle – they were either unrestrained, in a restraint that was not appropriate for their age, or in a restraint that was not fitted correctly. The report found that correct use of a restraint or seatbelt may have prevented the deaths of 20 children – almost one in three of all the 66 deaths that occurred.

The review also identified a number of factors associated with higher mortality rates (an increased likelihood of death), including:

- Children who lived in the lowest socio-economic areas of NSW
- Crashes that occurred outside of major cities, and/or on high-speed roads
- Aboriginal and Torres Strait Islander children, and
- Drivers who were found to have drugs in their system, along with other known risk factors such as driver fatigue and driver distraction.

Transport for NSW (TfNSW) supported all four recommendations. NSW Health agreed in principle with recommendation made jointly to NSW Health and TfNSW, noting that although its Centre for Health Record Linkage provides health data and linkage services to TfNSW, the linked dataset itself is held by TfNSW.

To what extent have the recommendations been implemented?

TfNSW has taken a number of steps to implement the recommendations:

- Neuroscience Australia has been engaged to conduct a study to estimate child restraint practices in NSW across 10 selected Local Government Areas.
- The Centre for Road Safety is undertaking regular monitoring of road trauma (crash injuries and fatalities) in NSW across all ages and road user classes, including children.

15. NSW Ombudsman (2019). The role of child restraints and seatbelts in passenger deaths of children aged 0-12 years in NSW, published 5 June 2019.

- TfNSW are actively working to promote best practice for restraining children that targets vulnerable children and communities, including holding additional local community engagements events, developing educational activities, and providing tailored content. A possible partnership with the Wiggles to create Aboriginal and CALD editions of the *Be Safe & Buckle Up* song is also being investigated.
- Ongoing programs are in place to reduce the incorrect use of child restraints in motor vehicles, such as the Child Restraint Evaluation Program (CREP) and RMS Authorised Restraint Fitting Station Scheme. In addition, 13 service providers have been engaged and trained to correctly fit child restraints, and local community engagement events held in a number of centres to train and fit restraints for Aboriginal communities.
- Revision of the CREP ease-of-use protocol is underway to provide a full five star rating for products that have implemented NeuRA's guidelines.

The Appendix provides TfNSW's full response (pg 85-87).

Our assessment of progress

We are satisfied that the intent of recommendations 5, 6 and 7 has been met, and will no longer monitor these recommendations.

However, we will continue to monitor recommendation 4 regarding a study of child restraint practices in NSW that focuses on areas of socio-economic disadvantage and outside of major cities.

Our recommendation: low speed run-over incidents

Recommendation 8, Biennial report of the deaths of children in NSW: 2016-17 (published June 2019)

In the context of our observation that there has been no real change in the number of children who have died in low speed vehicle run-over incidents over the past 15 years, we recommended that:

> **Transport for NSW (Centre for Road Safety) should, in the context of the evaluation of 'They're counting on you', consider further action to prevent low speed vehicle run-over incidents through promoting good practice and carer education.**

Why we made the recommendation

On average, two children die each year in low speed vehicle run-over incidents. Our reviews have consistently shown that the driver often does not know a child is nearby, or assumes the child is being looked after elsewhere. The *'They're counting on you'* campaign was established to educate drivers on driveway safety. Carer awareness and education is a critical prevention tool in this context.

Transport for NSW (TfNSW) advised it supported the recommendation.

To what extent has the recommendation been implemented?

TfNSW has implemented a number of initiatives to promote good practice and carer education, for example:

- creating the 'It only takes a second' teddy bear poster.
- sharing driveway safety messages via the Road Safety Facebook page throughout the year.
- developing a Driveway Safety Kit, which highlights the difficulty drivers have seeing small children, especially behind reversing vehicles.
- partnering with the Georgina Josephine Foundation to launch their inaugural National Low Speed Vehicle Run Over Prevention Awareness Day.
- updating the Motor Vehicle Operational Guidelines.

The Appendix provides TfNSW's full response (pg 85-87).

Our assessment of progress

We acknowledge the positive work of TfNSW in promoting safety messages, and accept the intent of this recommendation has been met. We will no longer monitor this recommendation.

Our recommendation: quad bikes

Recommendation 9, Biennial report of the deaths of children in NSW: 2016-17 (published June 2019)

We recommended that:

> **SafeWork NSW should establish a specific focus on children within the Quad Bike Safety Improvement Program. The program should strongly promote the message that children under 16 years of age should not operate, or be a passenger on, an adult quad bike under any circumstances or for any reason.**

Why we made the recommendation

Each year, on average between one and two children under 16 years die in quad bike crashes on private property in NSW. We have previously recommended that the NSW Government consider introducing legislation to prohibit children under 16 from riding adult quad bikes. In the context of the government's decision not to adopt this proposal, there is a critical need for well targeted and impactful messaging about the danger quad bikes pose to children.

SafeWork supported this recommendation.

To what extent has the recommendation been implemented?

SafeWork's 'Quad bikes and side-by-side vehicles' webpage[16] states that *'No child under 16 should ride or be a passenger on adult sized quad bikes.'* SafeWork's 'Child Safety on Farms' webpage[17] also contains clear statements about the danger of quad bikes to children.

On 15 April 2020, SafeWork launched its latest child safety campaign – consisting of print, radio and digital regional advertising – over a three month period, April-June 2020. The campaign featured a key message *'It's not worth your child's life. Just say no to them riding adult quad bikes'*. The campaign included a warning to quad bike owners to 'keep kids off quad bikes' during the school holidays, along with information about why quad bikes are so dangerous, and the story of one family whose daughter was killed in 2017.[18]

The *Quad Bike Safety Improvement Program* continues to promote child safety messages through social channels, and at agricultural field and farm safety days throughout the year.

The Appendix provides SafeWork's full response (pg 88).

Our assessment of progress

We acknowledge and commend SafeWork for the positive initiatives noted.

It is not clear to us, however, that SafeWork has established a specific focus on children within the *Quad Bike Safety Improvement Program*. For example, the program's FAQs webpage[19] does not appear to include any information about the dangers of children using quad bikes.

We will therefore continue to monitor this recommendation.

16. https://www.safework.nsw.gov.au/hazards-a-z/quad-bikes-and-side-by-side-vehicles accessed 9 July 2020
17. https://www.safework.nsw.gov.au/your-industry/agriculture,-forestry-and-fishing/farming/child-safety-on-farms accessed 9 July 2020
18. https://www.safework.nsw.gov.au/news/safework-media-releases/keep-kids-off-quad-bikes-during-school-holidays accessed 19 August 2020.
19. https://www.safework.nsw.gov.au/resource-library/agriculture,-forestry-and-fishing-publications/quad-bike-pubs/quad-bike-safety-improvement-program-FAQs accessed 9 July 2020

8.1.4. Suicide deaths

Our recommendations: focused prevention plan, managing and containing risk

Recommendations 10 and 11, Biennial report of the deaths of children in NSW: 2016 and 2017 (published June 2019)

We recommended that:

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) universal strategies that promote wellbeing in children and young people

(b) early intervention designed to arrest emerging problems and difficulties

(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.

The NSW Government should direct funds associated with the Strategic Framework for Suicide Prevention in NSW 2018 – 2023 to address gaps in the delivery of appropriate specialist mental health services for children and young people in NSW.

Why we made the recommendations

Our work has shown that, unlike other causes and circumstances of death, the suicide rate for young people age 10-17 years has increased over the past decade, and that school-aged young people have particular vulnerabilities and needs that should be taken into account in suicide prevention strategies.

Our reviews of suicide deaths have also identified that the majority of school-aged young people who died by suicide were known to mental health or related support services. We have noted that NSW generally has good systems for identifying young people who are at risk of suicide or who are dealing with mental health problems, but intervention once a problem is identified can be episodic and fragmented. Identification of suicide risk must be supported by effective strategies to manage and contain risk in order to prevent suicide.

In NSW, demand for access to developmentally appropriate specialist mental health services for children and young people regularly outstrips the capacity to supply timely services. The *Strategic Framework for Suicide Prevention in NSW 2018-2023* supports whole of government suicide prevention activity across all NSW communities, including young people. Our second recommendation to the government (11) aims to address service delivery gaps.

The NSW Government supported both recommendations.

To what extent have the recommendations been implemented?

In June 2020, the Department of Premier and Cabinet (DPC) advised it is currently considering how best to act in the context of the Framework and *Towards Zero Suicides* Premier's Priority (announced in June 2019).

The Appendix provides DPC's full response, which includes details of a range of strategies already in place, including those being enhanced (pg 89-93). We also note DPC's advice that responsibility for these recommendations has now been transferred to NSW Health.

Our assessment of progress

We acknowledge advice that the government is still considering the issues, and also that funds allocated to support priority initiatives under Towards Zero Suicides and the Framework have relevance for children and young people and will potentially contribute to addressing gaps in mental health services for this group.

We will continue to monitor these recommendations through NSW Health, and will have close regard to the implementation of initiatives linked to the Framework and Premier's Priority.

Our recommendations: the role of schools – ongoing monitoring and evaluation

Recommendations 12, 13 and 14, Biennial report of the deaths of children in NSW: 2016-2017 (published June 2019)

Noting that the role of schools – both government and non-government – is critical in developing strategies to prevent suicide, and that strategies should be evidence-based and subject to ongoing monitoring and evaluation, we recommended that:

> **The NSW Department of Education should evaluate postvention initiatives in NSW government high schools, particularly the effectiveness of such initiatives in preventing suicide clusters** (recommendation 12).
>
> **Catholic Schools NSW should work with and assist member schools to examine the adequacy of suicide prevention, postvention and mental health and wellbeing programs currently provided to students in NSW Catholic Schools** (recommendation 13).
>
> **The Association of Independent Schools of NSW should work with and assist member schools to examine the adequacy of suicide prevention, postvention and mental health and wellbeing programs currently provided to students in NSW Independent Schools** (recommendation 14).

Why we made the recommendations

These recommendations were made against the background of findings and observations made by the NSW Parliamentary Committee on Children and Young People inquiry into prevention of youth suicide,[20] a review undertaken for the CDRT by the Australian Institute for Suicide Research and Prevention (AISRAP) of evidence-based prevention and postvention strategies and existing youth suicide prevention strategies,[21] and our ongoing work in reviewing the suicide deaths of school-aged children and young people in NSW.

Together, this work suggested suicide prevention activities in schools 'lacked coordination and consistency',[22] and that of the very limited literature and research addressing the topic of prevention of suicide clusters and specific postvention activities, no study has evaluated the overall effectiveness of these strategies in preventing future clusters.[23]

Suicide prevention and intervention strategies should be subject to ongoing monitoring and evaluation, and our recommendations aim to address gaps in this area.

The Department of Education, Catholic Schools NSW, and the Association of Independent Schools of NSW each advised they supported the recommendation directed to their agency.

To what extent have the recommendations been implemented?

Department of Education

Work to evaluate postvention initiatives in NSW Government high schools is underway. In June 2020, the Department of Education advised that after a procurement process, it has engaged Orgyen which is partnering with Everymind to conduct this work between April 2020 and March 2021.

The Appendix provides the Department's full response, including details of the evaluation framework (pg 94-95).

Catholic Schools NSW (CSNSW)

In June 2020, CSNSW provided a detailed overview of its policy frameworks, guidelines and practices, noting:

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20. Joint Committee on Children and Young People 2018, Prevention of youth suicide in New South Wales, NSW Parliament, Sydney.
21. NSW Child Death Review Team 2019. Review of suicide clusters and evidence-based prevention strategies for school-aged children, prepared by the Australian Institute for Suicide Research and Prevention. NSW Ombudsman, Sydney.
22. As before, Parliamentary Inquiry into the prevention of youth suicide in NSW.
23. AISRAP review, 2019

- Specialist inter-diocesan networks exist to support diocese and schools to develop clear policies and programs that educate student and staff, build positive school climates, monitor mental health trends and engage families and communities.
- All Catholic Schools have anti-bullying, child protection and student management policies and guidelines which promote student mental health and wellbeing and healthy behaviours.
- Where students are identified as vulnerable and/or at risk more targeted interventions are employed which may include individual assessment, learning plans and/or referral to the school counsellor service.
- Catholic Schools offer professional learning seminars and courses for school staff to assist them to prevent and respond to youth mental health issues, including suicide. In addition, bespoke courses are developed for staff and students that focus on mental health literacy, knowledge of suicide warning signs and help strategies.

Association of Independent Schools of NSW (AISNSW)

In June 2020, AISNSW advised it has strengthened the support provided to assist schools develop and review their strategies by providing consultancy support targeted to individual student needs and school contexts and supplementing existing professional learning with new, carefully targeted initiatives, including:

- the employment of two registered psychologists to support schools
- continuing to work closely with, and promote the services of, *headspace* to ensure schools can access specialist support, guidance and clinicians in response to a suicide within their community
- promoting the use of resources and services through the *Be You* initiative
- enhancing guidance for schools in the selection of external providers of activities and programs in the areas of suicide prevention, postvention, mental health and wellbeing
- offering targeted professional learning to schools, along with access to an AISNSW whole-school review process to evaluate their wellbeing practices, and
- the development of online learning modules that address mental health and suicide strategies for schools, including how to identify the warning signs of a young person at risk and understanding the appropriate planning, supports and adjustments that may be required, as well as broader training to support staff to identify and understand the needs of students who may require mental health support and incorporating whole-school approaches to wellbeing.

Our assessment of progress

Department of Education: We will continue to monitor this recommendation, pending the outcome of the evaluation project.

Catholic Schools NSW: We note the advice provided by CSNSW, and consider the intent of the recommendation has been met.

Association of Independent Schools NSW: We note the advice of the AISNSW and consider the intent of the recommendation has been met.

Our recommendation: the role of schools – review following suicide

Recommendation 15, Biennial report of the deaths of children in NSW: 2016-2017 (published June 2019)

The NSW Department of Education should establish a process of review after the suicide death of a child or young person in a public school. The process should involve considering, with the local school and district, the involvement of the school with the young person and their family – particularly in terms of identifying and responding to mental health or suicidal risk behaviours. Outcomes of the reviews should inform future practice and policy.

Why we made the recommendation

Schools are a critical part of the service systems for identifying and intervening early to prevent suicide of school-aged children and young people. The NSW Department of Education does not currently have a process to undertake a systems review of suicide deaths of students. Learning from missed opportunities and using that understanding to frame future practices and policy is critical to inform work with vulnerable young people, and should be a key strategy in improving the capacity of agencies to develop effective prevention strategies.

The Department of Education supported this recommendation.

To what extent has the recommendation been implemented?

Work to establish a process of review after the suicide death of a child or young person. In June 2020, the Department of Education advised it has engaged Orygen to conduct a review of the literature to identify the best available evidence regarding establishing a review process following a suicide death. The department will use the information obtained from this review to establish an appraisal process.

Our assessment of progress

We will continue to monitor this recommendation, pending further advice regarding the literature review and establishment of a review process.

8.2. NSW Ombudsman recommendations: reviewable child deaths

In addition to recommendations monitored by the CDRT, described above, the biennial report tabled in June 2019 included two recommendations that relate to reviewable child deaths (recommendations 16 and 17). These recommendations are monitored separately as part of the Ombudsman's responsibilities under Part 6 of the Act.

Appendix: agency responses to open CDRT recommendations

NSW GOVERNMENT | Health

Mr Michael Barnes
NSW Ombudsman
Level 24
580 George Street
SYDNEY NSW 2000

Our ref O20/1

Dear Michael Barnes

I refer to your letter of 1 May 2020 seeking an update on the implementation of recommendations made by the Child Death Review Team in their *Child Death Review Report 2015* and in the *Biennial Report of the Deaths of Children in NSW: 2016 and 2017*.

I am pleased to inform you that NSW Health has made progress against the five listed recommendations. To this end, please find attached to this letter a schedule providing a detailed progress report against each recommendation and a set of attachments as evidence of our endeavours.

Importantly, in the time since our previous status report, significant progress has been made by the Cross Agency Working Group (CAWG) as led by NSW Health, with a continued focus on the coordination of activity across whole-of-government programs. The attached status update provides further information regarding the activities of the CAWG and its approach to coordinating activity across NSW Government agencies.

If you have any further queries, please contact Paul Giunta, Director, Corporate Governance and Risk Management via email to [redacted] or on [redacted].

Yours sincerely

[redacted]

Elizabeth Koff
Secretary, NSW Health
15/7/20

NSW Ministry of Health
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NSW Government Progress Update - Sudden Unexpected Death in Infancy (SUDI)

Recommendations from the Child Death Review Team 2015 Annual Report

December 2018

Table of Contents

1. Introduction

This report provides the NSW Government's progress update on work to address Recommendations Two and Three of the Child Death Review Team's (CDRT) Annual Report 2015, which was released in November 2016.

Recommendation Two: *The NSW Government should consider a centralised model for SUDI response and investigation in NSW. This would be staffed by specialised health professionals to work with police, the family, pathologists and the Coroner to respond immediately and consistently to SUDI.*

Recommendation Three: *The NSW Government should devise a joint agency policy and procedure governing the individual and coordinated roles and responsibilities of NSW Health, the NSW Police Force and the NSW Coroner in SUDI investigation. The policy and procedure should incorporate all elements of a joint agency response to SUDI [elements in the table below].*

NSW Government agencies convened in 2017-18 to develop and implement practical actions to:

- Increase the proportion of SUDI cases that are explained.
- Ensure all families affected by SUDI in NSW are offered support and referral.

These practical actions include:

- Clarifying and better coordinating the interagency SUDI response.
- Building capacity and using expert advice to strengthen the SUDI response.
- Improving information collection to support the Coroner to determine cause of death.

Governance:
This work has been progressed through the SUDI working group:

- NSW Deputy State Coroner
- NSW Department of Premier and Cabinet
- NSW Ministry of Health
- Forensic Medicine, NSW Health Pathology
- NSW Ambulance
- NSW Police

Policy context:
In 2015, there were 42 cases of SUDI in NSW. This accounted for 14 per cent of all infant deaths in NSW, which is similar to the reported rate in the United States. A cause of death was determined in 11 of the 42 cases. This reflects the average result in NSW since 2006 – roughly a quarter of SUDI cases in NSW are explained. Best practice suggests a cause of death should be determined in 45 per cent of cases.

In 2015, there was evidence that 30 of 42 families who experienced SUDI received support. All parents/carers who experience SUDI should be offered support, and this should be documented in the infant's medical record. Support can include, for instance, access to a social worker, and referrals to support services such as Red Nose[1] (formerly SIDS and Kids).

Definitions:
SUDI refers to the sudden and unexpected death of an infant aged less than 12 months, where the cause was not immediately apparent at the time of death.

[1] NSW Health funds Red Nose to: provide counselling to families who have lost a child; resource the volunteer support program, which offers peer support to parents who have lost a child; and provide education and policy advice/advocacy.

Deaths classified as SUDI are either:

- Explained SUDI – deaths where a cause is found after investigations. For example, natural causes where an illness was not identified before death.
- Unexplained SUDI – deaths where the cause remains unidentified after investigations. This includes deaths classified as Sudden Infant Death Syndrome (SIDS).

Identifying a cause of death is important to:

- Help parents/carers understand the reason behind their loss.
- Identify medical or genetic implications for families.
- Learn lessons to prevent future deaths.

2. NSW Government progress update

The Government recognises the need for an effectively coordinated interagency SUDI response. A centralised model, however, has significant resource implications in a NSW context given SUDI is a rare event and can occur anywhere at any time. To ensure health professionals are involved in SUDI investigations as early as possible, Police access on-call expert advice via the Coronial Case Management Unit (CCMU) (Forensic Medicine, Sydney) and the Regional Triage Centre (RTC) (Forensic Medicine, Newcastle). The CCMU and RTC are staffed by a Clinical Nurse Consultant who can provide on-call advice to support police investigators at the death scene.

The Government has improved communication and guidance for agencies to support a better coordinated SUDI response. The Government has:

- Updated and aligned policy directives across NSW Police, NSW Ambulance and NSW Health, to clarify interagency roles and responsibilities.
- Improved guidance for frontline NSW Police and NSW Ambulance staff. For instance, the guidance now reinforces the need to transfer all infants who die suddenly and unexpectedly to their nearest emergency department. This is a vital step to enable a medical history to be taken and for parents/carers to receive support.
- Improved the quality and timeliness of information to support the Coroner to identify cause of death.

CDRT recommendations – elements of a joint agency response to SUDI	**NSW Government Action**

a. Expert paediatric assistance in death scene investigation and interviews with the family (noting that investigation of any suspicious death would be the responsibility of Police).	The Government recognises the value of clinical expertise in responding to SUDI.
	
	<u>Coronial Case Management Unit (CCMU)</u>
	• In October 2017, NSW Health Pathology and the then State Coroner, Michael Barnes, established the CCMU.
	• The CCMU is an interagency unit staffed by:
	  ○ NSW Department of Justice
	  ○ NSW Police
	  ○ NSW Health Pathology, Forensic Medicine, including a Duty Pathologist, Forensic Social Worker and Clinical Nurse Consultant
	• The CCMU provides expert, on-call advice to investigators at the scene of death, including SUDI cases.

CDRT recommendations – elements of a joint agency response to SUDI	NSW Government Action
	Regional Triage Centre (RTC): • In March 2018, NSW Health Pathology established the RTC at Forensic Medicine, Newcastle. The RTC is staffed by NSW Health Pathology employees including a Duty Pathologist, Forensic Social Worker, Case Coordinator and Clinical Nurse Consultant (currently in recruitment to the position). • The RTC provides expert, on-call advice to investigators at the scene of death, including SUDI cases.
b. Specialised training and development of resources for police in SUDI investigation.	Since October 2017, Police have had access to expert, on-call advice at the death scene from the Coronial Case Management Unit (CCMU). Police have reviewed and updated the Police Handbook to better support SUDI investigations. For example, the Police Coronial Support Unit is co-located in the CCMU which has improved access to death scene photographs for Forensic Medicine. The Clinical Nurse Consultant attached to the CCMU is available to consult with investigators. Forensic Evidence & Technical Services protocols have been updated to ensure appropriate forensic examination of scenes of death in SUDI matters.
c. Identified specialists to take the SUDI medical history, and review of the SUDI medical history form and the immediate post-mortem findings to enable further specific history taking where necessary.	Currently, a senior medical officer will take the medical history from the parents/carer at the hospital emergency department or other area in the hospital where the death occurred. Agencies have updated the relevant forms (listed below) to: • Provide a guide for clinicians taking the medical history that better aligns with usual clinical practice and thereby captures essential information in SUDI cases. • Decrease overlap in questions asked by NSW Police, Ambulance and senior medical officers to reduce the burden on parents/carers. • Ensure questions to parents/carers focus on information relevant to the SUDI investigation. • Guide paramedics on how best to observe the environment at the scene of death, to support the Coroner to determine cause of death. Forms include: • NSW Health's medical history form used in SUDI cases. • NSW Police's form to report a death to the Coroner ('P79A form'). • NSW Ambulance's protocol and clinical guidelines. Further potential revision of Police form P79A will be considered in 12-18 months' time.
d. Application and monitoring of standardised protocols for SUDI pathology, with specific requirements for standard screens in sudden unexpected infant death.	Forensic Medicine, NSW Health Pathology is developing a best-practice autopsy protocol for SUDI. The new protocol will be finalised by June 2019.

CDRT recommendations – elements of a joint agency response to SUDI	NSW Government Action
e. The conduct of SUDI post-mortems by specialist paediatric pathologists. Minimally, where post mortems are not conducted by paediatric pathologists, there should be consultation with paediatric specialists.	Forensic Medicine is working with NSW Health Pathology on ways to consult with paediatric pathologists when conducting SUDI post-mortems. Options include using video and telehealth services to consult paediatric pathologists during autopsy. It is important to note workforce issues regarding paediatric pathologists: • There are national and international shortages of paediatric pathologists. • NSW Health Pathology is exploring options to address workforce shortages and training issues, including interstate and international recruitment. NSW Health Pathology has developed a new state-wide 'Perinatal Post-Mortem and Related Service Model' to better manage non-coronial perinatal post-mortems. The model includes a fee structure (funded by referring facilities) that will contribute to engaging more paediatric pathologists, provided they can be attracted and trained to work in NSW. The new state-wide perinatal post mortem service Midwife Care Coordinator will improve collaboration and coordination with the Forensic Pathology service in relation to the notification of in-hospital neonatal deaths, so that a Paediatric/Perinatal Anatomical Pathologist is consulted early in all cases.
f. Multi-disciplinary review following post-mortem. The review should be chaired by an informed paediatrician, and involve relevant health providers to review the case. Reviews should consider all possible genetic issues and necessary investigations for surviving children and parents, and prevention strategies for the family in the context of identified risks.	<u>Multi-disciplinary review</u> In December 2017, Forensic Medicine, NSW Health Pathology established a multi-disciplinary Paediatric Death Review team to review SUDI post-mortem reports before they are sent to the Coroner. The team includes a paediatrician, paediatric pathologist, Deputy State Coroner, autopsy forensic pathologist, forensic counsellor and Coronial Information Support team member. The potential to invite clinical staff from the treating hospital who were involved in the case will be explored. It is envisaged that the Director of Medical Services at the treating hospital would be the point of contact (to identify relevant clinical staff) for Forensic Medicine. The purpose of this review is to: • Review the post-mortem report against the proposed new CDRT SUDI classification system. • As part of the classification validation process, discuss the autopsy findings and suggest options for further investigation, including possible genetic testing where relevant. The Terms of Reference for the review team will be developed to reflect a 2 year time limited approach, in the first instance, to evaluate the impact of a multidisciplinary approach.

CDRT recommendations – elements of a joint agency response to SUDI	NSW Government Action
g. The introduction of clear procedures to ensure families are provided with: i. Appropriate advice and referral, particularly where genetic causes are indicated or suspected, and ii. Ongoing contact, including for provision of grief counselling.	Revision of NSW Health's Policy Directive on SUDI. The policy includes guidance on immediate support, advice, access to existing processes and services as well as referral to grief counselling/support for parents/carers. These services are available from within Heath and via the Coronial Information and Support Program. Forensic Medicine, NSW Health Pathology is in the process of developing a state-wide model of care for Forensic Counselling services, including SUDI client support. The model is expected to be implemented from April 2019. <u>Genetic testing</u> Currently, genetic testing occurs if the SUDI medical history and the post-mortem examination identifies a potential genetic predisposition. The SUDI working group consulted a number of medical specialists working in molecular cardiology, clinical genetics and genomics. Following consultation, the working group determined that genetic testing will be conducted in SUDI cases at the discretion of clinical paediatric specialists and/or the Forensic Pathologist involved in the investigation. Routine genetic testing in SUDI cases has a very low yield in identifying cause of death for the 0-1 year cohort. Genetic testing cannot be definitive if the SUDI investigation cannot rule out environmental factors as a cause of death. Gene testing can reveal multiple symptoms with uncertain relevance making it unclear which, if any, are in fact linked to the death. This can lead to further distress for families. Guthrie cards and tissue blocks can also be used by Forensic Medicine for retrospective genetic testing in relevant cases.

3. Next steps

The Ministry of Health will work with NSW Ambulance, Forensic Medicine, NSW Health Pathology, NSW Police and the NSW Child Death Review Team (CDRT) to establish a monitoring process for this work. This process will examine the impacts of these actions against the objectives:

- Increase the proportion of 'explained SUDI' in NSW.
- Ensure all families affected by SUDI in NSW are offered support and referral.

Measures of success may include the proportion of explained SUDI deaths, the proportion and quality of medical histories received by Forensic Medicine, and staff and patient (parents/carers) experience.

A Coronial Inquest will be held in 2019 to explore the sudden and unexpected deaths of two infant children. In both matters, the identity of the infants, as well as the date and place of their deaths, is not controversial. The medical causes of the sudden deaths of both infants remain unclear. A key focus of the inquest is likely to be Sudden Unexplained Death in Infancy ('SUDI') investigation and examination procedures in NSW on a broader, systemic level, including the practicability of a revised multi-agency approach to SUDI investigation and other areas of potential reform. It is hoped the inquest will build on the positive work already being undertaken by both the Child Death Review Team and NSW Government agencies in this area.

STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the deaths of Kayla Ewin and Iziah O'Sullivan
Hearing dates:	**2 September 2019 – 4 September 2019**
Date of findings:	**29 November 2019**
Place of findings:	State Coroners Court, Lidcombe
Findings of:	State Coroner, Magistrate Teresa O'Sullivan
Catchwords:	CORONIAL LAW – cause and manner of death – investigation and management of sudden unexpected death in infancy (SUDI) deaths in NSW – recommendations as to the adequacy of the policy and procedures of the relevant agencies in responding to SUDI deaths in NSW
File number:	Kayla - 2012/398593 Iziah - 2014/221198

Representation:	(1) Counsel Assisting Ms Kate Richardson SC and Ms Tracey Stevens of counsel, instructed by Ms Clara Potocki of the NSW Crown Solicitor's Office (2) NSW Commissioner of Police Ms Danielle New of counsel, instructed by Ms Emma O'Brien of New South Police Force, Office of General Counsel (3) NSW Ministry of Health and NSW Health Pathology Mr Stuart Kettle of counsel, instructed by Ms Rosslyn Cooke of Hicksons Lawyers (4) Ambulance Service of NSW Ms Kathleen Crilly, NSW Ambulance Service

Findings for Kayla:	**Identity of deceased:** The deceased person was Kayla Ewin. **Date of death:** Kayla died on 23 December 2012. **Place of death:** Kayla died at her home in Nowra, NSW. **Cause of Death:** Unascertained (SUDI 0+) **Manner of death:** Sudden Unexpected Death in Infancy (SUDI) within the category SUDI 0+.

Findings for Iziah:	**Identity of deceased:** The deceased person was Iziah O'Sullivan. **Date of death:** Iziah died on 26 July 2014. **Place of death:** Iziah died at his home in Quakers Hill, NSW. **Cause of Death:** Unascertained (SUDI 0) **Manner of death:** Sudden Unexpected Death in Infancy (SUDI) within the category of SUDI 0.

Recommendations:	**<u>To the Ambulance Service of NSW:</u>** 1. That the Ambulance Service of NSW consider amending its policies to instruct attending paramedics to take the aural temperature of a deceased infant under 12 months (and the time that it was taken) where clinically appropriate. **<u>To NSW Police</u>**: 2. That NSW Police revise the 'SUDI' section of the Police Handbook to contain an instruction to police officers attending a scene or managing an investigation to assess whether it is preferable to use the term 'coronial scene' rather than 'crime scene' and in doing so, consider the impact of the use of the terminology on the family. 3. That NSW Police Forensic Evidence and Technical Services Branch and the Crime Scene Services Branch use the term 'coronial scene' rather than 'crime scene' in regard to infant deaths determined to be accidental. 4. That NSW Police revise the 'SUDI' section of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene and the hospital. 5. That NSW Police review its policies and training procedures in order to ensure that guidance is provided to officers in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death. 6. That NSW Police consider amending the P79A form and the Standard Operating Procedures entitled "Crime Scene Manual (Specialist) – Death Investigation" and SUDI section 2.4.14 to include additional SUDI questions on the matters as set out in paragraph 90 of these Findings.

	To NSW Health Pathology: 7. That NSW Department of Forensic Medicine review its policies to encourage forensic pathologists to routinely request, and then review, crime scene photographs prior to signing off an autopsy report. 8. That the Department of Forensic Medicine review its policies to ensure that the role of the Clinical Nurse Consultant (CNC) includes ensuring that the SUDI medical history form has been received and provided to the case forensic pathologist in a timely manner. **To NSW Ministry of Health:** 9. That NSW Ministry of Health review its training policies to determine whether guidance is given to staff in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death. 10. That NSW Ministry of Health implement their proposed audit of the revised SUDI medical history form over a period of 12 months and evaluate whether the form is being sufficiently completed and whether it is consistently being provided to the Department of Forensic Medicine in a timely manner. 11. That NSW Ministry of Health implement their proposal to monitor the issue of duplication in taking a medical history from the family of a deceased infant over the next 12 months in order to ascertain the most useful and sensitive approach.

	To NSW Ministry of Health and NSW Police: 12. That NSW Ministry of Health and NSW Police implement the proposal for an interagency early clinical review meeting to take place within 1 week of every SUDI death in NSW, or as soon as practicable thereafter and no later than 1 month after the death, and evaluate the implementation of this proposal within 12 months from the date of its commencement. **To the State Government of NSW:** 13. That the State Government give consideration to the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU) trained in SUDI investigations in order to provide centralised support available 24 hours a day to agencies in NSW investigating SUDI and accidental child deaths in NSW.

6

Table of Contents

The Coroners Act in s. 81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the deaths of Kayla Ewin and Iziah O'Sullivan.

Introduction

1. This inquest concerns the deaths of infants Kayla Ewin and Iziah O'Sullivan.

2. In NSW every year between 40 and 50 infants under the age of 12 months die suddenly and unexpectedly.[1] Kayla Ewin and Iziah O'Sullivan were two such infants, each under the age of 12 months and died unexpectedly in their homes.

3. The role of a Coroner, as set out in s. 81 of the *Coroner's Act 2009* (the Act), is to make findings where possible as to:

    a. The identity of the deceased person;

    b. The date and place of the person's death;

    c. The physical or medical cause of death; and

    d. The manner of death, in other words, the circumstances surrounding the death.

4. A secondary purpose of an inquest, as set out in s. 82, is to determine whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death. With the support of the Ewin and O'Sullivan families, an inquest was held in order to determine not only the manner and cause of the deaths of Kayla and Iziah, but also to consider any recommendations as to the adequacy of the policy and procedures of the relevant agencies in responding to SUDI deaths in NSW. To this end, NSW Police, NSW Ministry of Health, the Ambulance Service of NSW, and Department of Forensic Medicine have participated in the hearing. These agencies have all participated in the inquest in a positive and collaborative manner. The NSW Police and NSW Ministry of Health have provided constructive submissions that are supportive of the implementation of various recommendations proposed by Counsel Assisting. The Ambulance Service of NSW supported the submissions and recommendations proposed by Counsel Assisting.

5. Numerous experts have also provided evidence to this Court on the management of SUDI in NSW. An expert conclave comprised of Dr Matt O'Meara (Chief Paediatrician, NSW Ministry of Health), Ms Deborah Matha (Director, Maternity Child Youth and Paediatrics, NSW Ministry of Health), Mr Allan Loudfoot (Executive Director Clinical Services, NSW Ambulance), Professor Heather Jeffrey (International Maternal and Child Health, University of Sydney), Detective Superintendent Scott Cook (Head of Homicide, NSW

[1] NSW Health 2019 revised policy, tab 66A at p.1.

Police) and Dr Loraine Du Toit-Prinsloo (Forensic Pathologist, Staff Specialist, NSW Health Pathology, Department of Forensic Medicine). In addition, single experts Professor Noel Woodford and Ms Rebecca Shipstone provided expert reports and gave evidence before the Court. I am very grateful for their assistance in this regard.

6. The evidence before the Court included the current SUDI classification scale utilised in NSW in order to categorise SUDI infant deaths. A copy of the SUDI Classification is **annexed** to these findings.

Kayla Ewin

7. On 30 September 2012 Kayla was born to Terri and Matthew Ewin in Shoalhaven Hospital. She was born naturally and breastfed by Terri from a few days after birth. Terri and Matthew remember Kayla as a gorgeous, sweet little girl with big eyes and curly hair like a little doll. Terri said she had "a sweet Cheshire smile that would crack the hardest heart."[2]

8. According to the hospital notes, as at Kayla's birth and while breastfeeding, Terri was prescribed and was taking antidepressants (in the form of 40 mg a day or fluoxetine and 100 mg a day of olanzapine).[3] Terri was taking fluoxetine prior to pregnancy, stopped when she found out she was pregnant with Kayla, and then reduced her dose throughout the pregnancy. She was taking the medication when Kayla was born and up until about four weeks after the birth. In the interview on the day after Kayla's death Terri said that "I haven't been on anti-depressants for a couple of months now and we have been doing really well."[4]

9. At the time of Kayla's birth, Terri and Matthew had been in a relationship for approximately one year and had married only weeks before Kayla's death.[5]

10. Terri had two other children, aged 5 and 7 years at the time of Kayla's death. The family were living in a four bedroom house with friends. All four adults smoked cigarettes outside the house and Terri smoked throughout her pregnancy with Kayla.[6]

11. Terri described Kayla as a 'great' baby, though she had some trouble with breastfeeding. She says that Kayla was not putting on enough weight and so she transitioned to bottle feeding with formula around the 8th or 9th of December.[7]

12. On 14 December 2012 (nine days before her death), Kayla was admitted to Shoalhaven Hospital Emergency Department. She was reported as presenting with reduced feeding following a change from breast-feeding to

[2] Transcript, Day 3, Terri Ewin, p.11.
[3] Shoalhaven Memorial Hospital Clinical Records, Kayla Ewin, tab 28 at pp.275-276.
[4] Interview with Terri Ewin, tab 18 at pp.110-111.
[5] Interview with Matthew Ewin, tab 19, p.184.
[6] Interview with Terri Ewin, tab 18, p.146.
[7] Interview with Terri Ewin, tab 18, p.114.

bottle feeding; with a temperature; restlessness and crying. On examination Kayla's vital signs were within the normal range and she was afebrile. Kayla was assessed as well and happy and discharged on advice to recommence feeding.[8]

13. In the week preceding her death, Kayla routinely slept in a cradle in Terri and Matthew's bedroom from around 7pm-8pm; would wake most nights around 1am – 2am and fed and changed, and then would wake again at around 4am or 5am.[9] When Matthew would get up to attend to Kayla in the night he would often feed her in the lounge room and then put her back to sleep in a bassinet in the spare room. She slept routinely in a nappy and wrap or a 'woombie' (a zipped baby sleeping bag).[10] The 'woombie' was described by Terri as a body-sized sleeping bag without sleeve holes or arm lengths, with a zipper opening from the top down that Kayla slept in and felt secure.[11]

14. At around 8.30pm on the evening prior to her death, Saturday 22 December 2012, Kayla appeared to be feeding normally. She was put to bed in her cradle in the main bedroom.[12]

15. At around 2:30am on Sunday 23 December 2012 Kayla woke up and was restless. She was bottle fed and changed by Terri and put back to bed in her cradle in the main bedroom at around 3am. She remained restless until about 4.30am.[13]

16. At around 4.30am Terri woke up Matthew so she could return to sleep. Kayla was wearing a nappy and her Woombie.[14] Matthew took Kayla out of the main bedroom. Matthew changed her on the lounge.[15] Matthew then fed Kayla in the spare room and attempted to settle her.[16] Matthew noticed that Kayla's head was sweaty when he picked her up.[17] Matthew dressed her in her Woombie and placed her on her back in her portable carrier. I accept the evidence of Matthew and Terri that that the portable carrier was made out of a soft cotton material and was pliable and had a foam mattress and a hood that could be folded over.

17. I also accept Matthew's evidence that the fabric cover on the bassinette was unzipped and folded back so as to not cover Kayla in any way on the night she died. He put Kayla to bed at around 5.30am in the portable carrier on her back with her head at the end of the carrier (where the hood was located).[18]

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[8] Expert certificate of Dr Stuart Clarke, Shoalhaven Memorial Hospital, tab 22, p.240; and Shoalhaven Memorial Hospital Clinical Notes, Kayla Ewin, tab 28, pp. 264-266; and interview with Terri Ewin, tab 18, p.129.
[9] Interview with Terri Ewin, tab 18, pp.117-118.
[10] Interview with Terri Ewin, tab 18, p.136.
[11] Transcript, Day 1, Terri Ewin, p.14.
[12] Interview with Matthew Ewin, tab 19, p.202.
[13] Interview with Terri Ewin, tab 18, pp.155-156.
[14] Interview with Matthew Evans, tab 19, p.205.
[15] Interview with Matthew Evans, tab 19, p.206.
[16] Interview with Matthew Ewin, tab 19, p.206.
[17] Interview with Matthew Ewin, tab 19, p.207.
[18] Transcript, Day 1, Matthew Ewin, p.21.

18. I accept the meteorological evidence before the Court that between the early hours of the morning and 9.30am the temperature in Nowra ranged from 18 – 25 degrees.[19]

19. Sometime after 9:30am, Matthew checked on Kayla and found her on her back in the bassinet, with her eyes slightly open, pale in colour and not breathing.[20] At this time Kayla looked bloated with her hair sweaty and her body quite warm.[21] I accept Matthew's evidence that he picked Kayla up and she was damp and not breathing. I also accept that when Terri was alerted to Kayla's condition, she saw that Kayla's lips and eyes had lost their colour and she did not have her normal pink skin tone.[22]

20. At 9.48am Matthew called emergency services and attempted resuscitation.[23]

21. At 9.56am an ambulance attended the house. Ambulance Officer Egan assessed Kayla to be "very hot to touch. Her hair was wet around the back of her head … The skin on the baby's torso was clammy to touch."[24] Officer Egan, when inspecting the bassinet, could see what appeared to be wetness on the bassinet mattress material. He did not know whether the wetness was from spilt milk from the bottle or possibly from vomit or mucus from the baby's mouth.[25] Officer Egan observed that the room: "was warm with a stuffy feel to it… I noticed a north facing window in the room but I am not sure if it was open or shut. I formed my opinion that the baby may have suffered heatstroke or some sort of heat related stress which resulted in the death."[26] Officer Egan formed the view, which I accept, that Kayla had been deceased for approximately half an hour.[27]

22. At approximately 10am police (Senior Constable Jason Klein[28] and Sergeant Andrew Drane) were informed of a death of a baby and attended the house at 15 Ernest Street Nowra.[29]

23. At 10.30am Senior Constable Vicki Ferraris and Senior Constable Granado attended the house and spoke with ambulance officers and the family. They obtained permission from Kayla's parents to enter the house and a crime scene was established.[30] Senior Constable Ferraris noticed the home was cluttered but not dirty and the air was heavy. The spare room where Kayla

[19] Bureau of Meteorology Data, tab 16.
[20] Interview with Matthew Ewin, tab 19, p.211.
[21] Interview with Matthew Ewin, tab 19, pp.217-18.
[22] Transcript, Day 1, Terri Ewin, p.16.
[23] Ambulance Electronic Medical Record, tab 25, p.248.
[24] Statement of Jeffrey Egan, tab 24, [11].
[25] Statement of Jeffrey Egan, tab 24, [12].
[26] Statement of Jeffrey Egan, tab 24, [16].
[27] Statement of Jeffrey Egan, tab 24.
[28] As he then was. He is now Detective Senior Constable Klein and is the officer in charge of the coronial investigation.
[29] Statement of Senior Constable Jason Klein, tab 7, p.52 at [5] and crime scene log at tab 10, p.77.
[30] Statement of Senior Constable Vicki Ferraris, tab 9, p.75 at [5].

had been sleeping was airless and unventilated and the room was warmer than the rest of the house.[31]

24. At 10.40am Senior Constable Klein and Sergeant Drane attended the house and spoke with the ambulance officers and Matthew and Terri. Senior Constable Klein observed that the room in which Kayla was sleeping was congested and messy. Kayla was situated in her portable carrier in a nappy. She had very pale skin and her hair was sweaty, with some frothy bubbles around her mouth.[32]

25. Investigating police spoke with Matthew and Terri at their house where Terri was understandably very distressed, in shock and not able to speak when asked questions. Investigating police decided, quite properly, to remove Kayla and take her to Shoalhaven Hospital. Terri and Matthew travelled with the police and Kayla in the ambulance.[33] Senior Constable Klein explained in oral evidence that: "we made the decision to take the body to Shoalhaven Hospital, and the reason was I think our crime scene officer had to travel from Wollongong on that particular day and that would have been – we were given the estimated time of about two hours. That's a long time to leave a baby at the scene with mum and dad in a grieving state. So we took our initial photos and then made the decision to, to take the baby in the ambulance to the hospital where the crime scene officer could examine the baby in due course as well as examine the scene."[34]

26. On arrival at the hospital, Senior Constable Klein placed Kayla in a cradle in a quiet room in the Emergency Department. Matthew and Terri were directed to social workers and later spent time with Kayla in the room. A religious support person attended the hospital and spent time and said prayers with Kayla and her parents.[35]

27. At 12pm Kayla was declared deceased at Shoalhaven District Memorial Hospital.[36] Matthew formally identified Kayla to Senior Constable Klein and he completed the identification statement.[37]

28. Unfortunately, there is no record of the completion of any SUDI Medical History Form at the hospital. This is contrary to the requirement of the NSW Health Policy Directive PD 2008-70 at tab 65).

29. Kayla's parents remained at the hospital for some hours and upon leaving, Senior Constable Klein took Kayla to the mortuary, where police undertook a forensic examination including taking photographs. Kayla was then conveyed to the Glebe morgue.[38]

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[31] Second statement of Senior Constable Vicki Ferraris, tab 9A, at [7].
[32] Statement of Senior Constable Jason Klein, tab 7, p.53 at [8].
[33] Statement of Senior Constable Jason Klein, tab 7, p.54 at [11-13].
[34] Transcript, Day 1, Detective Senior Constable Klein, p.11.
[35] Statement of Senior Constable Jason Klein, tab 7, p.55 at [15].
[36] Life Extinct Form, tab 2, p.10.
[37] Identification statement, tab 3, p.11.
[38] Statement of Senior Constable Jason Klein, tab 7, p.55 at [16].

30. At 5.50pm an entry was made by the hospital social worker in the clinical notes for Kayla, indicating that Terri and Matthew had a number of supportive family members attend the hospital during the day. The social worker commented that the parents: "were not in a place to discuss anything past the 'now' so I gave the father and the mother papers" to consider when appropriate. It is not clear what 'papers' were provided to the family, though it is likely these related to further available support and information. The social worker further commented that "I will also ring them in a few days and if appropriate arrange to see them next weekend."[39]

31. Senior Constable Klein completed a report of death to the Coroner on a Form P79A.[40] In evidence Senior Constable Klein explained that it was routine procedure for this form to be completed as soon as possible and before any further and formal statements are taken by family and witnesses.[41]

The expert evidence in relation to Kayla's death

32. An autopsy was performed by forensic pathologist Dr Rebecca Irvine and Kayla's cause of death was unascertained.[42]

33. Dr Irvine concluded that the total body post-mortem x-rays revealed no deformity or acute or chronic injury (though the x-rays were not reviewed by a paediatric radiologist).[43]

34. Dr Irvine was initially of the opinion that Kayla may have died of hyperthermia due to environmental heat exposure (where she likely had an inborn error of metabolism). However, following Kayla's death further screening was undertaken for the metabolism disorder (Isovaleric Acideamia (IV)) and Dr Carolyn Ellaway, Senior Staff Specialist at the Genetic Metabolic Disorders Service at the Sydney Children's Hospital Network, confirmed that Kayla did not have mutations of the relevant gene and did not present with the clinical features of a baby with this disorder. Accordingly, I do find that Kayla suffered from this disorder and there is an insufficient basis for any finding of hyperthermia.

35. Dr Irvine is of the opinion, which I accept, that Kayla's death should be classified as SUDI 0+.[44] She commented that: "The scene investigation was not sufficient, not only because it did not meet current standards of infant death investigation in general, but because a potentially unsafe environment (hot room), a major extrinsic risk factor, was recognised but was not objectively documented. The only other risk factor that I can identify is smoking in the household (extrinsic risk factor). Although the SUDI 3 category mentions overdressing, which is also a potential significant factor in this case,

[39] Shoalhaven Memorial Hospital Clinical Records, Kayla Ewin, tab 28 at pp.258-259.
[40] P79A, tab 1 at p.1.
[41] Transcript, Day 1, Detective Senior Constable Klein, p. 9.
[42] Addendum Autopsy report, tab 4, p.12.
[43] Addendum Autopsy report, tab 4, p.14.
[44] Supplementary report of Dr Irvine, tab 4A, p.3 of report. For a description of the various SUDI classifications (including "SUDI 0+") see tab 66 p.2 (vol 3).

the unsafe (modifiable) factors in this category relate to asphyxia and suffocation."[45]

36. Professor Woodford gave written and oral evidence at the inquest and agreed that Kayla's death should be classified as SUDI 0+.[46]

Iziah O'Sullivan

37. On 30 June 2014, Iziah O'Sullivan was born to Thomas O'Sullivan and Maddison Wadsworth in Blacktown hospital. He was a natural birth.[47] Maddison suffered from premature contractions and was admitted to hospital on numerous occasions in the weeks leading up to the birth.[48]

38. At the time of his birth, Thomas and Maddison had been together for approximately one year. On return from the hospital Iziah slept in a bassinet next to his parents' bed. Iziah was breast fed for approximately one week and was then transitioned to formula. Iziah's family remember Iziah as a beautiful boy. His paternal grandfather Robert told the Court that "Tom and Maddison were the best parents."[49]

39. In the weeks prior to Iziah's death, he would routinely wake at around 8am and would be fed and changed every few hours throughout the day. He would have a final feed at around 10pm and would then sleep until approximately 4am.[50]

40. On 7 July 2014 Iziah attended at Blacktown General Practice and assessed as a 'well infant' by Dr David Wang at his one week check-up.[51]

41. On the afternoon before Iziah's death, Maddison and Thomas took him to visit family and watch a soccer game. During the outing Iziah became upset and restless and unsettled.[52] Iziah's maternal grandmother observed he was a little bit sweaty and red in the face.[53]

42. Iziah was given an evening feed at 10pm and a further feed at 12.30pm. I accept Maddison's evidence that she dressed Iziah in a two piece pyjama outfit, wrapped him in a grey woollen blanket and laid him on his back in the bassinette (tucked into a sheet from the waist down).[54] I also accept her oral

[45] Supplementary report of Dr Irvine, tab 4A, p.3 of report.
[46] Report of Professor Woodford, tab 71A, p.4.7 and 4.9 of report.
[47] Blacktown Hospital clinical records, tab 58, pp.514-515 and tab 59, p.651.
[48] Statement of Maddison Wadsworth, tab 44, p.371 at [5-6] and Blacktown Hospital clinical notes, tab 58, pp.452-477.
[49] Transcript, Day 3, Robert Wadsworth, p.11.
[50] Statement of Maddison Wadsworth, tab 44, p.373 at [11].
[51] Blacktown General Practice medical records, tab 61, p.711.
[52] Statement of Maddison Wadsworth, tab 44, p.373 at [16-17].
[53] Statement of Janelle Wadsworth, tab 47, p.386 at [13].
[54] Statement of Maddison Wadsworth, tab 44, p.374 at [18].

evidence that it was cold on that night and she wrapped him and placed him on his back and tucked him in with a sheet.[55]

43. At about 3am that night, Iziah woke up crying and Thomas fed him, burped him, "rugged him up again" and returned him to his bassinette.[56]

44. At around 4.15am Thomas woke up to get ready for work. I accept Thomas' account of events that at around 4.30am he discovered Iziah unresponsive with a small amount of blood coming out of both of his nostrils.[57] In oral evidence he said that Iziah was in the same position in which he left him earlier that morning (on his back and tucked into bed).[58] Professor Woodford described the position of Iziah as a "sleeping environment [that is] as optimal as can be."[59]

45. Once Thomas alerted the family, Iziah's maternal grandmother, Janelle Wadsworth, called 000.[60]

46. Iziah's maternal grandfather, Robert Wadsworth, attempted resuscitation. During CPR, a small amount of vomit came out of Iziah's mouth.

47. At 5.30am the first ambulance arrived at Iziah's family house.[61] The ambulance officers took over resuscitation on Iziah and placed an oropharyngeal airway. At this time Iziah was cool to touch, was not breathing, had no pulse and had some mottled skin. Following the arrival of the further ambulance officers, Iziah was administered adrenaline and intubated.[62] His heart remained asystole and he was monitored accordingly.[63]

48. At 5.41am the second ambulance arrived at Iziah's family house and ambulance officers provided further assistance.[64] Iziah was placed in the ambulance and taken to Westmead Children's Hospital.

49. At 6.18am Iziah was admitted into the Emergency Department of Blacktown Hospital. Further unsuccessful attempts were made to resuscitate Iziah at the hospital.[65]

50. At 7.30am at the hospital Iziah was moved to a parents room with his immediate family. Thomas and Maddison were present, with Maddison's parents and five younger siblings.[66]

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[55] Transcript, Day 1, Maddison Wadsworth, p.28.
[56] Statement of Thomas O'Sullivan, tab 45, p.379 at [18].
[57] Statement of Thomas O'Sullivan, tab 45, p.379 at [19].
[58] Transcript, Day 1, Thomas O'Sullivan, p.34.
[59] Transcript, Day 2, Professor Woodford, p.8.
[60] Statement of Janelle Wadsworth, tab 47, p.387 at [16].
[61] Ambulance Incident Detail Report, tab 52, p.397.
[62] Statement of Caitlin McAlister, tab 49, p.390 at [9-13] and statement of Philippa Matthews, tab 51, p.395 at [9].
[63] Ambulance Electronic Medical Record, tab 53, p.403.
[64] Statement of John Hando, tab 48, p.388 at [7-8].
[65] Westmead Hospital Clinical Records, tab 60, pp.666-667and 688.
[66] Westmead Hospital Clinical Records, tab 60, p.669.

51. At 10am Detective Senior Constable David Boylan[67] attended Iziah's family house with other police officers and assisted with taking crime scene photographs.[68] After this task was completed, he travelled with other police to Westmead Children's Hospital and took forensic photographs of Iziah.[69] Iziah's family house was secured as a crime scene with a crime scene log.[70]

52. At 10.40am the next on-call social worker was contacted and arrived at 11.45am to assist with Iziah's grieving family. The social worker already present stated in the clinical notes that: "I had anticipated leaving and handing over at this point at that point however the enormous grief reaction and police involvement I made the decision that we needed 2 social workers to assist the family… Eventually each family member held and said goodbye to Iziah." The social worker also noted that "Eventually baby was handed over to police for eventual escort to Coroner… Jenni L (a social worker) will call hand over to Coroner this afternoon and to ensure counselling is offered and the process explained again from here."[71]

53. At some stage on 26 July 2014, Iziah was formally identified by his father Thomas.[72]

54. The Westmead Hospital clinical records only contained an inadequate and incomplete "SUDI Medical History" form for Iziah.[73] Moreover, this incomplete form was not provided to the forensic pathologist.

The expert evidence in relation to Iziah's death

55. An autopsy was conducted by forensic pathologist Dr Rianie Janse Van Vuuren and she concluded that his cause of death was undetermined.[74] In the hearing Dr Van Vuuren was provided the opportunity to consider the (incomplete) SUDI Medical History and no information contained therein changed her opinion.[75] Both Dr Van Vuuren and Professor Woodford confirmed in evidence that the discharge of blood from the nose is a commonly reported occurrence in the circumstances and is usual after death.[76]

56. Although there was some evidence of agonal aspiration in Iziah (being thick yellow mucus found in focal areas), there is no basis for any finding that this was relevant to the cause of death (such as due to the potential aspiration of milk). Dr Van Vuuren found no evidence of aspiration pneumonia or any

[67] Officer in charge of the coronial investigation.
[68] Statement of Detective Senior Constable David Boylan, tab 36, p.343 at [8].
[69] Statement of Detective Senior Constable David Boylan, tab 36, p.344 at [11].
[70] Statement of Sergeant Gregory Frail, tab 39, p.366 and crime scene log tab 42.
[71] Westmead Hospital Clinical Records, tab 60, p.670.
[72] Identification statement, tab 31, p.298.
[73] Westmead Hospital Clinical Records, tab 60, p.685.
[74] Autopsy report, tab 34, p.326.
[75] Supplementary report of Dr Van Vuuren, tab 35A, at p.2 of report.
[76] Supplementary report of Dr Van Vuuren, tab 35A, at p.1 of report and Report of Professor Woodford, tab 71A, p.5.5 of report.

reaction associated with the agonal aspiration of fluid.[77] Professor Woodford was unable to determine whether the thick yellow mucus found in focal areas comprised the residuum of feeds, respiratory secretions (including sputum) or a combination of the two.[78]

57. In the original autopsy Dr Van Vuuren identified that Iziah had an atrial septal defect together with a probe patent ductus arteriosus.[79] She concluded – under the heading 'microscopic examination of tissues' – that "the heart is unremarkable. The ductus arteriosus is probe patent, with a thickened tunica media. There are no abnormalities."[80]

58. In her original autopsy report, Dr Van Vuuren commented on an association between an atrial septal defect, abnormally large fontanelle and tetrasomy 9p (a rare condition where a person has too much of one gene, though the condition is not usually associated with death).[81]

59. However, Dr Van Vuuren has since re-examined her report and the photographs taken at autopsy. Following this re-examination, she is of the opinion that Iziah more likely had a patent foramen ovale (where the foramen ovale fails to close), as opposed to an atrial septal defect (where there is no septal tissues between the atria.) She states that the significance in Iziah is not known.[82] Dr Van Vuuren confirmed before the Court that the finding was more likely a patent foramen ovale and this was a finding that is seen often in infants.[83]

60. Professor Woodford agrees that a patent foramen ovale is a not uncommonly observed finding and is unlikely to be of significance.[84] I accept the evidence of Professor Woodford and the revised evidence of Dr Van Vuuren in this regard.

61. Dr Van Vuuren is of the opinion that Iziah's death should be classified as SUDI 0.[85]

62. Professor Woodford agrees that Dr Van Vuuren's finding appears reasonable and that Iziah's death should be classified as SUDI 0.[86] I accept that the appropriate classification for the death of Iziah is SUDI 0.

[77] Supplementary report of Dr Van Vuuren, tab 35A, at p.1 of report.
[78] Report of Professor Woodford, tab 71A, p.5.7 of report.
[79] Autopsy report, tab 34, p.328.
[80] Autopsy report, tab 34, p.337.
[81] Autopsy report, tab 34, pp.328-329.
[82] Supplementary report of Dr Van Vuuren, tab 35A, at p.2 of report.
[83] Transcript, Day 1, Dr Van Vuuren, p.38.
[84] Report of Professor Woodford, tab 71A, p.6.2 and Transcript, Day 2, Professor Woodford, p.7.
[85] Supplementary report of Dr Van Vuuren, tab 35A, at p.2 of report. For a description of the various SUDI classifications (including "SUDI 0") see tab 66 p.2 (vol 3).
[86] Report of Professor Woodford, tab 71A, p.6.5 and 6.9.

Issues arising in the investigation and management of SUDI deaths in NSW

Overview

63. As at the time of Kayla and Iziah's deaths, the primary policy in relation to the management of SUDI deaths was the 'NSW Health Policy Directive – Death – Management of Sudden Unexpected Death in Infancy' (PD2008_70).[87]

64. In July 2019, NSW Health significantly revised this policy: 'Management of Sudden Unexpected Death in Infancy (SUDI)' (PD2019_XXX).[88] The new version of the policy was produced following lengthy engagement with other agencies and participation in the NSW SUDI Cross Agency Working Group and NSW Child Death Review Team.

65. The recently revised NSW Health Policy is a significant improvement on the policy in force as at the time of Kayla and Iziah's deaths. This has been the product of engagement with the other relevant agencies and reflects the actual practice of management of SUDI deaths in recent years and the adoption of a local hospital response to the management of SUDI deaths in NSW.[89]

66. A key change under the revised NSW Health Policy is that, instead of being taken to a designated hospital, the deceased infant is to be taken to the nearest local hospital by ambulance in order for medical professionals to take a timely SUDI medical history and provide care for the family.[90] Another key change is the different approach that is now to be taken when compiling the SUDI medical history form (as discussed at paragraphs [102-110] below).

67. Given these considerable recent policy improvements, the expert evidence at the hearing was adduced by Counsel Assisting in order to identify only current concerns in the management of SUDI deaths in NSW in light of the experience of Kayla and Iziah's families. The purpose of this evidence was to identify any further practical improvements to policy and practice for the future. The expert evidence in this regard focused on the roles of the NSW Police, the Ambulance Service of NSW, NSW Ministry of Health and the Department of Forensic Medicine: from the point at which a family seek the assistance of police and paramedics in the event of a death; to the role of medical professionals at hospital; through to the determination of the cause of death by forensic pathologists.

[87] Tab 65.
[88] Tab 66A.
[89] Transcript, Day 2, Dr O'Meara, p.74. This sentiment was echoed by representatives of NSW Police and Ambulance NSW and by Ms Shipstone, who stated that a localised response is more appropriate and responsive to the needs of families. See Transcript, Day 3, Ms Shipstone, p.3.
[90] Transcript, Day 2, Dr O'Meara, p.46.

68. In my view there are further practical improvements that can be made in regard to the management of a SUDI death in NSW by a number of the key agencies, as set out below.

The body temperature of the infants at the scene of a SUDI death

69. In the case of Kayla, the temperature of the room and the body of the infant was relevant in consideration of the likely cause of death. Dr Irvine stated that "extremely strong circumstantial evidence" would need to be available to a forensic pathologist in order to find that a cause of death in an infant was hyperthermia.[91] The evidence clearly supported a finding that the temperature of the room in which an infant died is important circumstantial evidence (particularly when coupled with evidence of the difference between the temperature of the room and the temperature of the child). Dr Irvine stated that the temperature of the child would need to be taken as soon as possible to be of value.[92] Professor Woodford agreed that this clinical information was very useful for determination of cause of death. His evidence was that the temperature of an infant should be taken with an aural thermometer and as rapidly as possible by a person with medical training.[93]

70. Professor Woodford suggested that an ambulance officer would be in the ideal position to perform this task.[94] The Ambulance Service of NSW, through Mr Loudfoot, accepted that paramedics could and should undertake this task.[95] Dr Du-Toit Prinsloo confirmed that, if paramedics were to take the temperature, forensic pathologists would be able to readily access it given that paramedic records sit with NSW Ministry of Health (of which they are a part).[96] NSW Ambulance did not make any submissions against this proposal.

71. I accept the submission made by Counsel Assisting that it is important and useful for the temperature of a deceased infant to be taken as soon as possible by responding paramedics where there has been concern about overheating.

Recommendation: That the Ambulance Service of NSW consider amending its policies to instruct attending paramedics to take the aural temperature of a deceased infant under 12 months (and the time that it was taken) where clinically appropriate.

The exposure of the deceased infant to other children at the scene

72. In oral evidence Terri expressed her concern that her two older children were present when the ambulance arrived and said that: "the ambulance officer walked into the lounge room holding Kayla in his arms with her little arm

[91] Transcript, Day 1, Dr Irvine, p.53, p.64.
[92] Transcript, Day 1, Dr Irvine, p.55.
[93] Transcript, Day 2, Professor Woodford, p.4.
[94] Transcript, Day 2, Professor Woodford, p.4.
[95] Transcript, Day 2, Mr Loudfoot, p.21.
[96] Transcript, Day 2, Dr Du-Toit Prinsloo, p.45.

dangling down in front of the children."[97] Matthew agreed that it was difficult for the older children to deal with the memory of the paramedic taking Kayla out to the ambulance in front of them.[98] I agree with the submission of Counsel Assisting, and no doubt shared by the other parties in the hearing, that this situation aptly demonstrates the challenges faced by family and attending medical professionals in the event of the death of an infant.

73. Mr Loudfoot, on behalf of Ambulance NSW, responded to this concern and properly accepted that paramedics attending such a scene should certainly take into account the exposure of the infant to older and other children.[99] He also conveyed to the Court that SUDI deaths are tragic but rare and, as a result, many paramedics may have never encountered the death of an infant. Mr Loudfoot stated in conclave: "The reality … is that these cases are rare. We would do a million cases a year [in NSW]. Out of those million cases there are 40 to 50 cases like this."[100]

The use of the term 'Crime Scene" by NSW Police when investigating a SUDI death

74. In 2014 police attended Iziah's family house in response to an emergency call regarding Iziah and established a crime scene. Detective Senior Constable Boylan gave evidence that the usual procedure in these circumstances is to obtain the consent of the family to establish a crime scene, and in the absence of consent, to seek a crime scene warrant.

75. The family of Iziah were concerned and distressed that their house was labelled and treated as a 'crime scene'. I accept this was and remains a legitimate concern for this, and indeed any family confronted with the unexpected death of an infant.

76. Detective Senior Constable Boylan explained in oral evidence that from the perspective of NSW Police, the establishment of a crime scene was a necessary process because the location of the death and the deceased "become evidentiary" in terms of the investigation. He said that the terminology is used for consistency and clarity and is used whether or not police have suspicions about the cause of death. He agreed that it may well be more appropriate for police to apply for a coronial scene order rather than a warrant in such circumstances.[101]

77. This issue was addressed in the conclave and alternatives to the term 'crime scene' were explored, including the use of the term 'coronial scene.' On behalf of NSW Police, Detective Superintendent Cook expressed reservations: "Police are in a difficult situation when they arrive on these scenes. On the one hand, there may be a crime. It may be many weeks or

[97] Transcript, Day 1, Terri Ewin, p.17.
[98] Transcript, Day 1, Matthew Ewin, p.22.
[99] Transcript, Day 2, Mr Loudfoot, p.66.
[100] Transcript, Day 2, Mr Loudfoot, p.20.
[101] Transcript, Day 1, Detective Senior Constable Boylan, pp.26 – 27.

months before they know if there is a crime or not. It may be that the evidence they collect, the conversations that they have, are all required to be admissible in a criminal jurisdiction. At the same time, they are required to be empathetic to a family who is suffering and so police are having to walk a fine line."[102]

78. The position of NSW Police is that it is preferable to "err on the side of suspicion" in the circumstances, and hence, consider the use of the term 'crime scene' to be necessary.[103]

79. Detective Superintendent Cook acknowledged that the term 'coronial scene' may be used in some circumstances other than 'crime scene', but this issue should be determined on a case by case basis.[104]

80. It is noted that the evidence before the Court was that approximately 95% of all child deaths are not suspicious.[105]

81. It was submitted by Counsel Assisting that NSW Police should be encouraged to use the term 'coronial scene' where appropriate rather than refer to the home as a 'crime scene'. In response, the Commissioner proposes to appropriately update the NSW Police Handbook in the manner set out in the Recommendations below:

Recommendation: That NSW Police revise the 'SUDI' section of the Police Handbook to contain an instruction to police officers attending a scene or managing an investigation to assess whether it is preferable to use the term 'coronial scene' rather than 'crime scene' and in doing so, consider the impact of the use of the terminology on the family.

Recommendation: That NSW Police Forensic Evidence and Technical Services Branch and the Crime Scene Services Branch use the term 'coronial scene' rather than 'crime scene' in regard to infant deaths determined to be accidental.

The presence of police officers at the hospital with a deceased infant

82. In oral evidence Iziah's family questioned the necessity for the attendance of police officers at the hospital following the death of an infant. Iziah's family found this experience to be understandably intrusive and stressful. Maddison gave evidence to the Court that there were a number of police officers in the room at the hospital and: "we didn't even know what happened … and I think because there were so many police officers in the room and when we were saying goodbye to our son we didn't even know … we didn't know if we'd

[102] Transcript, Day 2, Detective Superintendent Cook, p.23
[103] Transcript, Day 2, Detective Superintendent Cook, p.23
[104] Transcript, Day 2, Detective Superintendent Cook, p.23.
[105] Transcript, Day 2, Professor Jeffrey, p.33; Transcript, Day 2, Detective Superintendent Cook, p.34.

done anything wrong".[106] Thomas also gave evidence and explained that the police presence made them feel as though the family had done something wrong and they were unclear about whether they had done 'something wrong' for a long period of time after the death.[107] Maddison acknowledged that an investigation of the death was necessary by police but reflected that better communication by police and hospital staff could have been achieved.[108]

83. The position of NSW Police remains that it is necessary for two police officers to attend the hospital in order to properly investigate an infant death and acknowledges that police presence must be minimal. This issue was directly addressed by Detective Superintendent Cook in oral evidence, who apologised to Iziah's family and acknowledged that the presence of police can be intimidating. He explained that while there is no prescriptive policy on the number of police who attend the hospital, it is necessary for two police officers to attend (rather than one officer only) in order to investigate the death and complete the necessary tasks.[109] He assured the Court the attendance of two police officers at a hospital should not stop the family from spending appropriate time with the infant in the circumstances.[110]

84. However, NSW Police supports the amendment of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene *and the hospital*. I agree that such an amendment would be an appropriate step and so I will make a recommendation in those terms.

Recommendation: That NSW Police revise the 'SUDI' section of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene and the hospital.

Support and time for the family with the deceased infant at the hospital

85. At the hearing, the O'Sullivan family recounted that they did not feel comfortable at the hospital and found the experience confronting and very distressing. Maddison recalls not having enough time with Iziah. She stated to the Court: "I thought that there was, you know, he was going to be okay, that there was something they could do to help him or – so I, I was just coming to terms. I was 18. It was my first baby. I was clueless so I was just coming to terms with why he passed away."[111]

86. This issue was raised with Dr O'Meara in the conclave and he said that he would expect the clinicians to be "very much supporting the family."[112]

[106] Transcript, Day 1, Maddison Wadsworth, p.30.
[107] Transcript, Day 1, Thomas O'Sullivan, p.34.
[108] Transcript, Day 1, Maddison Wadsworth, p.32.
[109] Transcript, Day 2, Detective Superintendent Cook, p.65.
[110] Transcript, Day 2, Detective Superintendent Cook, p.82.
[111] Transcript, Day 1, Maddison Wadsworth, p.30.
[112] Transcript, Day 2 Dr O'Meara, p.84.

87. The complex question of how agencies, particularly hospitals, can best support families to have meaningful time with their infant in such difficult circumstances was also explored in the evidence of Ms Shipstone. In her view, agencies could offer more support to families.[113] The issue was dealt with constructively in conclave. Dr O'Meara said: "I'm sorry the O'Sullivan family had that experience. That shouldn't occur. There is no time frame. There just isn't. It depends on the family. It varies and with other family members coming in it can take hours and we expect it to take hours and that's fine."[114]

88. Detective Superintendent Cook also gave evidence that there is no imperative from a police perspective for families to be cut short in the time they have in saying goodbye to their child.[115] He agreed that the police could provide guidance to its officers about the sensitivities involved with families in saying goodbye to their child and that, if a recommendation were as proposed below, it could be implemented across the entire police organisation in a short space of time.[116] In this respect, NSW Police is open to updating the SUDI section of the Police Handbook to ensure that guidance is provided to officers to be mindful of the impact of police presence on a family in the context of a SUDI death (noting that the matter may not eventuate as a crime; to treat family members appropriately and ensure that they are given sufficient time to say goodbye to their child).

89. It was not clear from the evidence at the conclave whether NSW Ministry of Health provided any specific training in relation to the approach that NSW Ministry of Health staff should take in relation to a family seeking time to say goodbye to their child in the context of a SUDI death.[117] In my view, it is necessary and appropriate for NSW Ministry of Health to ensure their staff are properly trained to support the family in the event of an infant death. The NSW Ministry of Health supports this approach and has identified a number of options to continue to improve the ability of staff to meet the needs of the infant and parents / carers including the provision of education for all staff and utilising staff with bereavement skills from other areas such as midwifery.

Recommendation: That NSW Ministry of Health review its training policies to determine whether guidance is given to staff in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.

Recommendation: That NSW Police review its policies and training procedures in order to ensure that guidance is provided to officers in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.

[113] Transcript, Day 3, Ms Shipstone, p.2. Ms Shipstone in particular spoke about the approaches in other jurisdictions and the potential to approach the management of SUDI deaths from a more health based rather than criminal-justice based approach.
[114] Transcript, Day 2, Dr O'Meara, p.81.
[115] Transcript, Day 2, Detective Superintendent Cook, p.67.
[116] Transcript, Day 2, Detective Superintendent Cook, p.67.
[117] Transcript, Day 2, Dr O'Meara, p.83.

The P79A form and the potential for more fulsome documentation of the sleeping environment of the deceased infant

90. The Court was presented with an example of a Victorian police form ('Investigative Checklist: Sleep-Related Sudden Unexpected Death of an Infant or Child') used by investigating police in Victoria (Exhibit 6). The form contains an extensive list of medical and general questions and a diagram for completion by the investigating officer on the sleeping arrangements necessary for a thorough investigation. I accept the submission of Counsel Assisting that this form contains useful general (and non-medical) information for police in a SUDI investigation, including:[118]

    a. The details of the primary caregiver at the time of death;

    b. The details of the people at the premises at the time of death;

    c. The details of the siblings of the child (both alive and deceased);

    d. Details of the incident (including the status of the child when found, person who found the child, their relationship to the child, the date and time found, the circumstances in which the child was found, and whether resuscitation was attempted by someone other than a paramedic);

    e. Details of the sleeping location and surface where the child was found (including whether a bassinette / adult bed / cot / porta cot / pram / couch / other), whether the sleeping place was the normal place for the child to sleep, whether there was any signs of damage to the sleeping environment, the mattress type (foam / fabric / innerspring / water / other), the firmness of the mattress, whether the mattress was wrapped in plastic / sagging / was stained, whether there was a gap between the cot / basket and the mattress, and whether there was an additional mattress or padding placed in the bedding);

    f. Details of the bedding (including how many blankets were underneath and on top of the child, the number, type and condition of sheets, and whether the bedding was tucked in) and whether the bedding was soiled / wet / damp and whether there was a pillow and anything else in the bed;

    g. Details of the appearance of the child (characteristics of the child when found and whether any visible debris / signs of injury);

    h. Details of the child's airway (and whether airway obstructed and any objects covering or near the face);

    i. Details of the child's last feed and clothing worn;

[118] Exhibit 6, Investigative Checklist: Sleep-Related Sudden Unexpected Death of an Infant or Child.

j. Details of the sleeping arrangements for the child (including who put the child to sleep, why the child was put to sleep, the wrapping of the child, any pets present);

k. Description of the position of the child when placed to sleep and when found deceased (with diagrammatic options to nominate whether the child was placed with their head placed at the top of the cot, the middle of the cot or feet at the foot of the cot);

l. Description of any co-sleeping / bedsharing (and if so, with who, in what position when put to sleep, in what position when found, duration of co-sleeping, and alcohol and drug use by co-sleepers);

m. Details of the child's normal sleeping pattern (arrangements, time, any recent changes);

n. Details of the child's household environment (weather, heating and cooling in the child's room and house);

o. A narrative of events as described by the parent or carer in their own words;

p. Observations by police officer as to whether any cigarette odour or signs of drug or alcohol use in the house.

91. NSW Police agree that the inclusion of extra detail in the relevant P97A form may be useful to prompt and structure specific questions about sleeping environment and routines.[119] In conclave, Detective Superintendent Cook said that adding in additional prompts and structured questions to the P79A form would be beneficial because it would encourage police officers to focus on the level of detail that is required in a SUDI investigation (that might not otherwise be obvious to an officer).[120]

92. Some concern was later raised in submissions on the part of NSW Police that not all this information may be able to be obtained by the officer in charge in the circumstances. NSW Police submitted that:

a. the Crime Scene Officer may, instead, be the officer best trained to answer such questions;

b. while the P79A form may be updated to include the matters set out at paragraph 90 above, as a matter of practicality and proper approach, not all of those matters could or would be answered in a P79A form;

c. the Standard Operating Procedures (SOPs) that are to be followed by Crime Scene Officers in relation to a SUDI death (being SOPs

[119] Transcript, Day 2, Detective Superintendent Cook, p.58.
[120] Transcript, Day 2, Detective Superintendent Cook, p.58.

section 2.4.14) already deal with a number of the matters set out in paragraph 90 above (although in broader terms);

d. NSW Police is open to a recommendation that section 2.4.14 of the SOPs be updated to include the matters set out at paragraph 90 above in order to encourage Crime Scene Officers to consider those matters in that level of detail.

93. While NSW Police raised some reservations in its written submissions about updating the P79A form to include the matters set out at paragraph 90 above, I note the evidence of Detective Superintendent Cook at the hearing that the inclusion of extra detail in the relevant P97A form may be useful to prompt and structure specific questions about sleeping environment and routines. I accordingly propose to make a recommendation that NSW Police consider amending both the P79A form and the SOPs to include additional SUDI questions on the matters as set out in paragraph 90 above.

94. Mr Loudfoot of NSW Ambulance agreed that these extra prompts and structured questions would be useful given that, in the vast majority of cases, there is no photographic representation of the infant in situ because either family or attending paramedics remove the infant from the environment to attempt resuscitation.[121]

Recommendation: That NSW Police consider amending the P79A form and the Standard Operating Procedures entitled "Crime Scene Manual (Specialist) – Death Investigation" and SUDI section 2.4.14 to include additional SUDI questions on the matters as set out in paragraph 90 above.

The value of photographs in SUDI investigations

95. The forensic pathologists in the cases of Kayla and Iziah were not provided with any photographs of the environment in which the infants died and did not request them from NSW Police. When provided in Court with a photograph of Kayla's portable carrier and surrounding environment (Exhibit 4), it was clear that this evidence would be useful corroborative material in determination of manner and cause of death. In particular, Dr Du-Toit Prinsloo gave evidence in conclave that it would be useful to have access to the police photographs of the deceased infant at the scene (including the position of the deceased infant and surroundings, including bedding and environment) in as timely a manner as possible.[122]

96. The P79A form is completed by police officers after speaking with family members and other witnesses at the scene. The NSW Police Handbook dictates that the P79A form is completed on the day of the death and sent to the Coroner. It is ordinarily completed prior to the crime scene photographs being available. As such, there is currently no process whereby police

[121] Transcript, Day 2, Mr Loudfoot, p.58.
[122] Transcript, Day 2, Dr Du Toit-Prinsloo, p.41.

photographs (either crime scene photographs or otherwise) are included with this document.

97. The current informal practice in the Department of Forensic Medicine is such that forensic pathologists may request crime scene photographs from police via the Coronial Case Management Unit (CCMU). However, it became apparent in the expert conclave that this request process is likely under-utilised because police photographs are usually taken of the deceased once removed from the scene and not in the environment in which they died.[123] Moreover, an autopsy is usually performed within 24 hours of the death and police crime scene photographs are generally not available at this time (and do not accompany the P79A form as a matter of course, as set out above).[124] I accept the evidence of Detective Superintendent Cook that crime scene officers generally process and upload photographs of a crime scene within 1-2 days of the death.[125]

98. It became clear in the conclave evidence that forensic pathologists are not able to directly access such photographs.[126] Rather, it is up to the forensic pathologist to make a request of a police officer to provide them with such photographs. In Sydney, that request would be made to a police officer in the CCMU.[127]

99. Dr Du Toit-Prinsloo observed that forensic pathologists should be encouraged to routinely make a request of police to provide them with crime scene photographs.[128] She observed that, even though those photographs were unlikely to be available at the time of doing the actual autopsy, they would still be valuable if they were received a day or two later (and prior to the pathologist signing off the autopsy report).[129] Dr Du Toit-Prinsloo was unsure whether the manual or policy that forensic pathologists are required to follow when conducting autopsies requires the pathologist to review crime scene photographs prior to signing off an autopsy report.[130]

100. In my view, the work of forensic pathologists would be significantly assisted by efficient and timely access to crime scene photographs. Counsel Assisting proposed a recommendation whereby NSW Police consider amending the Police Handbook and the P79A form to provide that any crime scene photographs of a deceased infant under the age of 12 months are to be provided to the CCMU as soon as is practicable. However, this recommendation was not supported by NSW Police and it is their position that it would be more practicable for forensic pathologists to routinely request the photographs.

[123] Transcript, Day 2, Dr Du Toit-Prinsloo, p.41.
[124] Transcript, Day 2, Dr Du Toit-Prinsloo, p.41.
[125] Transcript, Day 2, Detective Superintendent Cook, p.39.
[126] Transcript, Day 2, Dr Du Toit-Prinsloo, p.40.
[127] Transcript, Day 2, Dr Du Toit-Prinsloo, pp.40-41.
[128] Transcript, Day 2, Dr Du Toit-Prinsloo, pp.41-42.
[129] Transcript, Day 2, Dr Du Toit-Prinsloo, pp.42.
[130] Transcript, Day 2, Dr Du Toit-Prinsloo, p.43.

101. It is clearly necessary for forensic pathologists to have timely access to such photographs. So much is supported by the NSW Ministry of Health. The NSW Ministry of Health proposed that any recommendation on the issue should not be couched in mandatory terms. I am therefore making a recommendation that the NSW Department of Forensic Medicine review its policies to encourage a forensic pathologist to obtain crime scene photographs prior to signing off an autopsy report.

Recommendation: That NSW Department of Forensic Medicine review its policies to encourage forensic pathologists to routinely request, and then review, crime scene photographs prior to signing off an autopsy report.

The completion of a SUDI medical history at the Hospital

102. A significant issue addressed in the evidence was that in neither Kayla nor Iziah's case was a complete and comprehensive SUDI medical history provided by the hospital to the forensic pathologist. Dr Van Vuuren gave evidence that a SUDI medical history is necessary in order to perform an infant autopsy and, in her experience, it was not always provided.[131]

103. The evidence before the Court was that prior to the recently revised NSW Health policy, the SUDI medical history form was completed and provided to the Department of Forensic Medicine on less than half the occasions it was required. This failure was accepted by NSW Ministry of Health. Dr O'Meara frankly acknowledged a clear problem in the 2008 policy and stated that: "The reasons for that are not clear … in the professional meetings with other clinicians they describe the tension between caring for the family and asking detailed questions at that moment, a few hours after the baby's died."[132]

104. Dr O'Meara further expressed the view that, as at the time of Kayla and Iziah's deaths, the form was not being adequately completed because it was long and the format was not clinically intuitive for practitioners to complete. He readily accepted that he could not explain why practitioners were not providing the form to the forensic pathologist.[133]

105. In response to this failure, the SUDI medical history form in the current (revised) policy has been redesigned in order to reflect how a clinician would ordinarily take a medical history in the sensitive context of the death of an infant.

106. NSW Ministry of Health proposes an audit of the revised SUDI medical history form to assess whether these changes are effective.[134] In my view, given the previous non-compliance with completion of this history form, this audit is necessary and should be implemented. The NSW Ministry of Health has embraced this approach and supports the recommendation I make below. I

[131] Transcript, Day 1, Dr Van Vuuren, p.42.
[132] Transcript, Day 2, Dr O'Meara, p.47.
[133] Transcript, Day 2, Dr O'Meara, p.48.
[134] Transcript, Day 2, Dr O'Meara, pp.47 – 48, Ms Matha, p.60.

note that Dr Du-Toit Prinsloo observed that the information contained in the SUDI medical history form is significant to forensic pathologists in terms of their ability to determine a cause of death.[135]

107. The evidence from the expert conclave was that given the recent introduction of the role of a clinical nurse consultant (CNC) at the CCMU in the Department of Forensic Medicine, this has 'improved matters' in terms of having someone to chase up the SUDI medical history form from the hospital (if it was not provided with the body of the infant, as should ordinarily be the case).[136] Dr Van Vuuren confirmed that if the form is not provided then the CNC will request and obtain the information.[137] The NSW Ministry of Health does not consider it the role of the CNC to 'chase up records' and comments that it may not be the best use of this scarce and highly specialised resource. However, given the crucial importance of the SUDI medical history, I consider that it is a necessary role for the CNC in the circumstances.

Recommendation: That NSW Ministry of Health implement their proposed audit of the revised SUDI medical history form over a period of 12 months and evaluate whether the form is being sufficiently completed and whether it is consistently being provided to the Department of Forensic Medicine in a timely manner.

Recommendation: That the Department of Forensic Medicine review its policies to ensure that the role of the CNC includes ensuring that the SUDI medical history form has been received and provided to the case forensic pathologist in a timely manner.

The duplication in taking a SUDI medical history from the family

108. It was apparent from the evidence of the various agencies in the conclave that some form of medical history taking is necessary to be taken by each relevant agency in regard to management of a SUDI death. For example, Detective Superintendent Cook explained that investigating police must consider and address the suspicion of a non-accidental injury or death and some medical history needs to be taken for this purpose.[138]In his view, there is some duplication, but "P79A is a very limited medical precis … it's not a comprehensive clinical history."[139]

109. Mr Loudfoot, for the Ambulance Service of NSW, commented that it is also necessary for some form of medical history to be taken by treating paramedics in order to fully inform resuscitation attempts and the provision of medical care at the scene. Mr Loudfoot said: "I think each of the environments is quite unique … I think it gives the greatest opportunity to get a true picture of what's occurred, that each individual [from each agency] can ask the

[135] Transcript, Day 2, Dr Du Toit-Prinsloo, p.51.
[136] Transcript, Day 2, Dr Du Toit-Prinsloo, pp.49-54.
[137] Transcript, Day 1, Dr Van Vuuren, p.50.
[138] Transcript, Day 2, Detective Superintendent Cook, p.59.
[139] Transcript, Day 2, Detective Superintendent Cook, p.55.

questions each time."[140] Further, by way of example: "when the paramedics are there with the families, it's extremely emotive … the families say as it happened and we get the information from them. Later on in the process, they may not remember what actually occurred even an hour ago because it's been so much of a whirlwind of emotions."[141] He also commented: "So I think if we do that in a really sensitive way and a careful way, there's a greater opportunity to get … a more comprehensive and clearer picture of what really occurred from the family's perspective."[142]

110. It was apparent that each of the agencies are aware of the potential for duplication of taking a medical history from the family of a deceased infant and the added trauma which may result. The NSW Ministry of Health supports the monitoring of this issue further over the next 12 months in order to ascertain the most useful and sensitive approach.[143]

Recommendation: That NSW Ministry of Health implement their proposal to monitor the issue of duplication in taking a medical history from the family of a deceased infant over the next 12 months in order to ascertain the most useful and sensitive approach.

Early clinical review meeting in SUDI cases

111. Ms Matha provided valuable evidence to the Court that NSW Ministry of Health has committed to implementing a protocol whereby an early interagency clinical review meeting takes place in relation to each SUDI death.[144] The proposed early clinical review meeting:

a. would include the case forensic pathologist and CNC from the Department of Forensic Medicine, investigating NSW Police and the paediatrician or medical professional who completed the SUDI medical history form at the hospital;[145]

b. would take place by way of teleconference after the post mortem has been conducted in order to identify progress in determining the cause of a SUDI death;[146]

c. would take place within the first week of the death of the infant;[147]

d. would provide a forum in which to identify what information is missing and what steps still need to be taken;[148]

[140] Transcript, Day 2, Mr Loudfoot, p.59.
[141] Transcript, Day 2, Mr Loudfoot, pp.59-60.
[142] Transcript, Day 2, Mr Loudfoot, p.60.
[143] Transcript, Day 2, Ms Matha, p.60.
[144] Joint Statement of Ms Matha and Dr O'Meara, Exhibit 3, pp.12-13.
[145] Transcript, Day 2, Ms Matha, Dr O'Meara, and supported by Dr Du Toit-Prinsloo, pp.60–62.
[146] Joint Statement of Ms Matha and Dr O'Meara, Exhibit 3, p.12.
[147] Transcript, Day 2, Dr O'Meara, and supported by Dr Du Toit-Prinsloo, pp.61-62.
[148] Transcript, Day 2, Dr Du Toit-Prinsloo, p.62.

e. would also address the requisite care needs of the family of the infant.[149]

112. Dr Du-Toit Prinsloo noted that the early clinical review meeting would be similar to a major crime review that takes place in relation to homicide or suspicious cases.[150]

113. The early review meeting would be of significant value in that it would provide accountability and peer review for the paediatrician or medical professional who was involved in the death and the completion of the SUDI history form.[151] As Dr O'Meara observed, the opportunity for the paediatrician / medical professional who completed the SUDI medical history form at the hospital to participate in the early clinical review meeting will allow them to see the value of the medical history form in the process and where it "fits in". Then, through communication and networking of paediatricians, they will spread the message that completion of the SUDI medical history form is important and therefore increase the likelihood that it will be completed by them in a fulsome way.[152]

114. The NSW Ministry of Health supports the introduction of an early review meeting and the proposed recommendation by Counsel Assisting, but proposed that such a review take place within one week or as soon as practicable thereafter. I accept that there may be circumstances where such a review is not possible within one week but I consider it is necessary for there to be a fixed time frame for the completion of such a process.

Recommendation: That NSW Ministry of Health and NSW Police implement the proposal for an interagency early clinical review meeting to take place within 1 week of every SUDI death in NSW, or as soon as practicable thereafter and no later than 1 month after the death, and evaluate the implementation of this proposal within 12 months from the date of its commencement.

The specialisation and training of forensic pathologists in SUDI deaths

115. The expert conclave also addressed whether it is appropriate for forensic pathologists to perform autopsies or whether specialist paediatric pathologists are required. Dr Van Vuuren informed the Court that the training for forensic pathologists is the same in regard to both adults and children and on average forensic pathologists perform three or four paediatric autopsies per year.[153] In her view it is within the general expertise of a general forensic pathologist to

[149] Transcript, Day 2, Dr O'Meara, p.63.
[150] Transcript, Day 2, Dr Du Toit-Prinsloo, p.62.
[151] Transcript, Day 2, Dr O'Meara, p.63. This should address the fact that many practitioners may only see one SUDI case in their professional experience and otherwise may have little or no practical experience with SUDI.
[152] Transcript, Day 2, Dr O'Meara, p.63.
[153] Transcript, Day 1, Dr Van Vuuren, p.43.

perform paediatric autopsies.[154] This view was supported by Dr Du Toit-Prinsloo in the conclave and endorsed by Ms Shipstone.[155]

116. The Court also heard evidence about the scarcity of specialist paediatric pathologists in NSW and in Australia generally.

117. In addition, the Court heard evidence from Dr Du Toit-Prinsloo that a specialist paediatric pathologist is likely to be engaged by the Department of Forensic Medicine in the near future on a 0.2 part-time basis. The role of that specialist paediatric pathologist would be available for consultation to the general forensic pathologist in charge of the SUDI case, for example in relation to histological slides.[156]

118. Given the circumstances as set out above, I do not consider that there is any sufficient basis to consider any recommendation in relation to the introduction or use of paediatric forensic pathologists in NSW.

The delay in completion of paediatric post-mortem reports in NSW

119. In both Kayla and Iziah's cases there was a significant delay in the completion of the post-mortem report and very limited information provided to the families in this regard. The assessment by Dr Irvine is that as at the current time, the average timeframe in NSW for a paediatric autopsy report is between eight or nine months. The primary reason for this extended time period is the delay in receipt of specialist reports such as a neuropathology report, which are necessary in SUDI matters and routinely take months to be prepared due to a high workload and in circumstances where "you're talking about very scarce specialists who are extremely busy."[157]

120. Dr Du Toit-Prinsloo endorsed this assessment and said: "It's absolutely a human resource issue. We've got [at the Department of Forensic Medicine in NSW] one neuropathologist who is not full-time appointed in forensic pathology … so he has got a part-time appointment only and he manages all the neuropathology across the State so it's not just the SUDI deaths."[158]

121. These circumstances can be compared with greater resources in other parts of Australia. For example, Professor Woodford informed the Court that the benchmark in the state of Victoria is to have 80% of forensic cases completed within three months.[159] Moreover, in Victoria the allocation of resources allow for neuropathology to be performed when required by a dedicated forensic

[154] Transcript, Day 1, Dr Van Vuuren, p.43.
[155] Transcript, Day 2, Dr Du Toit-Prinsloo, pp.67-68 and Transcript, Day 3, Ms Shipstone, p.5. Ms Shipstone informed the Court that she had spoken with Professor Roger Byard and he is of the view that the case pathologist in a SUDI death should be a general forensic pathologist.
[156] Transcript, Day 2, Dr Du Toit-Prinsloo, p.68.
[157] Transcript, Day 1, Dr Irvine, p.61.
[158] Transcript, Day 2, Dr Du Toit-Prinsloo, p.69.
[159] Transcript, Day 2, Professor Woodford, p.10.

neuropathologist and radiology by forensic paediatric radiologists from the Children's Hospital.[160]

122. In NSW, Dr Irvine commented that although it was within the expertise of a forensic pathologist to review and provide an opinion on paediatric x-rays, it would be preferable for a paediatric radiologist to undertake this review but this was "simply not possible" in NSW.[161]

123. I accept the submission of Counsel Assisting that the limited resourcing of the Department of Forensic Medicine is the cause of ongoing significant delays in the completion of post-mortem reporting in the NSW coronial jurisdiction.

The potential for the implementation of doll re-enactments in SUDI investigations

124. The use of dolls in re-enacting the placement of an infant (in their cot or bassinette in the environment in which they died) as part of a SUDI investigation was discussed by the expert conclave. The method was endorsed by Ms Shipstone and Professor Jeffery and requires the use of specialists such as death scene investigators or forensic pathologists attending the scene of the death.[162]

125. However, this was not supported by a majority of the conclave. NSW Ministry of Health has indicated that such an endeavour is outside the scope of the current policy due to resources.[163] The Ambulance Service of NSW expressed concern that such an exercise can be re-traumatising for paramedics if they are required to be involved in a re-enactment.[164]

126. On behalf of NSW Police, Detective Superintendent Cook expressed significant reservations and concerns about doll re-enactments, in particular in relation to disturbance of the crime scene and in relation to the evidentiary implications of such re-enactments in a death that later turns out to have been a suspicious death.[165]

127. Dr Du Toit-Prinsloo gave evidence that such re-enactments are used in other jurisdictions (such as South Africa) but in circumstances where the jurisdiction and procedures are materially different from that of Australia and in any case, doll re-enactments only assist in determination of cause of death in a small percentage of sudden infant deaths. Moreover, the value of such re-

[160] Transcript, Day 2, Professor Woodford, pp.10-11.
[161] Transcript, Day 1, Dr Irvine, pp.50–51. This view was supported by Dr Du Toit-Prinsloo who stated that it is "really very difficult to get a paediatric radiologist to comment on a forensic CT scan."
[162] Transcript, Day 2, Ms Jeffery, p.28; and Transcript, Day 3, Ms Shipstone, pp.3-4.
[163] Transcript, Day 2, Ms Matha, p.24.
[164] Transcript, Day 2, Mr Loudfoot, p.24.
[165] Transcript, Day 2, Detective Superintendent Cook, pp.27-38.

enactments can be largely replicated by careful documentation of the scene of an infant death (including photographs and detailed descriptions by police).[166]

128. I accept the evidence of the majority of the conclave that the use of doll re-enactments in NSW is not necessary in the coronial jurisdiction, due to the requirement for further significant resourcing and the other matters raised, namely; the potential trauma to the family and paramedics in re-enactment, practical limitations due to the remote and regional location of many infant deaths and implications for police investigations.

A joint agency approach to SUDI investigation

129. In an effort to further improve the investigation of SUDI deaths in NSW, the conclave canvassed the viability of adopting a 'joint agency' approach to the investigation and management of SUDI deaths in NSW. That is, involving forensic pathologists, paediatricians or other death investigators in death scene investigations and conducting an interview with the family jointly with police and health professionals.

130. Dr Irvine gave evidence of the use of medical death investigators (particularly in North America) and considered they are appropriate and better trained than police in regard to infant death investigation.[167]

131. The conclave discussed the value of this approach against the need to conduct a death scene investigation within a reasonable time frame and given geographic considerations in NSW and other resourcing issues.[168]

132. NSW Police indicated that a joint agency approach in NSW would likely be prohibitively resource intensive.[169]

133. Ms Shipstone stated that whilst a joint agency approach such as that adopted in the United Kingdom may be considered to be 'optimal' this must not be simply 'overlaid' in Australia given the vast geographical differences and some cultural differences.[170]

134. For the reasons set out above, I do not consider that a joint agency approach to the management of SUDI deaths is currently viable or appropriate. Instead, as set out below, I accept the submissions of Counsel Assisting that a less

[166] Transcript, Day 2, Mr Loudfoot, Mr Matha, Dr Du Toit-Prinsloo, pp.28 – 32. Ms Shipstone also identified that in the event doll re-enactments are used, the dolls must be appropriately weighted and the enactment conducted in a very particular manner in order for the exercise to be useful for pathologists (see Transcript, Day 3, Ms Shipstone, p.3).
[167] Transcript, Day 1, Dr Irvine, p.58.
[168] Transcript, Day 2, Dr O'Meara, Professor Jeffrey, pp.75 – 76. Ms Jeffrey promoted the centralised model, as based on the model developed and implemented in the United Kingdom. However, Dr Du Toit-Prinsloo expressed particular concerns about the viability and appropriateness of a pathologist attending the scene of an infant death.
[169] Transcript, Day 2, Detective Superintendent Cook, p.78.
[170] Transcript, Day 3, Ms Shipstone, p.6.

resource-intensive approach, in the form of a new centralised contact point for the agencies involved in a SUDI death, ought to be implemented.

A centralised contact point for SUDI investigations in NSW

135. The investigation of SUDI deaths in NSW would greatly benefit from the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU). The CNC would be trained in SUDI investigations in order to provide resources, telephone support, advice and follow-up to police, ambulance and health professionals involved in the management of a SUDI death. This role would likely require two full time roles in order to provide a service 24 hours a day.

136. NSW Police supported the proposal, with Detective Superintendent Cook stating "if there is a paediatric specialist available 24/7 even if it's by telephone, police will take that opportunity to engage with them for advice and I think particularly in rural areas … that would be a massive advance forward in this type of investigation."[171]

137. Mr Loudfoot, on behalf of the Ambulance Service of NSW also supported the proposal.[172] He agreed that a centrally coordinated position available 24 hours a day would be "really valuable" in terms of getting a consistent approach from paramedics in dealing with a SUDI death (after resuscitation efforts have been exhausted).[173]

138. Dr O'Meara, Chief Paediatrician, agreed that the proposal has potential. He agreed that if the person in the central position had training in relation to SUDI investigations that they could add value both in the first few hours following the death of an infant and then thereafter in terms of coordinating the receipt of information as part of the SUDI investigation.[174]

139. Ms Shipstone's view was that it is an exceptionally good idea and has the potential to respond to some concerns ventilated in the evidence as to the limited experience of professionals in dealing with a SUDI death in the community.[175] Ms Shipstone suggested that it would be both useful and appropriate for a specialised central contact in NSW to be trained and available to respond to all accidental and non-intentional coronial child deaths in the state.[176] This would enable the role to be viable, resourced and available 24 hours a day.

140. The evidence supports the creation of two full time roles for a paediatric CNC, so as to provide a service 24 hours a day, where the roles would extend to:

[171] Transcript, Day 2, Detective Superintendent Cook, p.71.
[172] Transcript, Day 2, Mr Loudfoot, p.71.
[173] Transcript, Day 2, Mr Loudfoot, p.71.
[174] Transcript, Day 2, Dr O'Meara, p.72.
[175] Transcript, Day 3, Ms Shipstone, p.6.
[176] Transcript, Day 3, Ms Shipstone, p.7. Ms Shipstone stated that other such child deaths where agencies would benefit from such expertise include low speed run overs in driveways; child suicides; and drownings in dams or on residential properties.

a. following-up the SUDI medical history form from the hospital and ensuring it is provided to the case forensic pathologist in a timely manner;

b. following-up and liaison with the family (for example in relation to the timing of the autopsy report and expectations in relation to the coronial process);

c. being the point of liaison in relation to genetic testing undertaken by the family and ensuring that the results of any such genetic tests are provided to the case forensic pathologist (and can be taken into account in determining the cause of death of the child).

141. In my view the new role of a paediatric CNC could and should be extended to all accidental coronial child deaths in the state (i.e. not just SUDI deaths).

Recommendation: That the State Government give consideration to the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU) trained in SUDI investigations in order to provide centralised support available 24 hours a day to agencies in NSW investigating SUDI and accidental child deaths in NSW.

Closing remarks

142. I would like to thank the interested parties for their co-operation and the constructive approach they have taken in the lead up to and throughout this inquest. I thank my counsel assisting, Ms Kate Richardson SC and Ms Tracey Stevens and their instructing solicitor, Ms Clara Potocki from the NSW Crown Solicitor's Office. They approached this inquest with great compassion, thoughtfulness and intelligence.

143. Finally, I extend my sincere sympathy to the Ewin and O'Sullivan families for the loss of Kayla and Iziah in such tragic and unexpected circumstances. I also wish to acknowledge the gracious and generous manner in which the Ewin and the O'Sullivan families have approached and participated in the coronial process. Their contributions have been invaluable.

Findings required by s. 81(1)

144. As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the deaths occurred and make the following findings in relation to them.

145. **Inquest into the death of Kayla Ewin:**

The identity of the deceased

The person who died was Kayla Ewin.

Date of death

Kayla died on 23 December 2012.

Place of death

Kayla died at her home in Nowra, NSW.

Cause of death

Unascertained (SUDI 0+)

Manner of death

Sudden Unexpected Death in Infancy (SUDI) within the category SUDI 0+.

146. **Inquest into the death of Iziah O'Sullivan:**

The identity of the deceased

The person who died was Iziah O'Sullivan.

Date of death

Iziah died on 26 July 2014.

Place of death

Iziah died at his home in Quakers Hill, NSW.

Cause of death

Unascertained (SUDI 0)

Manner of death

Sudden Unexpected Death in Infancy (SUDI) within the category SUDI 0.

Recommendations

147. I make the following recommendations, pursuant to s. 82 of the Act:

To the Ambulance Service of NSW:

1. That the Ambulance Service of NSW consider amending its policies to instruct attending paramedics to take the aural temperature of a deceased infant under 12 months (and the time that it was taken) where clinically appropriate.

To NSW Police:

2. That NSW Police revise the 'SUDI' section of the Police Handbook to contain an instruction to police officers attending a scene or managing an investigation to assess whether it is preferable to use the term 'coronial scene' rather than 'crime scene' and in doing so, consider the impact of the use of the terminology on the family.

3. That NSW Police Forensic Evidence and Technical Services Branch and the Crime Scene Services Branch use the term 'coronial scene' rather than 'crime scene' in regard to infant deaths determined to be accidental.

4. That NSW Police revise the 'SUDI' section of the Police Handbook to explicitly state that the officer in charge of a SUDI investigation should minimise the police presence at both the scene and the hospital.

5. That NSW Police review its policies and training procedures in order to ensure that guidance is provided to officers in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.

6. That NSW Police consider amending the P79A form and the Standard Operating Procedures entitled "Crime Scene Manual (Specialist) – Death Investigation" and SUDI section 2.4.14 to include additional SUDI questions on the matters as set out in paragraph 90 of these Findings.

To NSW Health Pathology:

7. That NSW Department of Forensic Medicine review its policies to encourage forensic pathologists to routinely request, and then review, crime scene photographs prior to signing off an autopsy report.

8. That the Department of Forensic Medicine review its policies to ensure that the role of the CNC includes ensuring that the SUDI medical history form has been received and provided to the case forensic pathologist in a timely manner.

To NSW Ministry of Health:

9. That NSW Ministry of Health review its training policies to determine whether guidance is given to staff in dealing appropriately with a family seeking time to say goodbye to their child in the context of a SUDI death.

10. That NSW Ministry of Health implement their proposed audit of the revised SUDI medical history form over a period of 12 months and evaluate whether the form is being sufficiently completed and whether it is consistently being provided to the Department of Forensic Medicine in a timely manner.

11. That NSW Ministry of Health implement their proposal to monitor the issue of duplication in taking a medical history from the family of a deceased infant over the next 12 months in order to ascertain the most useful and sensitive approach.

To NSW Ministry of Health and NSW Police:

12. That NSW Ministry of Health and NSW Police implement the proposal for an interagency early clinical review meeting to take place within 1 week of every SUDI death in NSW, or as soon as practicable thereafter and no later than 1 month after the death, and evaluate the implementation of this proposal within 12 months from the date of its commencement.

To the State Government of NSW:

13. That the State Government give consideration to the creation of the role of a paediatric clinical nurse consultant (CNC) at the Coronial Case Management Unit (CCMU) trained in SUDI investigations in order to provide centralised support available 24 hours a day to agencies in NSW investigating SUDI and accidental child deaths in NSW.

I close this inquest.

Teresa O'Sullivan
NSW State Coroner
Lidcombe
29 November 2019

6.2 Medical History Guide – Sudden Unexpected Death in Infancy (SUDI)

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

The unexpected death of an infant is a tragedy for the parents/carers. Investigating infant deaths can be difficult as the situation is highly charged and emotional, and so it requires a unique and sensitive approach.

This guide includes high level of detail about the infant's health, the infant's family and events in the hours before the infant's death, including the infant's exact position and the parent/carer behaviour and use of alcohol or drugs. While these questions may feel intrusive, they relate to known risks for infant mortality, help determine why the infant died and can be asked in a sensitive way.

A detailed medical history will help the forensic pathologist determine a cause of death, including whether the infant may have suffocated, or died from an undiagnosed medical problem. The history is also important in determining the presence of risk factors for Sudden Infant Death Syndrome (SIDS) and any potential child protection concerns.

The following points may assist you with the discussion:

- Where possible, have another clinician, such as a social worker or nurse, with you during the discussion with the family to provide support. If you choose to include the Police as observers while you take the history, agree on roles before starting.
- To build trust with the parents/carers start with less sensitive questions including contact information, general family history, the mother's pregnancy and health, psychosocial aspects and the infant's health, before moving onto the events leading up to the infant's death.
- Use the infant's name whenever possible. The Medical History Guide – Sudden Unexpected Death in Infancy (Section 6.1) uses [infant's name] as a prompt.
- A suggested introduction is:

  'I am so sorry about your loss. Some people describe feeling that it is not quite real, like a nightmare. I would like to help make sense of what has happened. I would like to find out why [infant's name] died and help you understand why. To do that I would like to find out as much as possible about your pregnancy, [infant's name] general health and sleeping and feeding patterns. I also need to ask some questions about you and your health as it will help us understand why some young babies die suddenly. Please let me know if you are uncomfortable with any of these questions.'

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

1. Identification

Infant's name
Date of birth
Date of death
Sex M/F
Ethnicity/Aboriginal/Torres Strait Islander
Address
Postcode

Personal information

Name of mother (and address if different from infant)
Date of birth
Name of father (and address if different from infant)
Date of birth
Consanguinity (degree of relatives)

Healthcare providers

Name of doctor completing the medical history
Social worker
Hospital contact person
Other professionals
Interpreter present
GP name and address

Information retrieved from medical record

As relevant, hospital, GP, midwife, infant's personal health record ('Blue Book')
Ambulance staff
Include growth chart in copy of medical record

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

2. Details of transport of infant to hospital

Place of death, home address as above/another location (specify)
Time found
Time arrived in emergency department (triage time)
Resuscitation carried out
At scene of death – police/ambulance/emergency department/hospital
By who? Parents/carers/GP/ambulance paramedic/hospital staff/other (specify)
Confirmation of death
By who
Time and date
Location

3. Medical history

Taken to emergency department/hospital by
History given by
Relationship to infant

Family history

Details of family and household members, including names, dates of birth, health, any previous or current illnesses including mental health, medications, occupation
Maternal parity and obstetric history
Parental relationships
Children, including children by previous partner
Household composition
Any previous childhood deaths in the family

Social history

Type and nature of housing
Major life events
Wider family support networks
History of family involvement with Family and Community Services
Domestic and family violence
Smoking, alcohol use

Infant's medical history

Pregnancy and delivery, perinatal history, feeding, growth, behaviour and development
Health and any previous or current illnesses, hospital admissions, medications
Routine checks and immunisations
Body systems review

Detailed narrative account of last 24 – 48 hours

(To include details of all activities and carers during the last 24-48 hours)
Any alcohol, medication consumed by parents/carers
Any medication given to infant
Details of infant's last sleep, including where and how placed to sleep
Details of feeding and care given
Further details of previous 2-4 weeks, including infant's health, any changes to routine, when infant last seen by a health professional

Medical History Guide - Sudden Unexpected Death in Infancy (SUDI)

Events surrounding death

When infant was last seen alive and by who
Who found the infant, where and when, appearance when the infant found
Details of sleep environment, type of surface, mattress, bedding, objects, overwrapping or over-heating. Face or head covered. Co-sleeping. Alcohol or drugs consumed by carers.
Who called emergency services
Details of any resuscitation at home, by ambulance and in hospital
For accidental/traumatic deaths, details of circumstances around the death, witnesses

Any other relevant history

May vary according to the age of the infant, nature of the infant's death

Genetic or metabolic disease

For concerns about genetic or metabolic disease, contact the paediatric metabolic specialist for advice about investigations required
For concerns about a condition that may have implications for other family members, for example cardiac dysrhythmia, contact the relevant specialist for advice about investigations required

Child protection and wellbeing

If you have any concerns about non-accidental injury or neglect, follow usual child protection procedures

4. Conclusion

Cause of death

From this history do you have an impression of the possible cause of death?

REFERENCE: R48 SUDI MEDICAL HISTORY

The following checklist has been provided by the Department of Forensic Medicine (NSW Health Pathology). The information contained within the checklist is vital in the investigation of Sudden Unexplained Death in Infancy (SUDI) cases. The information provided by paramedics assists with a timely and thorough investigation which may lead to the determination of the cause of death and aid in bringing closure to families of SUDI cases.

Paramedics should attempt to obtain and document as much information from the checklist as possible in a caring/sensitive manner.

SUDI MEDICAL HISTORY

1) Who the history was taken from (e.g. mother, father, other person)
2) When the infant was put to bed (time and date) and the position of the infant (e.g. prone, supine, side and the position of the infants head (i.e. turned left/right/unknown)
3) When the infant was last seen alive (time and date) and the position of the infant (e.g. prone, supine, side and the position of the infants head (i.e. turned left/right/unknown)
4) Time and date of when the infant found, the position of the infant (including the position of the head) and the location of where the infant was found (e.g. cot, bassinette/cradle/adult bed/ basked/sofa/mattress on floor etc)
5) Was there any evidence of wedging (infant trapped between bed and hard surface)?
6) Was the infant alone or sharing a sleeping surface. If not alone who was sleeping with the infant (number of people, age, approximate weight)
7) What bedding was UNDER the infant (type and number) e.g. Cotton sheets, pillows, plastic sheet etc
8) What bedding was OVER the infant (type and number) e.g. Cotton sheets, pillows, plastic sheet etc
9) Other items found near infant's face, nose or mouth (e.g. bumper pads, infant pillows, stuffed animals etc)
10) What clothing/swaddling was the infant in?
11) Is there evidence of smoking in the room where the infant was found?
12) Was the room hot, cold, normal or other?
13) Was a dummy used or any other devices near the infant (e.g. humidifier, vaporizer, air purifier, heater etc)
14) Where there any body fluids on the infants face/bedding (e.g. vomitus, blood, mucous)?
15) When was the last feeding time, who fed the infant and how was the infant fed (e.g. bottle/ breast/other)?
16) What prompted the person finding the infant to check on them?
17) Who cared for the infant in the preceeding 12 hours prior to the infant being found?
18) What was the condition when the infant was found? (e.g. Discolorations of skin, secretions present at mouth/nostrils, warm/cold to touch)

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Office of the Secretary

Our reference: BN-02150-2020
Your reference: ADM/2019/716

Mr Michael Barnes
Convener, NSW Child Death Review Team
NSW Ombudsman

c/- Ms Pamela Rowley
Principal Investigation and Review Officer, NSW Ombudsman
By email: [redacted]

Dear Mr Barnes

Thank you for your letter dated 1 May 2020 requesting information from the Department of Customer Service (formerly the Department of Finance, Services and Innovation) about its progress implementing recommendations arising from the NSW Child Death Review Report 2015. I apologise for the delay in responding to you.

Please find attached a progress report regarding the status of the recommendation to publish certain data from the NSW Swimming Pool Register each year.

Should your staff have any queries, please encourage them to contact Mr Dominic Wong, Manager Strategy and Industry Education, NSW Fair Trading on [redacted] or by email to [redacted]

Yours sincerely

[redacted]

Emma Hogan
Secretary

Date: 26/06/20

Encl.

Recommendation in *NSW Child Death Review Report 2015* and subsequent request for update in 2018	**Department of Customer Service (DCS) response – June 2020**
Recommendation 10, 2015 report: Publish annual data from the Swimming Pool Register, including but not limited to: (a) The number of pools registered (b) The number of pools that have been inspected (c) The proportion of inspected pools that were noncompliant at the time of inspection (d) The main defects identified at the time of inspection (e) Whether or not owners have rectified defects within a reasonable period of time. **Subsequent (2018) request for update on recommendation 10:** Provide advice regarding enhancements or changes to the Swimming Pool Register, and any improvements to the public reporting of data from this register.	The 2017-18 and the 2018-19 Annual Reports for the Building Professionals Board within the Department of Finance, Services and Innovation (now DCS) published information regarding items (a), (b) and (c) – that is, the numbers of pools registered, inspected, and found compliant/non-compliant as at 1 July 2018 and 1 July 2019 respectively. Regarding (d), as noted in page 14 of the draft report, the Swimming Pool Register (the **Register**) now requires inspection details for certificates of non-compliance to be entered on the Swimming Pools Register. The details are part of information on an individual pool on the Register. This reflects a legislative amendment in the *Swimming Pools Regulation 2018*, which commenced on 1 September 2018. Regarding (e), the result of subsequent inspections following an assessment of non-compliance are also recorded for each registered pool. However, the Register cannot currently provide an amalgamated report on defects and the time taken for rectification of non-compliance. DCS's Better Regulation Division (**BRD**) is preparing to transition to a new whole-of-NSW Government Licensing System which will provide added functionality to support all BRD's public registers. This is a major transformation piece and any upgrades or changes to BRD's public registers (including the Register) will not be available until 2021. BRD is considering the ability to provide amalgamated reports on a range of matters as part of this larger departmental information technology transformation.

NSW GOVERNMENT | Transport for NSW

5/06/2020

Our Ref: A8884617

Mr Michael Barnes
NSW OMBUDSMAN
Convenor, NSW Child Death Review Team
Level 24, 580 George Street
Sydney NSW 2000

Dear Mr Barnes

Thank you for your correspondence about advice from Transport for NSW (TfNSW) in relation to the progress regarding a number of recommendations made by the NSW Child Death Review Team (CDRT) in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*.

We look forward to continuing to work with you on these important recommendations and have included our response to the schedule of recommendations made by the NSW Child Death Review Team.

If you have any further questions, Mr Melvin Eveleigh, Director Safer Systems, would be pleased to take your call on [redacted] I hope this has been of assistance.

Yours sincerely

[redacted]

Rodd Staples
Secretary

Encl

Transport for NSW
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Schedule: Requested information - Biennial report of the deaths of children in New South Wales: 2016 and 2017

Reference	Recommendation	Summary of advice to date and requested information for reporting progress to NSW Parliament	Updated advice in response to request
Page 22-23 CDRT Annual Report 2018-19	**Safer vehicle choices:** Given the link between fatal car crashes, age and socio-economic status, we recommended that: Transport for NSW (Centre for Road Safety) should include, as part of the *Safer Vehicle Choices Save Lives* campaign website, a page targeted at young drivers purchasing a new vehicle. This should detail the features and vehicles to consider when purchasing the safest car in a range of price brackets - similar to the *'how safe is your first car?* website (Victorian Transport Accident Commission). *(Recommendation 3, Biennial report of child deaths in 2016-17)*	In August 2019, Transport for NSW (TfNSW) advised it supported the recommendation. TfNSW noted that further work will be carried out to enhance the content on the Safer Vehicle Choices Save Lives campaign website during 2019. In this context, we are seeking information about steps taken to include a page targeted at young drivers purchasing a vehicle on the campaign website, including specific details of the enhanced information provided. We would also welcome any other information that you think is relevant.	TfNSW launched the Towards Zero website in 2018, which includes a page providing advice on purchasing new and used vehicles. Additional content aimed at younger drivers is being developed for publication om this page by 30 June 2020. In 2020, the Vehicle Standards Research Group (VSRG), which produces the Used Car Safety Rating (UCSR), and of which TfNSW is a member, was officially incorporated into ANCAP as a sub-council. ANCAP and VSRG are now working on updating the ANCAP ratings to provide a seamless end-user experience, where the UCSR will replace the ANCAP rating when appropriate. Once the criteria for transitioning between the ratings is finalised, the ANCAP website will become a one-stop shop for both ratings in a manner that allows for customers to search cars within their price range, similar to the 'how safe is your car website'. Due to the strong brand recognition and trust of ANCAP, we expect this move to enhance the reach of the UCSR.
Page 22-23 CDRT Annual Report 2018-19	**Child restraints and seatbelts:** In the context of the findings a 10- year review of the role of seatbelts and child restraints in the deaths of 66 child passengers aged 0-12 years in vehicle crashes, we recommended that: • Transport for NSW should undertake a study of child restraint practices in NSW. The study should have a particular focus on areas of socio-economic disadvantage and those outside major cities. • NSW Health and Transport for NSW should use their data linkage system for regular surveillance and monitoring of crash injuries and fatalities of children under the age of 13. • Transport for NSW (Centre for Road Safety) should actively promote information on best practice for restraining children over the age of seven years. Promotion activities should particularly target culturally and linguistically diverse {CALO) communities, Aboriginal and Torres Strait Islander communities, and areas of low socio-economic status. • Transport for NSW should fund a comprehensive and ongoing program to increase the correct and age-appropriate use of motor vehicle child restraints in NSW. The program should draw on the learnings of the Buckle-Up Safely program and incorporate a range of settings. It should provide education about safe travel for children, access to appropriate restraints (including subsidies for low-income families), and expert fitting of child restraints. (Recommendations 4, 5, 6 and 7, Biennial report of child deaths in 2016-17)	In August 2019, TfNSW advised it supported recommendations 4, 5, 6 and 7. TfNSW noted that work is already underway which support these recommendations. TfNSW noted: • NeuRA has been engaged to conduct a study to estimate child restraint practices in NSW across 10 selected Local Government Areas • TfNSW will regularly monitor serious injuries and fatalities of children 0-12 years in crashes on public roads • The Centre for Road Safety will look to further enhance educational engagement activities targeting children over the age of 7 years in the Aboriginal community, and will create tailored content to target Aboriginal and CALO audiences on Facebook (Response required from SCE team), and • TfNSW will encourage manufacturers to implement guidelines produced by a NeuRA study of child restraint use by providing a full five star rating in ease-of-use if they implement the guidelines in their products. Against this background, we are seeking more detailed information about actions taken (completed, underway, planned) to implement each of the four child restraint-related recommendations. In particular: • Progress made in the NeuRA study to estimate appropriate and correct use restraint practices among children 0-12 in NSW, along with any findings or outcomes so far • Details of surveillance undertaken by TfNSW since June 2019 of crash injuries and fatalities of children under 13 years, including information about any trends, findings or emerging patterns identified through this monitoring (Response required from Information team) • Details of activities undertaken by TfNSW since June 2019 to promote information on best practice for restraining children over the age of seven years, and specifically, any new content or activities undertaken to target CALO and Aboriginal communities, and families residing in areas of greater disadvantage (Response required from SCE team). • Information about programs in place or planned, that draw on the learnings of the Buckle-Up Safety program, including specific details of education provided about safe travel for children, access to appropriate restraints, and expert fitting of restraints; as well as strategies in place to ensure families are made aware of, and can access such programs - particularly low-income and other more vulnerable communities We would also welcome any other information that you think is relevant.	• NeuRA has completed the work to conduct a study to estimate child restraint practices in NSW across all metro and outer metro Local Government Areas and partially completed those in regional LGAs. The bush fires followed by Covid-19 have prevented the researchers from conducting surveys in the regional areas, but they will complete the surveys once travel restrictions are lifted. • Although the Centre for Road Safety does not routinely publish reports on child road trauma in NSW, there is regular monitoring of trauma levels across all ages and road user classes, including children. For child age trauma, largely among passengers and pedestrians, fatal and serious injury levels have continued to trend downwards. Child passenger fatality and serious injury trends are shown in Figures 1 and 2 (below this table). The fatality (Figure 3) and serious injury rates per head of population for children (under 5 years, 5 to 16 years) have also improved over the years and continue to remain lower than all other older age groups • TfNSW has engaged and trained 13 service providers to correctly fit child restraints. The Aboriginal Engagement team has developed plans to hold local community engagement events to train and fit restraints for Aboriginal Communities. The program has been placed on hold due to the current COVID environment, but service providers have been engaged and trained, and are ready for when restrictions ease. Community engagement events held prior to the restrictions include events at Grafton, Malabugilmah, Baryulgil, Iluka, and Bourke. • CRS has begun investigating the possibility to leverage the partnership with the Wiggles to create Aboriginal and CALD editions of the Be Safe & Buckle Up song. • CRS has developed a Facebook post to support the Child Restraint message within the Aboriginal Community and will be in market before the end of the financial year. • CRS has begun investigating the possibility to leverage the partnership with the Wiggles to create Aboriginal and CALD editions of the Be Safe & Buckle Up song. • Transport for NSW has put programs that draw on the learning of the Buckle-up safety program in line with the Authorised Restraint Fitting Station Scheme where families with children can utilise the scheme and have direct contact with experts of fitting restraints. Currently there are more than 300 fitting stations across the state. TfNSW has been promoting the scheme through its website along with Facebook post to increase the schemes utilisation. TfNSW has also had a stand at Royal Easter Show targeting families with children and provided opportunities to have direct contact with an expert. • TfNSW as the leading agency of the Child Restraint Evaluation Program has progressed the revision to CREP ease-of-use protocol to provide a full five star rating for products that have implemented NeuRA's guidelines. It is aimed that the revision will be completed in early 2021.

Page 23 CDRT Annual Report 2018-19	**Low speed run-over incidents:** In the context of our observation that there has been no real change in the number of children who have died in low speed vehicle run-over incidents over the past 15 years, we recommended that : Transport for NSW (Centre for Road Safety) should, in the context of the evaluation of 'They're counting on you', consider further action to prevent low speed vehicle run-over incidents through promoting good practice and carer education. (Recommendation 8, Biennial report of child deaths in 2016-17)	In August 2019, TfNSW advised it supported the recommendation. TfNSW noted it will enhance its educational activities to promote the prevention of low-speed vehicle run over crashes involving young children. TfNSW provided examples of several promotional resources that have already been developed to promote good practice and education for families. Against this background, we are seeking information about further action considered, taken and/or planned to prevent low speed vehicle run-over incidents. We would also welcome any other information that you think is relevant.	• Since 2017-18, the Georgina Josephine Foundation has been awarded five grants totalling $76,000 under the Community Road Safety Grants Program to help raise awareness of driveway safety across NSW. • In 2018 Transport for NSW delivered an awareness campaign on social media with the Georgina Josephine Foundation and TV personality Scott Cam to raise awareness of LSRVO crashes. • The campaign reached out to parents, grandparents and carers of young children up to age 5 as well as the broader NSW community. • The NSW Road Safety Facebook page has more than 200k followers, reaches an average of 1.2m people per week and has a very engaged audience with an average of 88k page engagements per week. A recent driveway safety post in April 2020 reached 314k people, had over 12k reactions and was shared over 3k times. Link: https://www.facebook.com/nswroadsafety/photos/a.932998143415088/2807281359320081/ • Driveway safety messages are shared through the NSW Road Safety Facebook page throughout the year, often during school holidays, and include content from The Wiggles as well as Scott Cam. • In April 2020, Transport for NSW partnered with the Georgina Josephine Foundation to assist them to launch their inaugural National Low Speed Vehicle Run Over Prevention Awareness Day. • Transport for NSW is currently developing a Driveway Safety Kit for use at community activations and events. The kit highlights the difficulty drivers have seeing small children, especially behind reversing vehicles. • CRS worked with the Department of Finance, Services and Innovation to update the Motor Vehicle Operational Guidelines. The Guidelines were updated in June 2019 to require all government fleet vehicles to have a range of safety features, including reverse collision avoidance systems, such as cameras and/or monitors. This will both increase the market demand for reverse safety features, providing greater incentive for car manufacturers to supply these features, and also the supply of vehicles fitted with such features to the second hand market, as government fleet vehicles are sold on.

Fig 1

Fig 2

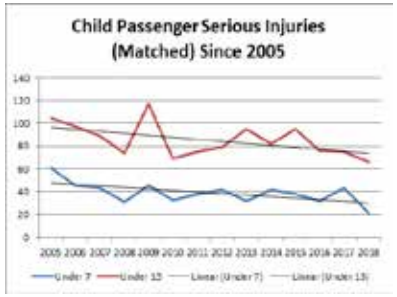
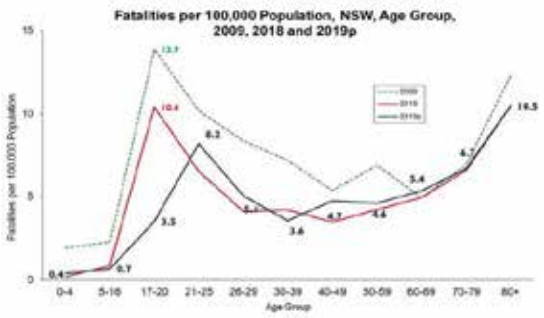


Fig 3



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Our reference: BN-01413-2020
Your reference: ADM/2019/716

Mr Michael Barnes
NSW Ombudsman
By email: [redacted]

Dear Mr Barnes

Thank you for your correspondence dated 1 May 2020 about the NSW Child Death Review Team (**CDRT**) and seeking advice from the Department of Customer Service about the progress of a recommendation made by the CDRT to SafeWork NSW in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017* (the **Report**).

The NSW Quad Bike Safety Improvement Program (**Program**), which was launched in 2016, offers direct support to farmers through a safety rebate and training package to reduce the unacceptable rates of death and serious injuries associated with the use of quad bikes on-farm.

The Program, in collaboration with relevant NSW government agencies, employer associations, unions and broader agriculture industry, has implemented a range of strategies to raise awareness of the dangers of children using adult-sized quad bikes in the farming community, including a safety campaign featuring a confronting child safety story and key messaging 'quad bikes are not toys' (released in 2017).

In April 2020 SafeWork launched its latest child safety campaign consisting of print, radio and digital regional advertising. The safety campaign featured a key message 'It's not worth your child's life. Just say no to them riding adult quad bikes'. The campaign is scheduled to run through to June 2020 and is supported by key social partners and their networks.

A virtual online farm safety day is also under development and will be available to the farming community from June 2020. The educational experience will include child safety with a focus on keeping children under 16 off adult-sized quad bikes.

The Program will continue to promote child safety messages through social channels supported by social partners, and at agricultural field days and farm safety days once re-established following easing of COVID-19-related restrictions.

Should you have any queries, please contact Diane Vaughan, Principal Project Manager, SafeWork NSW on [redacted] or by email to [redacted]

Yours sincerely

[redacted]

Rose Webb
Deputy Secretary
Better Regulation Division

Date: 01/06/20

Premier & Cabinet

Ref:A3592936

Mr Michael Barnes
Convenor, NSW Child Death Review Team
NSW Ombudsman
Level 24, 580 George Street
SYDNEY NSW 2000

Dear Mr Barnes

Thank you for your letter of 1 May 2020 regarding two recommendations made by the Child Death Review Team in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*.

Please find attached the NSW Government response on these recommendations outlining the progress made since the last report back.

I trust this information is useful and note your intention to publish this correspondence in full in your annual report.

Yours sincerely

Tim Reardon
Secretary

16 June 2020

CC: Mark Scott AO, Secretary, NSW Department of Education
Elizabeth Koff, Secretary, NSW Health

52 Martin Place, Sydney NSW 2000 ■ GPO Box 5341, SYDNEY NSW 2001
Tel: (02) 9228 5555 ■ www.dpc.nsw.gov.au

Recommendation 10: 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. universal strategies that promote wellbeing in children

b. early intervention designed to arrest emerging problems

c. the provision of targeted, sustained and intensive therapeutic support to young people at high risk – include strategies for reach those who are hard to engage.

Response

The NSW Government is currently considering how best to act in the context of the *Strategic Framework for Suicide Prevention in NSW 2018-23*. The Framework remains the key policy guidance for suicide prevention in the state and identifies 22 actions that are necessary and will contribute to the Towards Zero Suicides Premier's Priority to reduce the rate of suicide deaths by 20 per cent by 2023.

These actions will target children and young people including a local suicide alert system where information is quickly shared between programs and services about people at risk of suicide so they can respond appropriately and expanding aftercare services including piloting a Youth Aftercare service. More detail about this pilot service is in the response to recommendation 11.

It will also be important to focus on the implementation of the large-scale service system being delivered through the Towards Zero Suicides initiatives and the rapid implementation of additional activities developed under the Premier's Priority, all of which will benefit children and young people.

Apart from this work in developing the plan through the Mental Health Taskforce mechanism, the NSW Government continues to contribute to the wellbeing of children and young people, including through a range of initiatives – these are outlined in **Appendix 1**.

Recommendation 11: The NSW Government should direct funds association with the Strategic Framework for Suicide Prevention in NSW 2018-2023 to address gaps in the delivery of appropriate specialist mental health services for children and young people in NSW.

Response: The Premier announced $87 million in new funds to support implementation of priority initiatives under the Framework with its launch in October 2018. This was further strengthened in July 2019 by the Premier's commitment to reduce the suicide rate by 20 per cent by 2023 as part of the Premier's Priority. These funds have already been allocated to 9 of the Towards Zero Suicides initiatives, all of which have relevance for children and young people.

In particular, initiatives focused on expanding coverage of suicide attempt aftercare services, providing new suicide prevention outreach teams, and establishing new services that provide alternatives to presenting to an emergency department for people in crisis will contribute to addressing gaps in specialist mental health services for children and young people. The implementation of these initiatives began this financial year, although the COVID-19 pandemic has delayed some further implementation.

The NSW Government will also be undertaking the Youth Aftercare Pilot which is funded for $4.2 million over three years, which will be trialling new models of suicide attempt aftercare services for young people in at least two locations in NSW. The models will be co-designed with young people and their carers. The anticipated sites will be in one metropolitan and one rural area. This initiative is funded through the Commonwealth Health Innovation Fund, and an open tender process is currently being undertaken with service delivery to begin in June.

Appendix 1 – recommendation 10 initiatives

Universal strategies that promote wellbeing in children		
Cluster	**Initiative**	**Detail**
Education	**School Excellence Framework**	This supports schools to engage their communities in the development of a shared vision identifying strategic priorities and tracking ongoing progress.
Education	**Wellbeing Framework for Schools**	This is an important tool to support schools in implementing the School Excellence Framework. The Wellbeing Framework for Schools supports students to connect, succeed and thrive at each stage of their development and learning. All schools are required to have a planned approach to support the wellbeing of all students.
Education	**NSW Anti-Bullying Strategy**	This includes the NSW anti-bullying website that brings together evidence-based resources and information for schools, parents and carers, and students. The Strategy also provides a range of professional development initiatives to build the capacity of teachers and other school staff to prevent and respond to bullying behaviours
Education	**Teaching and learning**	Teaching and learning is related to mental health for all students from Kindergarten to Year 10 is included in the mandatory Personal Development, Health and Physical Education (PDHPE) curriculum. It is provided within the broader context of personal health choices, self and relationships and individual and community health.
Education	**Smiling Mind schools program**	The Smiling Mind program provides training to teachers who then work through their school to help all staff run mindfulness sessions. This program is being delivered in 400 public primary schools across NSW in 2019 and 2020. This will provide mindfulness training to about 100,000 students. Mindfulness helps support emotional awareness and self-regulation skills.
Education	**Youth Aware of Mental Health (YAM)**	YAM is a universal mental health program and suicide prevention program for young people aged 14 – 16 years. YAM has been delivered to over 14,000 Year 9 and 10 students in 90 high schools since 2017. In NSW public schools, YAM implementation is led by 16 Head Teacher Student Wellbeing Initiatives in a partnership with the Black Dog Institute. Preliminary findings from research by Black Dog Institute in NSW have shown that students participating in YAM report lower levels of depression and suicidal ideation up to six months after completing the program. They also report greater intentions to seek help for a personal or emotional problem up to six months after completing YAM.
Education	**batyr@school programs**	These programs are group preventative mental health programs for high school students in years 9 to 12, which are delivered by trained facilitators. Australian research in 2017 found batyr@school reduced stigma associated with mental ill health and improved attitudes and intentions towards seeking help from professional sources for mental health issues and suicidal thoughts.

Early intervention designed to arrest emerging problems		
Cluster(s)	**Initiative**	**Detail**
Education	**Additional $88.4 million over four years to support the mental health and wellbeing of NSW public school students**	This will allow the NSW Department of Education to: • Expand the school counselling service by employing up to 100 additional school counselling staff • Employ 350 additional student support officers • Provide dedicated services for rural and remote students • Partner with leading mental health organisations

Education	**Schools and Families Enhancing Minds (SAFEMinds)**	The NSW Department of Education has partnered with headspace, the National Youth Mental Health Foundation to deliver *SAFEMinds* to primary and high school staff. Face to face and online training, resources and tools, based on the latest research will enhance the capacity of schools to support the mental health and wellbeing of students. This training aims to enhance early intervention mental health support for children and young people in schools, specifically targeting mild mood disorders and self-harm.
Education	**Wellbeing and Health In-reach Nurse Coordinator Model**	The Wellbeing and Health In-reach Nurse Coordinator Model is a partnership between NSW Health and the Department of Education. The Wellbeing and Health In-reach Nurse works with primary and secondary schools in regional and rural NSW (Young, Tumut and Cooma and Deniliquin, Murwillumbah and Lithgow) to improve early identification of health and social concerns for vulnerable school students and their families and facilitate their access to health care.
Education and Health	**Getting on Track in Time - *Got It!***	Getting on Track in Time - *Got It!* is an early intervention program, delivered by Child and Adolescent Mental Health (CAMHS) clinicians in collaboration with schools. It is a specialised mental health early intervention program for children in Kindergarten to Years 2 who display emerging conduct problems such as defiant, aggressive and disruptive behaviours. Sixteen teams (thirteen additional teams since 2016) operate across the state. There are also modified pilots to address the particular issues in Department of Justice, a virtual model for remote communities and a culturally informed pilot for Aboriginal families.
Education and Health	**Project Air Strategy for Schools**	Project Air Strategy for Schools is a train-the-trainer model for school counselling staff to provide registered professional learning for school staff and skills-based training workshops and clinical resources for NSW school counselling staff and CAMHS mental health staff. Project Air Strategy is targeted at providing schools with professional learning and resources to better recognise and respond to young people with complex mental health problems.
Education and Health	**School Link Program**	A Memorandum of Understanding between the NSW Department of Education and the NSW Ministry of Health provides a framework for a collaborative approach to improving the mental health of children and young people through School-Link. The Program supports more than 21 positions (six additional positions since 2016) to ensure: • the early identification of mental health issues for children and young people, • the provision of evidence based early intervention programs in schools • early access to specialist mental health services and support for recovery.
Health	**Suicide Prevention Gatekeeper Training**	Funded for $2.35 million over three years to train key community members in suicide awareness and prevention skills, has funded 8 organisations including Northern Beaches Council and Twenty10 who will be working with young people in the Northern Beaches and LGBT young people.
Health	**Suicide prevention fund for community managed organisations**	The NSW Government has invested $8 million over four years from 2016-17 to establish a new Suicide prevention fund to support people at risk of suicide across NSW consistent with Lifespan's 'system approach'. Eight organisations were funded including: Community Activities Lake Macquarie; Compass Housing; Coomealla; Grand Pacific Health; ACON; and Hunter Primary Care.
Health	**Funding for Lifeline and the Kids Helpline**	• An additional $23.5 million over four years from 2019-20 to expand capacity at Lifeline and Kids Helpline to provide information and counselling to people distressed and in crisis, including new online services targeting young people.

Provision of targeted, sustained and intensive therapeutic support to young people at high risk including strategies to reach those who are hard to engage		
Cluster(s)	**Initiative**	**Detail**
Education	**Youth in Distress: Managing Suicidality and Self-Harm**	The Department of Education engaged the Black Dog Institute to customise its existing accredited Advanced Training in Suicide Prevention workshop for the school context. During 2018 and 2019, 1,196 school counselling staff received this training. Evaluation results showed positive measurable effects for improving school counselling knowledge and confidence in managing suicidality and self-harm that were sustained over time.
Education	**Responding to anxiety and depression: Resource toolkit for the school counselling service**	In collaboration with the Black Dog Institute, a series of professional learning webinars have been developed to introduce a new resource, *Responding to anxiety and depression: Resource toolkit for the school counselling service*. The training and evidence-based resource kit will assist in intervening with individual students presenting with anxiety, depression and emotional distress, at risk groups as well as developing an action plan to apply resources to support the broader school community.
Education	**Refugee Student Counselling Support Team**	In 2016, a team of school counselling staff was established to provide comprehensive support for refugee students and their families. This team works across NSW public schools facilitating professional learning for school staff to enhance support for refugee students, working alongside local school counselling staff to develop effective, evidence-based interventions and strategies, and assist develop local partnerships to coordinate support for families. Between 2016 and Term 1 2020, the team provided specialist psychological support to 266 metropolitan and 63 regional schools.
Education	**Networked Specialist Facilitators**	When a student's needs reach a level of complexity that requires additional case coordination or integrated service delivery, the networked specialist facilitator is available to add an additional level of expertise to support the work of schools and specialist support staff in addressing complex learning, mental health and wellbeing needs. The 22 network specialist centre facilitators' role is to: build systemic interagency relationships with other government and non-government agencies to establish and maintain a sustainable network of specialist support services; lead complex case coordination; and facilitate and support cross-agency initiatives and local solutions identified by a group of schools that address the complex needs of students.
Education	**Home School Liaison Program**	In 2019, the NSW Government invested $14.5 million in the Home School Liaison Program. Through this program, Home School Liaison Officers and Aboriginal Student Liaison Officers work alongside government schools, students and their families to address attendance concerns and reengage students with their education.
Health, Communities and Justice	**Alternate Care clinic (Western Sydney LHD)** **Out-of-Home-Care assertive outreach services (SWS LHD)** **ELVER Service**	Trauma services targeting children and young people and vulnerable children with complex needs who are, or are at risk of, entering the child protection system or Out-of-Home Care is highly relevant.

NSW GOVERNMENT | Education

Mr Michael Barnes
NSW Ombudsman
Convenor, NSW Child Death Review Team
Level 24, 580 George Street
SYDNEY NSW 2000

DGL20/277

Dear Mr Barnes

Thank you for your letter of 1 May 2020, to Mr Mark Scott AO, Secretary, Department of Education, regarding the Department's progress in implementing two recommendations included in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*. The Secretary has asked me to respond on his behalf.

Information regarding the progress the Department has made in relation to the two recommendations is attached. Following a procurement process, the Department has engaged Orygen who is partnering with Everymind to evaluate the effectiveness of postvention initiatives in NSW high schools.

Suicide prevention and postvention is a high priority for the Department. The NSW Government has invested more than $290 million since 2015-2016 to support the wellbeing and mental health of students.

In 2019, an additional $88 million has been allocated over four years to provide every public high school with two dedicated mental health professionals so that students have access to vital mental health and wellbeing support.

The Department continues to work with other government agencies and leading mental health organisations including NSW Health, headspace and Black Dog Institute to support public schools in delivering best practice suicide prevention.

Yours sincerely

[redacted]

Ben Ballard
R/Executive Director, Learning and Wellbeing
4 June 2020

NSW Department of Education
105 Phillip Street Parramatta NSW 2150 GPO Box 33 Sydney NSW 2001 1300 679 332 education.nsw.gov.au

Department of Education progress in response to the NSW CDRT *Biennial report of the deaths of children in New South Wales: 2016 and 2017*

Report Recommendations	Progress Report
Chapter 11 Section 11.6.3 The NSW Department of Education should evaluate postvention initiatives in NSW government high schools, particularly the effectiveness of such initiatives in preventing suicide clusters.	The Department has engaged Orygen who is partnering with Everymind to evaluate the effectiveness of postvention initiatives in NSW government high schools, particularly the effectiveness of such initiatives in preventing suicide clusters. The evaluation will be conducted between April 2020 and March 2021. The Evaluation Framework includes: • Literature review outlining evidence based suicide prevention and postvention approaches in schools that have been shown to be most effective • Benchmarking the Department's *Response to Student Suicide – Support Guidelines for Schools* against postvention best practice • Mapping postvention activities, programs, and staff training, including prevention and cluster response activities in NSW high schools • Consultations with key stakeholders involved in postvention/cluster response activities and analysis of relevant data
Chapter 11 Section 11.6.4 The NSW Department of Education should establish a process of review after the suicide death of a child or young person in a public school. The process should involve considering, with the local school and district, the involvement of the school with the young person and their family – particularly in terms of identifying and responding to mental health or suicidal risk behaviours. Outcomes of the reviews should inform future practice and policy.	The Department has engaged Orygen to conduct a review of the literature to identify the best available evidence regarding establishing a review process following a suicide death. The Department of Education will use the information obtained from this review to establish an appraisal process.

NSW Department of Education
105 Phillip Street Parramatta NSW 2150 GPO Box 33 Sydney NSW 2001 1300 679 332 education.nsw.gov.au

Catholic Schools NSW

Catholic Schools NSW Submission

NSW Ombudsman Review of Suicide Based Prevention Strategies

June 2020

Background

The NSW Child Death Review Team (CDRT) reviews the deaths of children in NSW. The purpose of the CDRT is to prevent and reduce child deaths. In June 2019, the NSW Ombudsman, as the CDRT Convenor, undertook a review of suicide clusters and evidence-based prevention strategies for school aged children.

The following document has been prepared by Catholic Schools New South Wales (CSNSW) at the request of the NSW Ombudsman. It provides a high-level overview of current policy frameworks, guidelines and practices employed by the Catholic school sector in response to the recommendations of the 2019 Review and an introductory comment on the Catholic School Counsellor Service.

A Focus on Student Wellbeing

Student wellbeing (and pastoral care) is considered to be a cornerstone of Catholic education. Recognising the strong link between wellbeing and learning, Catholic schools aim to authentically integrate wellbeing into each student's academic program. Value is placed upon the growth and development of the spiritual, emotional, social, physical and academic domains. Experiencing positive relationships, developing autonomy and creating a sense of purpose are important components of wellbeing. Catholic schools use whole school and system wide approaches to support all students and targeted intervention strategies to assist those identified as vulnerable.

Wellbeing in the Curriculum and School Programs

As provider of schooling from the early years through to Year 12, Catholic education has a range of initiatives in place that bridge the learning continuum.

The Early Years Framework is seen as an essential foundation upon which all children can experience quality learning that is engaging and builds success for life[1]. It supports an integrated approach to education and care where parents are encouraged to act as collaborators in their child's academic, social and emotional learning. Catholic prior to school services such as pre-schools and long day care centre implement the Early Years Framework. CSNSW also has a sector-wide policy network focussed on sharing practice and building capacity around learning in the early years, including the roll-out of the Australian Early Development Census (AEDC)[2]. CSNSW has also designed a Foundations for Learning in the Early Years resource which provides teachers and families with strategies and

[1] The Early Years Framework (2017) Australian Government Dept Education, Skills and Employment https://www.education.gov.au/early-years-learning-framework-0)

[2] The AEDC is a nationwide data collection of early childhood development at the time children commence their first year of full-time school. The AEDC highlights what is working well and what needs to be improved or developed to support children and their families by providing evidence to support health, education and community policy and planning. The Instrument collects data relating to five key areas of early childhood development referred to as 'domains', these include:

- Physical health and well being
- Social competence
- Emotional maturity
- Language and cognitive skills (school-based)
- Communication skills and general knowledge

The AEDC domains have been shown to predict later health, wellbeing and academic success.

resources to support the development of early literacy and numeracy skills and will include a component on wellbeing for learning.

Once a child transitions to school, social skills, resilience and anti-bullying programs supplement the curriculum (particularly the PDHPE curriculum) across all stages of learning in order to support prosocial behaviours and exert protective effects for the mental health of students, including reducing the risk of suicide.

From Kindergarten to Year 12 different evidence-based, developmentally appropriate, programs and practices are embedded into the learning program. Some examples include The Friends program, The Resilience Donut, Peer Support, mindfulness activities, Restorative Justice, e-safety, Bullying. No-Way.

Particular emphasis is placed on anti-bullying programs due to the association between bullying and depression[3]. All Catholic schools have anti-bullying, child protection and student management policies and guidelines which promote student mental health and wellbeing and healthy behaviours. These are publicly available on school websites. They are further supported by frameworks such as Positive Behaviour for Learning (PBL), Be You (formerly KidsMatter & MindMatters) and the Australian Student Wellbeing Framework. Programs are implemented and evaluated to enhance student support and reduce the risk factors associated with mental health, behavioural issues and suicide. Student Wellbeing and Pastoral Care Policies also support wellbeing practices and strengthen community-wide connections. Example: https://sydcatholicschools.nsw.edu.au/policies/student-wellbeing-and-pastoral-care-policy.

Strengthening community-wide connections to support suicide prevention

Knowing your learner is recognised as being an important factor in engaging a young person in learning and in developing protective relationships that help to reduce the risk factors of suicide.

From Kindergarten the AEDC data is used, alongside other data such as Best Start Kindergarten[4], to gain a general understanding of a cohort and to identify strengths and vulnerabilities of individuals and the group. This enables school staff to facilitate holistic peer group programs to address any potential social and emotional issues and to provide proactive individual support plans in a timely and purposeful fashion. These types of assessments and data offer a starting point to develop a shared vision for children's wellbeing and development. Various forms of assessment continue as students progress through their education with staff, student and parent surveys providing feedback on student engagement and wellbeing. Examples include: Tell Them From Me, Your School Wellbeing Check (Student Wellbeing Hub), Behaviour Emotions Thoughts Learning & Social Relationships (BELTS) Observation Tool.

Where students are identified as vulnerable and/or at risk more targeted interventions are employed which may include individual assessment, learning plans and/or referral to the school counsellor service.

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[3] Hertz, M, Donato, I, Wright, J (2013) Bullying and Suicide: A Public Health Approach. Journal of adolescent Health Vol 53. Issue 1, https://www.jahonline.org/article/S1054-139X%2813%2900270-X/fulltext.

[4] https://education.nsw.gov.au/literacy-and-numeracy-strategy/primary-school-initiatives/best-start-kindergarten#:~:text=Best%20Start%20Kindergarten%20is%20an,student's%20literacy%20and%20numeracy%20knowledge.

The School Counsellor service

Catholic schools provide a school counsellor service (free of charge) which offers mental health assessments and short - medium term counselling intervention for students K-12.

School counsellors are mental health clinicians (social workers and psychologists) who specialise in working with children and young people. They provide consultation to teachers and parents (regarding diagnostic and treatment options) and work with external agencies to support students with complex mental health needs that require more specialist interventions.

For students from K-Year 6, the school counsellor interviews parents prior to working with a student in order to ensure they obtain an appropriate developmental history of the student and gain an understanding of the family dynamics (including family history of mental health problems, history of loss, trauma, grief, family cohesion, changes to family living arrangements etc). This is in line with current best practice which identifies complex family issues as being a risk factor in youth suicide.

For students in Years 7-12, more autonomy exists when accessing school counsellor services. Consequently, in addition to assessing a student's mental health needs, counsellors are well placed to effectively help students address suicidal tendencies, by supporting them to develop healthy coping strategies and referring them to specialists for further assessment and intervention. They often serve as advocates for the young person when negotiating adjustments to the curriculum and they can offer psycho-education to staff and parents and assist in developing appropriate school safety plans. All these factors help mitigate the risk of suicide.

Developing local partnerships

CSNSW recognises that 1 in 7 young people between the ages of 4-17 years has a mental health disorder and that suicide is the leading cause of death in this age group[5]. As a result, CSNSW supports Catholic school systems and schools to develop local partnerships with government and non-government agencies, including the NSW Department of Education, NSW Health, HeadSpace School Support, the BlackDog Institute. Representatives from the Catholic education sector sit on local School Link Committees to discuss mental health needs and trends in their communities. They work collaboratively to develop interagency guidelines to assist young people to seek appropriate support and to remain at school, where possible. Most Catholic dioceses have a Head of school Counselling who is a mental health clinician. They work with local health units (eg CAMHS) to assist in transitioning students back to school after mental health admissions and use a case management approach to care to ensure the young person is supported by relevant professionals inside and outside the school. In situations where a suicide occurs these teams work together - notifying each other of all relevant known facts (without breaching confidentiality), identifying other vulnerable at risk students and integrating service provision where possible.

[5] The Mental Health of Children and Adolescents. Report on the Second Australian Child & Adolescent Survey on Mental Health & Wellbeing. (2015) https://www1.health.gov.au/internet/main/publishing.nsf/Content/9DA8CA21306FE6EDCA257E2700016945/$File/child2.pdf

Since 2015 Catholic school systems and schools have developed specific guidelines for supporting students with complex mental health issues, including suicidal ideation. Recognising the vulnerabilities of this group, guidelines focus on increasing help-seeking and partnering with schools and external providers to ensure mental health issues are not dealt with in the same manner as more general behavioural problems.

A case management approach in line with best practice guidelines forms the basis of this practice. Example: https://sydcatholicschools.nsw.edu.au/policies/supporting-students-with-complex-social-and-emotional-needs-policy

Professional Learning

Recognising the increasing need for all staff to be aware of the mental health needs of young people, Catholic schools offer professional learning seminars for school staff to assist them to prevent and respond to youth mental health issues, including suicide. This professional learning also includes how to implement relevant guidelines and practices. Some examples of these professional learning courses include:

- Youth Mental Health First Aid (2 day NESA accredited course outlining the most common mental health issues in children and young people, including suicidal ideation and with a framework for response);
- School Safety, Self Harm and the Duty of Care (1 day course on the legal obligation to provide a safe & supportive environment and how to risk assess self harm);
- Non-Suicidal Self Injury (half day course to equip staff with knowledge on self harm, and suicidal ideation);
- Alex Wildman: Lessons for Schools from the Coronial Enquiry (reinforcing duty of care, proactive and reactive intervention strategies);
- Postvention (responding to youth suicide);
- Teen Mental Health First Aid (staff supported peer program);
- ReachOut - supporting a young person in crisis.

Other bespoke courses are developed for staff and students that focus on mental health literacy, knowledge of suicide warning signs and help strategies. In 2019/20 many Catholic dioceses are in partnership with Black Dog who are providing customised training for Youth In Distress: Managing suicidality and self harm and/or Advanced Training in Suicide Prevention.

Professional learning often focuses on suicide prevention and upskilling school staff to recognise when a young person requires professional assistance so they can refer them for appropriate support and follow-up (intervention). Postvention training for school staff is generally provided by HeadSpace School Support and complements general critical incident management training. The Suicide Postvention Toolkit is commonly used in secondary schools as a guide for postvention.

School counsellors are also trained in crisis management which includes guidelines for identifying and managing other vulnerable students who may be at risk of suicide; debriefing staff and student cohorts. School chaplains and other religious personnel may also offer support to affected school communities.

Conclusion

The above-mentioned practices are evidence-based strategies used for suicide prevention in Catholic schools. Curriculum resources, pastoral care and wellbeing initiatives also exist to enhance the engagement and wellbeing of students.

CSNSW recognises the efficacy of facilitating system-wide, multidisciplinary initiatives to support suicide prevention, intervention and postvention and enhance student safety and wellbeing. Specialist inter-diocesan networks exist to support diocese and schools to develop clear policies and programs that educate students and staff, build positive school climates, monitor mental health trends and engage families and communities. Currently, professional networks exist in the following areas: Child Protection, Mental Health, Behaviour and Wellbeing, Student Attendance.

CSNSW acknowledges the support of government and non-government agencies in assisting to provide an effective case management response to supporting young people with complex mental health issues, including suicidal ideation.

CSNSW would be pleased to provide further information, including case-studies, as appropriate.

empowering independent education

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Your reference: ADM/2019/716

5 June 2020

Mr Michael Barnes
NSW Ombudsman
Convenor, NSW Child Death Review Team
Level 24, 580 George Street
SYDNEY NSW 2000

Sent by email [redacted]

SUBJECT: AISNSW progress update – Recommendation 14, Biennial report *of the deaths of children in New South Wales: 2016 and 2017*

Dear Mr Barnes

Thank you for your letter of 1 May 2020 seeking advice from the Association of Independent Schools of NSW (AISNSW) on progress regarding recommendation 14 in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017:*

> The Association of Independent Schools of NSW should work with and assist member schools to examine the adequacy of suicide prevention, postvention and mental health and wellbeing programs currently provided to students in NSW Independent Schools.

AISNSW provides both proactive and responsive support for schools coordinated across a network of consultants with expertise in wellbeing, child protection and mental health. These consultants work collaboratively with schools in response to any vulnerable or at risks students, as well in the promotion of positive, whole school approaches to wellbeing.

In implementing the recommendation, AISNSW has strengthened the support provided to assist schools develop and review their strategies by providing consultancy support targeted to individual student needs and school contexts and supplementing existing professional learning with new, carefully targeted initiatives.

Recognising the increasing need in mental health, particularly suicide prevention and suicide postvention, AISNSW has employed two registered psychologists. Schools have welcomed the support of these psychologists who are able to target complex mental health queries more specifically. AISNSW continues to work closely with and promote the services of Headspace to ensure schools have specialist support and guidance when responding to a suicide within their community. This includes liaising with headspace regarding notifications of student deaths by suicide and linking the school with headspace to access specialised clinicians. AISNSW also promotes the use of resources and services as provided through the Be You initiative.

AISNSW assists schools implement evidence-based strategies and practices to address suicide prevention, postvention and mental health and wellbeing and to assess how available programs, activities, services and resources can be best utilised in individual school contexts. To assist schools assess the need for, and quality of, external providers in the areas of suicide prevention, postvention, mental health and wellbeing, AISNSW has enhanced guidance for schools in the selection of external providers of activities or programs. Schools have reported that this guidance

has helped them to better assess the quality of a provider/program and engage the most appropriate one to meet the needs of the school and its students.

Targeted professional learning is also offered to schools where teams can unpack the resources available in an external program and develop implementation plans for their use in school programs. This process involves supporting schools to critically analyse the content and make informed decisions about the usefulness of the content for their own school. In addition, schools have access to an AISNSW whole-school review process to evaluate their wellbeing practices, including their approaches to student suicide prevention and mental health.

To further support school staff build their knowledge and capacity in student mental health needs, AISNSW is currently developing three online learning modules that specifically address mental health and suicide prevention strategies for schools, including how to identify the warning signs of a young person at risk and understanding the appropriate planning, supports and adjustments that they may require. The modules are designed to assist schools respond in a collaborative and supportive manner across all three tiers – individual support, small groups and whole school. Additional online modules and professional learning opportunities on student wellbeing will provide schools with broader training and support staff to identify and understand the needs of students who may be vulnerable and require mental health support, while also working towards incorporating best practice whole-school approaches to wellbeing.

AISNSW remains committed to assisting member schools examine suicide prevention, postvention and mental health and wellbeing programs provided to students in NSW independent schools.

Yours sincerely

[redacted]

Dr Geoff Newcombe AM

Chief Executive

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