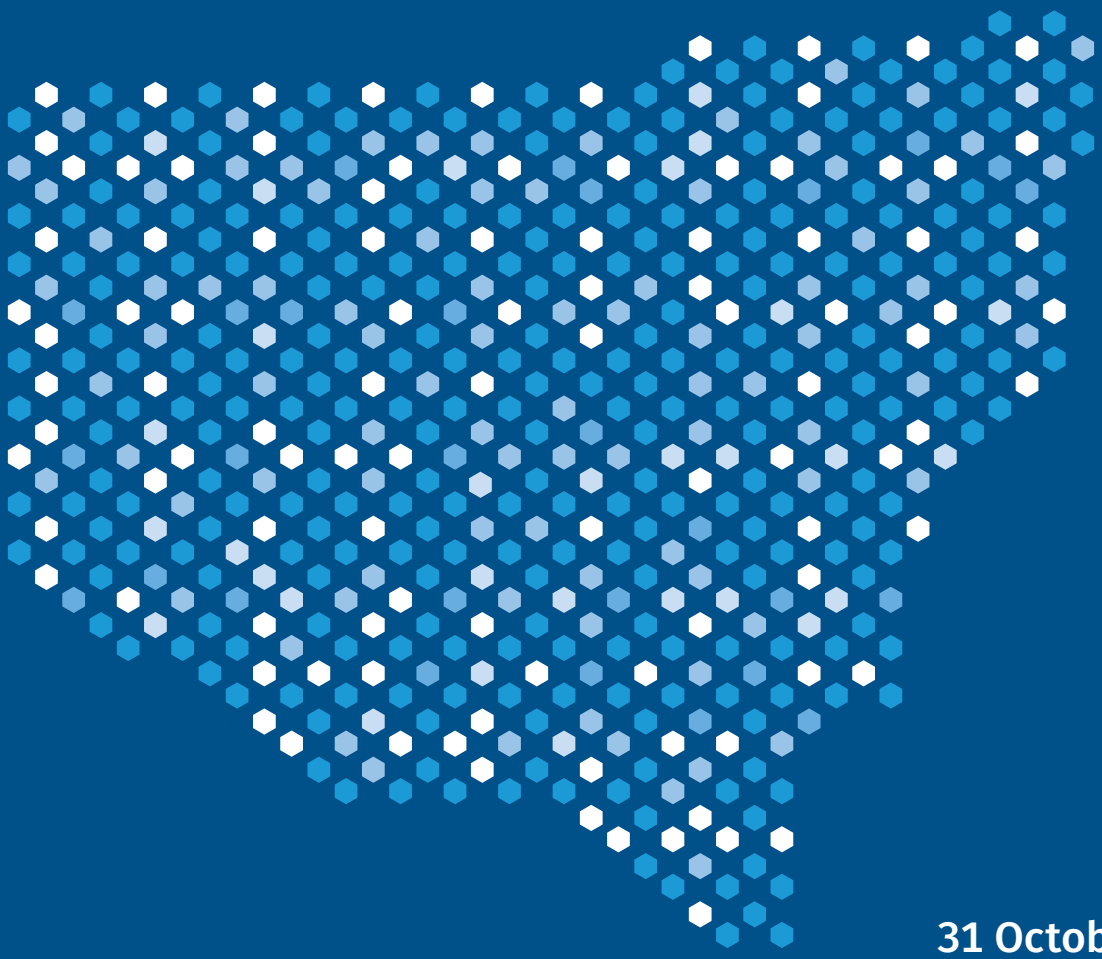
Ombudsman
New South Wales

NSW Child Death Review Team Annual Report 2018–19



31 October 2019

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31 October 2019

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 2018–19

As convenor of the NSW Child Death Review Team (CDRT), I am pleased to present the *NSW Child Death Review Team Annual Report 2018–19* for tabling in Parliament.

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

I hereby present the report for tabling in the Parliament and request that you make the report public forthwith.

Yours sincerely

Michael Barnes
Ombudsman

Ombudsman
New South Wales

NSW Child Death Review Team Annual Report 2018–19

31 October 2019

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About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during the period 1 July 2018 to 30 June 2019.

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 – an overview of the CDRT, its members and the functions of the Team.
- Chapter 3: Reporting of child deaths – an overview of the most recently published report of child deaths in NSW – deaths in 2016 and 2017.
- Chapter 4: Research to help reduce child deaths – details of our research and projects to meet our purpose and functions.
- Chapter 5: Other activities – provides a summary of some of the other activities we are engaged in.
- Chapter 6: Our plans – progress against our strategic priorities and our future priorities.
- Chapter 7: Disclosure of information – details of the disclosure of information for the purpose of research.
- Chapter 8: Our recommendations – details the response by agencies to CDRT recommendations, and progress towards implementation. The appendix provides 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, reviewing and reporting to the NSW Parliament on 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*.

CDRT membership is prescribed by the Act. Members are:

- The NSW Ombudsman, who is the Convenor of the CDRT
- The Advocate for Children and Young People
- The Community and Disability Services Commissioner
- Two persons who are Aboriginal persons
- Representatives from NSW Government agencies:
  - NSW Health
  - NSW Police Force
  - Department of Family and Community Services[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 Attorney General and Justice[2]
  - Office of the NSW State Coroner
- Experts in healthcare, 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. From 1 July 2019, the former Department of Family and Community Services and Department of Attorney General and Justice have been merged to form the Department of Communities and Justice.
2. Ibid.

CDRT members in 2018–19

Ex officio members

Mr Michael Barnes (Convenor)

NSW Ombudsman

Mr Steve Kinmond (to December 2018)

Community and Disability Services Commissioner
Deputy Ombudsman

Mr Paul Miller (from April 2019)

Community and Disability Services Commissioner
Deputy Ombudsman

Mr Andrew Johnson

NSW Advocate for Children and Young People

Agency representatives

Ms Kate Alexander

Executive Director, Office of the Senior Practitioner
Department of Family and Community Services

Ms Robyn Bale

Director, Student Engagement and Interagency Partnerships, Department of Education

Ms Clare Donnellan (to June 2019)

Executive Director, Statewide Services
Department of Family and Community Services

Ms Jane Gladman (to December 2018)

Coordinator, Coronial Information and Support Program, State Coroner's Office

Ms Eloise Sheldrick (from May 2019)

Coordinator, Coronial Information and Support Program, State Coroner's Office

Dr Elisabeth Murphy
Director Child Youth and Family, Primary and Community Health, NSW Health

Mr Daniel Noll (from May 2017)

Criminal Law Specialist
Department of Attorney General and Justice

Ms Larisa Michalko (from November 2018)

Criminal Law Specialist
Department of Attorney General and Justice

Detective Superintendent Scott Cook

Commander Homicide
NSW Police Force

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/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

Director Child and Adolescent Mental Health Services, Sydney Local Health District;
Conjoint Professor of Child and Adolescent Psychiatry, Sydney Medical School

Professor Heather Jeffery

International Maternal and Child Health
University of Sydney
Royal Prince Alfred Hospital

Professor Ilan Katz

Professor, Social Policy Research Centre
University of NSW

Dr Helen Somerville (to June 2019)

Visiting Medical Officer,
Department of Gastroenterology
The Children's Hospital at Westmead

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 2018–19 include:

- Professor Les White, former NSW Chief Paediatrician and CDRT member for NSW Health
- Dr Julie Brown, Senior Research Scientist, Neuroscience Research Australia
- Dr Kairi Kolves, Principal Research Fellow and Associate Professor, Australian Institute for Suicide Research and Prevention; Co-Director, WHO Collaborating Centre for Research and Training in Suicide Prevention, Griffith University
- 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
- Mr Simon Sullivan, Principal, Risk Analytics, Deloitte Risk Advisory
- Ms Elisabeth Gonsalves, Senior Manager, Risk Analytics, Deloitte Risk Advisory

Researchers undertaking projects on our behalf may also be appointed as expert advisers. Chapter 4 provides details of 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 on our website – 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:

- Monitor and review 'reviewable' deaths
- 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
- Maintain a register of 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.

Reports of reviewable deaths of children are available on our website – www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-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
- 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
- **Other reports** (s 34H), which provides for the CDRT to report to Parliament at any time the results of research undertaken in the exercise of our research functions. The CDRT is expected to report on its research at least once every three years. Details of recent and current research are provided in Chapter 4.

The CDRT *Biennial Report of the Deaths of Children in New South Wales: 2016 and 2017* was tabled in the NSW Parliament in June 2019. That report incorporated the Ombudsman's report of reviewable child deaths, and this will continue to be the approach to our reporting of child deaths. 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 biennial report is available on our website – www.ombo.nsw.gov.au/__data/assets/pdf_file/0020/71237/Biennial-report-of-the-deaths-of-Children-in-NSW_2016–17.pdf.

2.2. The Register of Child Deaths

The Register contains details of causes of death, demographic information and other relevant factors. The information is drawn from records we obtain from government and non-government agencies. Under the Act, agencies must provide information to the CDRT if it is 'reasonably required' for the purpose of exercising its functions.

2.3. Meetings of the CDRT

The CDRT met formally on four occasions in 2018–19: in August (a planning meeting), December, March, and June.

Chapter 3. Reporting of child deaths

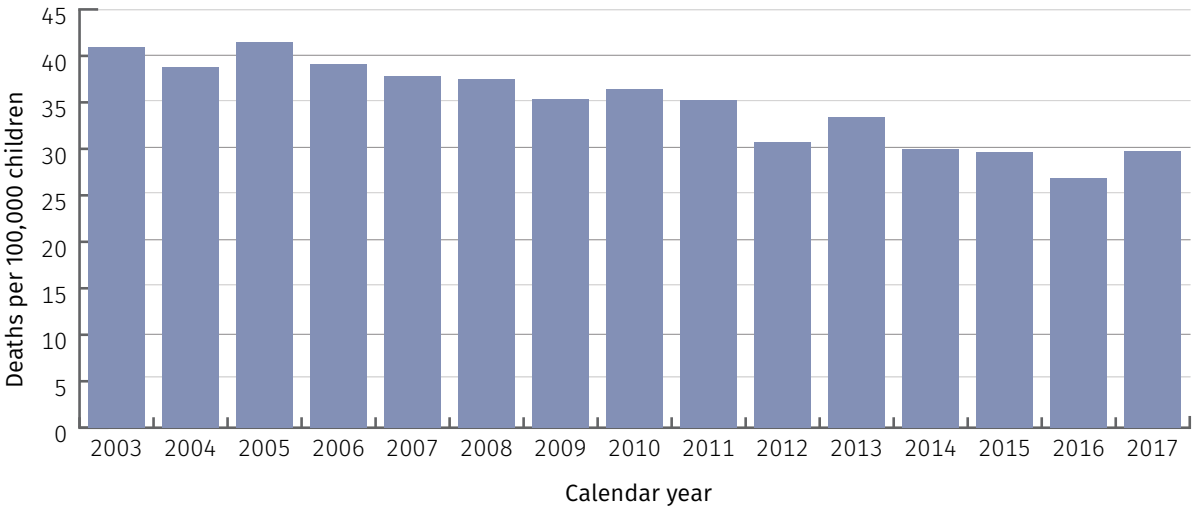
On 25 June 2019, the Ombudsman tabled the *Biennial Report of the Deaths of Children in New South Wales: 2016 and 2017, Incorporating Reviewable Deaths of Children.*

In the two-year period (2016 and 2017), 981 children aged from birth to 17 years died in NSW – a mortality rate of 28.4 deaths per 100,000 children.

3.1. Trends of deaths of all children in NSW

Over the 15 years to 2017, the mortality rate for children declined by 27 per cent in NSW. This mostly reflects a significant decline in the deaths of infants aged less than 12 months.

Figure 1: Deaths of all children aged 0–17 years in NSW, 2003–17



While this decline is reassuring, the decline in mortality rate has not been uniform. For example, in the most recent five-year period 2013–2017, the rate remained higher for:

- Aboriginal and Torres Strait Islander children (2.0 times higher than for non-Indigenous children)
- Children in remote areas (1.8 times higher for children in remote areas than for those in major cities)
- Children living in the most disadvantaged areas of the state (2.3 times higher than for those in the least disadvantaged areas).

3.2. Causes of death

In 2016 and 2017, three in four children (731 of 981) died from natural causes – most of these children were infants in the first weeks of life.

The proportion of deaths due to natural causes (75% of all deaths) has been consistent over the 15 years to 2017.

Leading causes of death

Leading cause of death differed by age group:

- For infants – the leading cause of death was perinatal conditions, followed by congenital conditions.
- For children aged 1–4 years – the leading cause of death was cancers and tumours, followed by drowning.

- For children aged 5–9 years and 10–14 years – the leading cause of death was cancers and tumours, followed by transport-related fatalities.
- For children aged 15–17 years – the leading cause of death was transport-related injuries, followed by suicide.

The leading causes of death also differed for Aboriginal and Torres Strait Islander children aged 1–17 years, for whom the top three leading causes of death were all injury-related causes – transport-related injuries, followed by suicide and drowning.

Injury-related causes of death

Over the two-year period 2016 and 2017, 185 children aged 0–17 years died from injury-related causes in NSW. This represents almost one in every five children who died.

Almost two thirds (119) of the deaths were due to unintentional injury – transport-related deaths (66), drowning (22), accidental suffocation of infants (14), and deaths from other injuries sustained unintentionally (17) – such as poisoning, falls and fire. For children under five years, lack of supervision and access to hazards are particular risks. Older children and teenagers are more involved in the physical environment, and alcohol and other drug use and risk-taking behaviours can also contribute to serious injury.

Fifty-four children and young people died from suicide (54). A further 20 children died from injuries that were the result of abuse (11) or neglect (2), or that otherwise occurred in suspicious circumstances (7).

Young people aged 15–17 years have the highest injury mortality rate of any age group.

Aboriginal and Torres Strait Islander children, families known to child protection services, and children living in the most disadvantaged areas of NSW are over-represented in injury-related deaths.

Suicide deaths

Unlike other causes of death, the suicide rate for children aged 10–17 years has increased. Since 2003, there has been a significant increase in the suicide rate – the rate in 2017 was the highest in the 15 years to 2017. The majority of school-aged children and young people who died by suicide were identified as being at some risk, and many were known to mental health or other support services. A focused suicide prevention plan for young people in NSW is needed, and would provide for well-targeted interventions to prevent suicide.

Aboriginal and Torres Strait Islander children and young people aged 10–17 years accounted for 15% of suicide deaths in the five-year period 2013 to 2017, but they made up only 5% of the age-adjusted population. Over the same five years, the rate of suicide was significantly higher for Indigenous young people aged 15–17 years compared to non-Indigenous young people (23 vs. 6 deaths per 100,000 young people, respectively).

Sudden unexpected deaths of infants

In 2016 and 2017, the deaths of 83 infants were classified as Sudden Unexpected Death in Infancy (SUDI). This represents 15 per cent of all infants who died in NSW over the two-year period.

The rate of SUDI in NSW has not changed significantly over the past decade.

A disproportionate number of sudden and unexpected infant deaths occur in vulnerable families and/or those living in disadvantaged areas. Agencies need to focus prevention initiatives on targeting interventions to infants in these families.

3.3. Recommendations

The biennial report made 17 recommendations in relation to SUDI (2), transport-related fatalities (7), suicide (7) and abuse and neglect-related deaths (1). Over the next year, we will seek information from agencies about actions they are taking to implement them.

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.

In deciding on projects to pursue, we assess and prioritise proposals against the criteria below.

- Is there a strong link between the intended outcome of the research and the objectives of the CDRT to prevent and reduce deaths of children in NSW?
- Is there evidence the research is needed? For example:
  - Does the Register indicate
    - a high number of deaths
    - a spike in a particular cause of death
    - a particular lack of decrease in the rate of death?
  - Is there a sentinel event that highlights a systemic issue?
  - Is there a particular trend emerging from death reviews?
  - Is there evidence of gaps in knowledge, policy or legislation that presents a risk to children?
- Is the research timely and will it provide important information about this particular issue and inform prevention strategies?
- Is any other agency or body already considering or researching the issue (including interstate CDRTs)? If so, would CDRT research at this time add value?
- Are there developments in public policy (eg. legislative review, government inquiry) that the research could directly contribute to and influence?
- Is there a body or agency that might be better placed to undertake the research – either alone, or jointly with the Team?
- Are there less resource intensive or other more effective ways to address concerns and/or prevention strategies?
- If the issue is understood and well researched, would it be more effectively addressed by a public or targeted education campaign?
- Could the issue be resolved through negotiation with a government agency or other body?

4.1. Completed research in 2018–19

In 2018–19, we tabled reports from two research projects:

- The role of child restraints and seatbelts in passenger deaths of children aged 0–12 years in NSW, and
- Review of suicide clusters and evidence-based prevention strategies for school-aged children.

Review of seatbelts and child restraints in car crashes

In 2017, we commissioned Dr Julie Brown from Neuroscience Research Australia (NeuRA) to examine the deaths of 66 children aged 0–12 years who died as passengers in NSW during the 10-year period, 2007–16.

The research had three parts:

- A review of current legislative requirements governing the use of child restraints and seatbelts for children.
- A review of literature relating to the use of child restraints and seatbelts to reduce injuries and deaths associated with motor vehicle crashes.
- An analysis of CDRT data held in relation to the 66 child passenger deaths.

The report was tabled in Parliament on 5 June 2019. The full report is available on our website – www.ombo.nsw.gov.au/__data/assets/pdf_file/0020/70733/The-role-of-child-restraints-and-seatbelts-in-passenger-deaths-Children-0-12years-in-NSW.pdf.

Restraint factors

The review found that just over half the children who died (35 of 66) were not properly restrained in the vehicle:

- Fifteen (15) children were unrestrained.
- Fourteen (14) children were using the right restraint for their age, but the restraints were not correctly fitted (eg. seatbelts placed under the arm, children laying across the seat with the seatbelt on, poor routing of sash belts through booster seats, and tethers not anchored correctly).
- Six (6) children were using the wrong restraint for their age. Almost all were young children (2–6 years) using seat belts when they should have been using a dedicated child restraint system.

Of the 35 children who were not properly restrained, in some cases (15) the crash was so severe that an appropriate and well-fitted seatbelt or restraint would likely not have prevented the fatality. However, for 20 children – almost one-third of the 66 children – analysis of crash information indicates that correct use of a restraint might have prevented the child's death.

Socio-economic status

Two-thirds (41 of 66) of the children who died lived in the lowest socio-economic areas of NSW (Quintile 1 and 2 of the Index of Socio-economic Disadvantage). The mortality rate was five times as high for children from the most disadvantaged areas compared to those from areas of least disadvantage (Quintile 1 compared with Quintile 5).

Remoteness

The majority of children – four of every five – died in crashes that occurred outside of major cities in NSW. Most children (56 of 66) also died on roads with posted speed limits of 80km/hr or more.

Aboriginal and Torres Strait Islander children

Indigenous children were over-represented in child passenger fatalities. In the 10-year period, the rate for child passenger deaths of Aboriginal and Torres Strait Islander children was 4.2 times as high, compared with non-Indigenous children.

Driver factors

In most cases (70%), the driver of the vehicle in which the child travelled was the 'driver at fault'. One-fifth (13) of the drivers of vehicles in which the child was travelling were found to have drugs (illicit and/or prescription) in their system at the time of the crash – for example, methamphetamine, cannabis, methadone and oxycodone. Much fewer (2) cases involved alcohol.

Driver fatigue and driver distraction were also identified as key factors in a number of crashes.

Conclusions

Considering all factors, the review proposed that:

- Regular monitoring of child restraint practices across NSW should be introduced, particularly in areas of socio-economic disadvantage and outside major cities. There has been no population estimate of restraint use among NSW children since 2008, yet significant legislative reform has been introduced since that time. There is a need to understand if the practices observed among fatally injured children reflect population trends or are a marker of other risk factors associated with involvement in high severity and fatal crashes.
- Measures to increase restraint use should be developed and implemented.
- Programs and policies ensuring the high quality and performance of child restraints sold in Australia should continue.
- Greater attention should be given to identifying and implementing measures to reduce misuse through restraint design and product standard requirements – and to removing barriers to vulnerable population groups accessing restraint fitting programs and services. Access to programs like the NSW Restraint Fitting Stations Network, and Restraint Fitting Checks should be expanded in areas of most need. It is also imperative that families at highest risk of serious crash involvement and misuse of restraint be identified.
- Current legislative controls over minimum restraint use should be maintained, alongside wider dissemination of information on best practice for restraining children – particularly children over the age of seven. Dissemination strategies must ensure these messages reach and are understood by those sectors of the community most in need.

- Road safety initiatives should account for the higher involvement of people from the lowest areas of socio-economic disadvantage in transport-related deaths.

These proposals resulted in a range of recommendations that we incorporated into our biennial report, described above. Over the next year, we will seek and monitor agencies' responses to the recommendations.

Review and analysis of suicide clustering and evidence-based prevention

In 2017, we commissioned Dr Kairi Kolves from the Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University to undertake a literature and policy review of suicide clustering among school-aged children and young people, and to examine evidence-based prevention and postvention strategies and existing youth suicide prevention strategies.

The report was tabled on 25 June 2019. The full report is available on our website – https://www.ombo.nsw.gov. au/__data/assets/pdf_file/0015/71241/Review-of-Suicide-clusters-and-evidence-based-prevention-strategies-for-school-aged-children.pdf.

Exposure to suicide deaths

The review found the majority of studies reported that young people are at higher risk of suicide clusters than adults. A suicide cluster refers to:

> *'a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected on the basis of statistical prediction or community expectation'.*[5]

Cluster-specific factors identified by the review included recent direct or indirect exposure to a suicide – for example, a direct link to someone who died or social dissemination including through different types of media. Studies have also suggested that individuals in cluster suicides have a high prevalence of common suicide risk factors – such as psychiatric disorders, a personal and family history of suicidal behaviour and social isolation – and may therefore be more vulnerable.[6]

It has been suggested that the internet and social media may contribute to the development of – and increase the incidence of – suicide clusters as the geographical area becomes less relevant. Robinson *et al*[7] highlights five reasons for the role of the internet in the potential increase of suicide clusters in young people:

- Wider social networks make exposure to a larger number of suicides more likely.
- There is less control over the accuracy and delivery of the information about suicide cases.
- There are web pages to memorialise people who died by suicide, which tend to be excessively glorifying – shown to increase imitative behaviour in mainstream media.
- Vulnerable young people may congregate on the websites.
- Information can be shared about suicide methods, particularly about unusual methods.

Postvention and prevention strategies in schools

The AISRAP review identified the NSW Government, in collaboration with research and community organisations, has developed comprehensive guidelines for postvention and prevention for school-aged children.[8] The key policy guiding NSW government schools is *Responding to Student Suicide – Support Guidelines for schools*, developed in collaboration with the NSW Ministry of Health, NSW Department of Education and Headspace.[9] These guidelines supplement existing initiatives to support the mental health and wellbeing of school students in NSW. They aim to enable a comprehensive and timely response and facilitate holistic support for the entire school when a student dies by suicide.

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5. Centers for Disease Control 1988. CDC recommendations for a community plan for the prevention and containment of suicide clusters. *Morbidity and Mortality Weekly Report*, 37(6), 1–12.
6. 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.
7. Robinson *et al* 2016. *Spatial Suicide Clusters in Australia between 2010 and 2012: A Comparison of Cluster and Non-cluster among Young People and Adults. BMC psychiatry*, 16, p.417.
8. 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.
9. NSW Education 2015. *Responding to Student Suicide – Support Guidelines for Schools*. NSW Education, Sydney.

The review also noted, however, that very limited research has addressed the topic of prevention of suicide clusters and specific postvention activities. No study has evaluated the overall effectiveness of these strategies in preventing clusters.

4.2. Proposed research

Social determinants in child deaths

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

The intent is to build on our previous work in relation to spatial analysis of child deaths in NSW. We aim to complete this work in 2021.

Review of infant deaths

In 2018, we commenced work on a project to review infant deaths related to perinatal asphyxia.

The review will consider all infant deaths associated with perinatal asphyxia over the four-year period 2016 to 2019, in order to identify opportunities to improve practice and prevent similar deaths in future. The review also has the potential to beneficially impact on 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 will consider a range of issues, such as:

- level of monitoring for women in labour
- recognition of abnormal traces via monitoring
- timeliness and appropriateness of decision-making in relation to women at risk.

We aim to complete this work in 2021.

Other related review activity

Sepsis deaths

In 2019, we reviewed child deaths from sepsis in NSW over the five-year period 2014 to 2018 to identify any patterns or issues that may be evident when considering a group of deaths from the same cause. Sepsis was the leading cause of child deaths in NSW from infectious diseases over the 15 years to 2017 (39% of all deaths from infectious diseases).[10] Early recognition and prompt treatment is essential to improve survival. Delayed treatment is associated with high mortality rates and significant morbidity.

This work confirmed the need for us to continue to focus on identifying issues regarding recognition and management of sepsis.

10. NSW Ombudsman (2019). *Biennial Report of the Deaths of Children in NSW: 2016 and 2017*, June 2019.

Chapter 5. Other activities

In addition to our review and research work, we are also involved in a range of other relevant 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)

Our previous reports have included information about our work to develop an alternative classification for SUDI.[11] One of the key aims of this work has been to ensure that information about factors that may contribute to SUDI are captured consistently – particularly modifiable risk factors present in the infant's environment and background. The revised classification we have developed provides a rich source of information for prevention initiatives.

In December 2018, we received advice from the State Coroner that, after a pilot trial period, forensic pathologists and coroners in NSW would officially commence using the new SUDI classifications that we developed.

Internationally, deaths are classified using the World Health Organization's (WHO) International Classification of Diseases (ICD). The ICD is the foundation for the identification of health trends and statistics globally, and the international standard for reporting diseases and health conditions.

Earlier we submitted our proposed classification to the ICD revision taskforce to consider its inclusion in the 11th edition of the ICD (ICD-11). Countries around the world will start reporting using ICD-11 on 1 January 2022.[12] In June 2019, we received advice from the taskforce that our proposal had been reviewed and was being forwarded to the ICD-11 revision Mortality Reference Group (MRG) for their consideration about whether the proposal will be accepted into the ICD-11. We have an opportunity to provide the MRG with up-to-date information about our classification system and how it is applied, as well as to answer possible questions the MRG may have later this year. The ultimate aim of this work is a consistent worldwide classification for SUDI.

5.2. National child death review group

In 2018, NSW took over the responsibilities of chairing the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) for a three-year period. 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.

As the new Chair of the ANZCDR&PG, we were responsible for organising and hosting the 2019 conference, held in Sydney in April 2019. In addition to members from each jurisdiction, the conference was attended by the National Children's Commissioner, a number of CDRT members (generally acting as presenters and session leaders), and other experts, such as the head of the Australian Institute of Health and Welfare's Indigenous and Maternal Health Group.

Conference sessions focused on specific topics of relevance, and particularly how child death reviews can contribute to prevention. For example, sessions were held in relation to:

- SUDI – emerging knowledge and issues
- child death review as a discipline – demonstrating value and developing our capabilities as review teams into the future, both as separate functions and nationally
- adding value through a national data set
- suicide, and
- unintentional injury (death and serious injury).

The group's next meeting will be held in 2020.

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11. For example, the *NSW Child Death Review Team Annual Report 2017-18*, NSW Ombudsman, October 2018.
12. https://www.who.int/classifications/icd/en/, accessed 31 July 2019

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 continued to put in place the actions agreed in our Strategic Priorities Plan 2016–19.

6.1. Meeting our priorities

The figure below details progress against the key strategic priorities 2016–19.

Figure 2: Progress report for CDRT strategic priorities 2016–19 (at June 2019)

Priority	Status	Comments
Annual/biennial reports		
Child Death Review Report – Deaths in 2015	Completed 2016	Tabled 21 November 2016
CDRT Annual Report 2016–17	Completed 2017	Tabled 20 October 2017
CDRT Annual Report 2017–18	Completed 2018	Tabled 22 October 2018
Biennial Child Death Review Report – Deaths in 2016 and 2017	Completed 2019	Tabled 25 June 2019
Projects		
Between 2016 and 2019, we will deliver at least three research reports:		
• Child deaths from infectious disease: a ten year review	Completed 2016	Tabled 21 November 2016
• Childhood injury prevention: strategic directions for NSW	Completed 2017	Tabled 15 November 2017
• Geospatial analysis of child deaths in NSW	Completed 2018	Tabled 12 April 2018
• Review of suicide clusters and evidence-based prevention strategies	Completed 2019	Tabled 25 June 2019
Between 2016 and 2019, we will undertake and report on at least two detailed group reviews, which will be included as areas of focus in our biennial report:		
• Transport deaths – preventable deaths linked to the absence or misuse of seatbelts or child restraints in car crashes	Completed 2019	Tabled 5 June 2019
• Quad bike and side-by-side vehicle fatalities 2006–2015	Completed 2016	Reported in the Child death review report (2015 deaths) – tabled 21 November 2016
• Drowning deaths in private swimming pools 2006–2015	Completed 2016	Reported in the Child death review report (2015 deaths) – tabled 21 November 2016
• Cancer deaths (trial review)	Completed 2018	Reported in the CDRT Annual Report 2017–18 – tabled 22 October 2018

Priority	Status	Comments
Infrastructure		
Finalise fixes required following the implementation of the revised Register of Child Deaths (database)	Completed 2018	Revised Register in operation at 1 July 2018
Establish a dashboard of key data	Completed 2019	The dashboard (based on live data) was finalised in June 2019
Develop a detailed data dictionary for the Death Review System (DRS)	Completed 2018	
Liaise with the Centre for Health Record Linkage – aiming for an appropriate set of data from DRS becoming a data linkage key	Under ongoing consideration	This is a longer-term goal. Stage one – a design review of the Child Death Register and development of a comprehensive data dictionary – was completed in 2018
Identify relevant external datasets and strategies to link the information (including the Perinatal Data Collection)	Ongoing	Perinatal data collections are now being provided by NSW Health Arrangements have been made for regular information exchange with NSW Health regarding deaths from infectious diseases
Engagement and communication		
Continue and strengthen our involvement with the Paediatric Injury Research and Management Forum	Progressed	CDRT, NSW Health and NSW Advocate for Children and Young People agreed on establishment of an alternative forum by the NSW Advocate – first meeting July 2018. CDRT will maintain membership
Join and actively participate the Australian Injury Prevention Network	Ongoing	Membership and participation in annual injury prevention conferences
Identify key stakeholders and consultand liaise in regard to common issues and collaboration	Ongoing	When possible and/or appropriate
Prepare fact sheets from our annual report 2016 and biennial report 2018 and research reports, and publish these on our website	Ongoing	Fact sheets prepared and published for annual reports, research reports and biennial report of child deaths in 2016 and 2017
Prepare fact sheets on high fatality rate deaths and/or other topical issues	Ongoing	Fact sheets associated with the CDRT annual report and combined biennial report have been produced
Provide data and advice through submissions to relevant external reviews and inquiries	Ongoing	Information provided to NSW Fair Trading infant safe sleeping project (2018), and the State Coroner's Office in relation to inquests

Priority	Status	Comments
Work with the State Coroner's Office and other relevant stakeholders to achieve a consistent approach to defining SUDI	Ongoing	Meetings with Coroner's Office and forensic services in 2017–18. Revision of classification, and trial in forensic services (2018). Adoption of classification by State Coroner/forensic services December 2018
Scope of our work		
Develop a CDRT position paper on the role of the CDRT in injury and disease prevention, including the capacity of the Team to examine morbidity as well as mortality	Completed	Final position paper 2017
Develop a CDRT position paper on the role of the CDRT in relation to stillbirths, including the capacity of the team to review or include stillbirths in child death review and reporting	Not progressed	Decision to adopt a 'watching brief' rather than position paper in the context of the Senate Select Committee Inquiry into Stillbirths in Australia (finalised in December 2018). CDRT to review progress in August 2020, and review role/position of Team at that time.
Develop strategies to implement the recommendations of the Ombudsman's review of the definition and reporting practices of fatal neglect	Completed 2018	Change to biennial report agreed, changes to definition and reporting of neglect implemented

6.2. Strategic priorities 2019–22

A new strategic priorities plan (2019–22) will be finalised in 2019.

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 2018–19, no disclosures were made under s 34L (1) (b).

7.2. Other information disclosures

Section 34D (3) of the Act 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. In this context, we provided information to agencies in Queensland and the Australian Capital Territory:

- On behalf of the Australia and New Zealand Child Death Review and Prevention Group (ANZCDR&PG), Queensland has taken on the role of coordinating high-level data from all state and territory CDRTs to provide a basic national data set. In July 2018, we provided information to the Queensland Family and Child Commission on the number of deaths of children in NSW by age, sex, Aboriginal status and broad cause of death (disease or morbid conditions, injury or SUDI) for deaths that occurred in 2016. In June 2019, we provided the same information for deaths that occurred in 2017. Inter-jurisdictional data received by Queensland was reported in the *Annual Report: Deaths of Children and Young People, Queensland 2018–19.*
- The ACT child death register includes children who normally live in the ACT, but whose death occurs outside of the ACT. In January 2019, 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 2018.

Under separate provisions, we also provided information to the State Coroner and other agencies as prescribed by our legislation. For example:

- NSW Health's NSW Notifiable Conditions Information Management System includes notifications of infectious diseases reported in NSW. Following recommendations made in the *Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005–2014* report (published 2016) we established an annual database check with Health Protection NSW (NSW Health) in relation to child deaths from vaccine preventable diseases. In December 2018 and March 2019, we exchanged information with NSW Health (key demographic and cause of death data) in relation to child deaths from vaccine preventable diseases during the period 2015–18. This information is exchanged under s 34K (1)(a) and 34L (1)(a).
- *I*n 2018–19, we provided information to the Coroner in relation individual child deaths under section 34L (1)(c)(iii) of the Act.
- In 2018–19, we provided information to the Domestic Violence Death Review Team, as requested under section 101L (1) of the *Coroners Act 2009*, in relation to child deaths that occurred in the context of domestic violence.

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.

The Act also requires 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 – four previous and 15 new – 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.[13] These recommendations are detailed below, along with a summary of agency responses and our comments on progress.

Original correspondence from agencies is included at appendix 1.

8.1. Progress on previous recommendations

Sudden Unexpected Death in Infancy (SUDI)

Our recommendations: SUDI investigation

Recommendations 2 and 3, Child Death Review Report 2015

We recommended that the NSW Government, in the context of previous CDRT recommendations and the work of Garstang *et al*:[14]

> **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.**

13. In addition to the 19 recommendations monitored by the CDRT, the Ombudsman is monitoring a small number (5) of recommendations that relate to reviewable child deaths.
14. Garstang J., Ellis C., and 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.**

Background to the recommendations

Each year in NSW, around 40–45 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, health (emergency departments and forensic services) and the Coroner's Office.

The CDRT has consistently identified gaps in investigation of SUDI, noting that there is no whole-of-government policy in NSW to direct the cross-agency coordination of responses to SUDI.

In 2017, the NSW Government advised that it supported improving the interagency approach to SUDI investigation. The Department of Premier and Cabinet (DPC) was tasked with leading work to achieve this goal. A cross-agency working group was established involving representatives from DPC, the NSW Coroner's Office, NSW Police Force and NSW Health (including NSW Ambulance and the Department of Forensic Medicine). The role of the working group was to agree on some immediate, practical actions that NSW agencies could take to improve responses to SUDI.

Progress in 2018–19

In December 2018, the NSW Government provided a progress update on actions and steps taken by the DPC-led working group towards achieving elements of a joint agency response to SUDI. Positive changes implemented included:

- Updated and aligned policy directives across NSW Police Force, NSW Ambulance and NSW Health to clarify interagency roles and responsibilities.
- Improved guidance for frontline police and ambulance staff – for example, 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.

The update also outlined other actions and initiatives that have been developed or are underway to ensure expert, on-call advice is available to investigators in responding to SUDI, appropriate forensic examination occurs, and essential relevant information is captured. For example, a paediatric pathologist either performs, or is consulted about, autopsies for all SUDI cases. The NSW Coroner's Court and the Department of Forensic Medicine (DOFM) are also trialling a multidisciplinary paediatric review team meeting – a group of specialists who review SUDI post-mortem reports before they are sent to the Coroner. The impact and value of this approach will be evaluated in late 2019 or early 2020.

Key actions still to be finalised include:

- Publication of a revised NSW Health Policy Directive on SUDI, including an updated medical history form used in SUDI cases.
- Implementation of a newly developed state-wide model of care for Forensic Counselling services, including SUDI client support.
- Development of a best-practice autopsy protocol for SUDI.
- Publication of a revised NSW Police form to report a death to the Coroner (P79A form).
- Full operation of the Coronial Case Management Unit (CCMU) and Regional Triage Centre (RTC) with suitably qualified staff to provide expert, on-call advice to investigators at the scene of death for all SUDI cases.

The NSW Government's update marked the end of DPC's involvement in the cross-agency working group. The advice noted that the Ministry of Health will now work with agencies to establish a monitoring process for ongoing work to develop an effectively coordinated interagency SUDI response.

Given the ongoing nature of work in this area, the number of outstanding actions, and the government's decision not to proceed with a centralised model, we will continue to actively monitor and report on progress in developing and implementing the recommendations.

Our recommendation: unintentional bed sharing

Recommendation 6, Child Death Review Report 2015

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.**

Background to the recommendation

In the five-year period 2011–15, we identified that 18 infants died in circumstances of unintentional bed sharing. In all cases, the infant was being fed on a bed or lounge and the adult carer fell asleep. Pathologist reports noted the possibility of overlaying and asphyxia for a number of the infants. We considered that safe sleep advice and education should identify and share strategies to assist parents and carers to avoid this situation.

We also identified that almost one-third of infants' mothers were aged 21 years or under, and noted that it was critical that clear messages about safe sleeping and safe environments be developed and delivered to specific high-risk populations.

In 2017, NSW Health and Red Nose advised us that they supported this recommendation, and had held joint preliminary discussions to discuss safe sleeping. NSW Health detailed a number of awareness-raising strategies for SUDI, including the development of a cot card for use in NSW Health maternity facilities. Red Nose detailed a range of resources and education initiatives being planned or delivered.

In 2018, the agencies advised ongoing dialogue was occurring between them. NSW Health reported other initiatives undertaken included the development of a Safe Sleeping eLearning module to increase the awareness of the risk of SUDI and safe sleeping messages among health clinicians, revision of the child Personal Health Record (Blue Book) and the Aboriginal Maternal and Infant Health Service (AMIHS) and Building Strong Foundations *Safe sleeping for your baby* brochure to include the six safe sleeping messages provided by Red Nose Saving Little Lives, and Facebook posts linked to its 'Stay Strong and Healthy – It's Worth It' campaign. Red Nose provided advice about a range of services and supports to promote safe sleeping, and advised it was looking to expand the avenues used to do so.

Progress in 2018–19

In preparing our biennial report of child deaths in 2016 and 2017 (published in June 2019), we identified a further 12 infants had died in circumstances of unintentional bed sharing during the two-year period.

In August 2019, Red Nose advised it 'has broadened its safe sleep education suite by creating a simple, user friendly 'Co-Sleeping Tool' to support all parents who co-sleep; both intentionally and unintentionally'. Red Nose is also looking to condense and simplify information available on its website, focusing on making messages easy to read and highlighting risk minimisation strategies. Red Nose has also developed a communication strategy to target young mothers.

In August 2019, NSW Health advised that in addition to the previous initiatives, it has drafted a revised policy and guideline that aims to provide consistent information to facilitate safe sleeping messaging to expectant parents, parents, caregivers and/or extended family members across the birth to 12 months continuum. The revised draft documents include information about risks associated with unintentionally falling asleep with a baby. NSW Health also noted it will liaise with Red Nose regarding opportunities for alternative media messaging.

We acknowledge the actions taken by NSW Health and Red Nose to increase awareness about SUDI and safe sleeping, including risks associated with unintentional bed sharing. We also acknowledge their work to broaden messaging to include parents to be, parents, extended family and other caregivers, and to jointly consider how best to ensure messages reach potentially vulnerable families.

We acknowledge the initiatives being progressed by both Red Nose and NSW Health. We will invite both agencies to update on progress next year.

Drowning: private swimming pools

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

Recommendation 10, Child Death Review Report 2015

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.**

Background to the recommendation

Our *Child Death Review Report 2015* noted that there is little publicly available data on the outcomes of the regulatory regime for swimming pool safety and inspection. In the context of transparency and outcomes measurement, we considered there should be open and regular reporting by government on key aspects of swimming pool regulation, including the number of pool inspections carried out across NSW, compliance with legislative requirements identified through inspections or orders issued to rectify non-compliance, and whether owners rectify faults and within what timeframe.

In 2017, the Office of Local Government (OLG) supported this recommendation in principle. Although the OLG advised us that councils are required to include in their annual reports the number of mandatory inspections carried out, along with the number of certificates of compliance and certificates of non-compliance issued, our review of local government annual reports for 2016–17 identified a low level of compliance with this requirement.

On 1 January 2018, responsibility for the administration of the Swimming Pool Register transferred from the OLG to the Department of Finance, Services and Innovation (DFSI). In May 2018, DFSI advised that the department had been 'reviewing the IT infrastructure supporting the Swimming Pool Register', and was considering enhancements to the ability to report defects and consolidated data reporting across councils. The Swimming Pool Register also now requires inspection details of non-compliance certificates to be entered.

Progress in 2018–19

In February 2019, DFSI advised us that the Swimming Pool Register cannot currently provide an amalgamated report on defects identified and the time taken for rectification of non-compliance. DFSI is considering further enhancements to the Register, including the ability to provide amalgamated reports.

In June 2019, DFSI confirmed their previous advice, noting that some of the recommended data was published in the NSW Fair Trading's *Building Professionals Board Annual Report 2017–18*, and that publishing data about the reasons pool barriers fail inspections, and whether non-compliances were rectified by the owner within a reasonable timeframe will require upgrades to the Register to enable amalgamated reporting. DFSI further advised that enhancements to the Register were still being considered as part of a larger departmental information technology project.

In June 2019, we reported that we would continue to monitor this recommendation.[15]

8.2. New recommendations

In 2019, the CDRT made a number of new recommendations to agencies that aim to address issues identified in our child death review work. Over the coming year, we will monitor agency responses and actions taken in relation to the recommendations.

Sudden Unexpected Death in Infancy (SUDI)

Our recommendation: safe sleeping in vulnerable families

Recommendation 1, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

Our work has identified the disproportionate number of infants who die suddenly and unexpectedly 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 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.**

NSW Health's response to the new recommendation

In August 2019, NSW Health advised it supports the new recommendation.

NSW Health advised that it will meet with Family and Community Services representatives to discuss opportunities to work together to support vulnerable families.

We will monitor progress on this recommendation over the next year.

15. NSW Ombudsman (2019). *Biennial Report of the Deaths of Children in NSW: 2016 and 2017*, June 2019.

Our recommendation: identification of illness in infants

Recommendation 2, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

For deaths that occurred in 2016 and 2017, we identified that preceding infectious illness was present for more than half the infants who died suddenly and unexpectedly, and that for some infants, undiagnosed illness was fatal. Against this background, 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.**

NSW Health's response to the new recommendation

In August 2019, NSW Health advised it supports this new recommendation.

NSW Health advised that it is in the process of contacting Red Nose to work collaboratively to promote evidence-based and evaluated resources for parents and carers.

We will monitor progress on this recommendation over the next year.

Transport-related fatalities

Our recommendation: safer vehicle choices

Recommendation 3, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

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. 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 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).**

Our recommendations: child restraints and seatbelts

Recommendations 4, 5, 6 and 7, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

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)**.**

Our recommendation: low speed run-over incidents

Recommendation 8, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

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.**

Transport for NSW's response to new transport-related recommendations

In August 2019, Transport for NSW advised us they supported all six recommendations directed to the agency (3, 4, 5, 6, 7 and 8), and noted that work is already underway which supports these recommendations.

In relation to specific recommendations, Transport for NSW advised:

- Further work will be carried out in 2019 to enhance the content on its Towards Zero website, including the addition of more information on safety features.
- Transport for NSW has engaged Neuroscience Research Australia to conduct a study to estimate restraint practices in terms of appropriate and correct use among children 0–12 years across NSW.
- Transport for NSW and NSW Health will regularly monitor serious injuries and fatalities for children under 13 years involved in crashes on public roads.
- During 2019–20, the Centre for Road Safety will look to further enhance educational engagement activities targeting children over the age of seven years in the Aboriginal community, and will also create tailored content to target Aboriginal and culturally and linguistically diverse audiences on Facebook.
- Ongoing programs to reduce the incorrect use of child restraints in motor vehicles include the Child Restraint Evaluation Program (CREP), planned work (through CREP) which will encourage manufacturers to implement restraint guidelines by providing a full five-star rating in ease-of-use if they implement these guidelines in their products, and ongoing supports for the RMS Authorised Restraint Fitting Station Scheme.
- Transport for NSW will enhance its educational activities to promote the prevention of low-speed vehicle run-over crashes involving young children across a number of platforms.

We will monitor progress on this recommendation over the next year.

NSW Health's response to recommendation 5

In August 2019, NSW Health advised it 'agreed in principle' with the recommendation. (i.e. using data linkage systems to monitor crash injuries and fatalities involving children aged 0–12 years).

NSW Health noted that while its Centre for Health Record Linkage (CHeReL) provides health data and linkage services to Transport for NSW, the linked dataset itself is held by Transport for NSW. As a result, NSW Health considers feedback on the recommendation should come from Transport. Notwithstanding this, NSW Health will continue to provide health data and linkage services to support Transport for NSW's work.

In light of NSW Health's advice, we will seek further advice in relation to recommendation 5 from Transport for NSW, as noted above.

Our recommendation: quad bikes

Recommendation 9, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

In the context of survey results published by SafeWork NSW in relation to the impact of the *Quad Bike Safety Improvement Program*, and the NSW Government's decision not to accept our previous recommendation that it consider legislation changes regarding the use of adult quad bikes by children under 16 years, 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.**

SafeWork's response to the recommendation

In August 2019, SafeWork confirmed its support for this recommendation, noting that its Quad Bike Safety Improvement Program includes strategies to raise awareness of the dangers of children using adult-sized quad bikes, as well as preventative measures. SafeWork also advised that its online guidelines state that children under 16 years of age should not be allowed to ride adult-sized quad bikes.

We will monitor progress on this recommendation over the next year.

Suicide deaths

Our recommendation: focused prevention plan

Recommendation 10, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

In support of a recommendation by the Parliamentary inquiry into the prevention of youth suicide in NSW that the government develop a youth specific suicide prevention plan, 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.**

Our recommendation: managing and containing risk

Recommendation 11, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

Noting the difficulty in supplying timely and developmentally appropriate specialist mental health services for children and young people, we recommended that:

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.

The NSW Government's response to recommendations 10 and 11

In August 2019, the NSW Government advised it supported both recommendations 10 and 11.

We will monitor progress on these recommendations over the next year.

Our recommendations: the role of schools (government)

Recommendations 12 and 15, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

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.

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 of Education's response to the recommendations

In August 2019, the Department of Education advised it supported both recommendations, noting that it will:

- commission an evaluation of postvention initiatives in NSW government high schools
- establish an appraisal process after the suicide death of a student to inform future practice and policy.

The Department confirmed suicide prevention is a high priority, and that an additional $88 million has been allocated over four years to provide every government high school with two dedicated mental health professionals to ensure its students have access to mental health and wellbeing support.

We will monitor progress on this recommendation over the next year.

Our recommendations: the role of schools (non-government)

Recommendations 13 and 14, Biennial Report of the Deaths of Children in NSW: 2016 and 2017

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.

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.

Catholic Schools NSW's response to recommendation 13

In August 2019, Catholic Schools NSW (CSNSW) confirmed its support for recommendation 13, noting its concern at the prevalence of suicide among children and young people.

CSNSW advised it has existing mechanisms which support student wellbeing and that it works with Catholic school agencies on these matters.

We will monitor progress on this recommendation over the next year.

The Association of Independent Schools of NSW's response to recommendation 14

In August 2019, the Association of Independent Schools of NSW (AISNSW) advised it supports recommendation 14.

AISNSW further advised it provides both proactive and responsive support for schools through a multi-faceted, coordinated and sensitive systematic approach to each school's individual context. AISNSW's approach is informed by best practice and are focused on supporting schools with the establishment of sound whole-school processes for wellbeing, mental health and suicide prevention.

We will monitor progress on this recommendation over the next year.

8.3. NSW Ombudsman recommendations: reviewable child deaths

In addition to recommendations monitored by the CDRT, described above, the recently tabled biennial report included two recommendations that concern 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

Premier & Cabinet

Ref: A2796800

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

Dear Mr Barnes

Please find enclosed the NSW Government's progress update on recommendations two and three of the Child Death Review Team's 2015 annual report. These recommendations relate to Sudden Unexpected Death in Infancy (SUDI).

The Department of Premier and Cabinet and the Deputy State Coroner, Magistrate Teresa O'Sullivan, have worked with NSW Government agencies to implement responses to these recommendations. Work has progressed through a Cross-Agency Working Group (CAWG) with NSW Police, NSW Health (including NSW Ambulance and Forensic Medicine) and the NSW State Coroner's Court. The CAWG has implemented some immediate, practical actions to improve responses to SUDI.

This update marks the end of the Department of Premier and Cabinet's involvement in this work. NSW Health will continue to work with agencies to monitor and review progress. This will focus on ensuring all families who experience SUDI are offered support and referral, and on increasing the proportion of SUDI cases with an established cause of death.

I trust this information is useful and note your intention to publish an overview of this progress update in your biannual report in April 2019.

Yours sincerely

Tim Reardon
Secretary

21 December 2018

CC: Deputy State Coroner, Magistrate Teresa O'Sullivan.

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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.

NSW GOVERNMENT | Health

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

Our ref O19/3

Dear ~~Mr~~ Michael Barnes

I refer to your letter of 19 July 2019 seeking an update on the status of recommendations made for NSW Health as part of the *CDRT Child Death Review 2015* as tabled in November 2016 and those made in the *Biennial Report of the Deaths of Children in New South Wales in 2016-17* which was tabled in June 2019.

The schedule attached to this letter lists the recommendations made in both reports and includes a progress report for each. The table also lists NSW Heath's position on those new recommendations made in June 2019 as part of the *Biennial Report*, noting that a more detailed response will be provided when requested in 2020.

If you have any further queries, please contact Mr Paul Giunta, Director, Corporate Governance and Risk Management via email to Paul.Giunta@health.nsw.gov.au or on 9391 9654.

Yours sincerely

Elizabeth Koff
Secretary, NSW Health

22/8/19

NSW Ministry of Health
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Schedule: August 2019 progress report on implementation of recommendations of CDRT Review Report 2015

NSW Child Death Review Report 2015

Reference	Recommendation	Summary of Advice to date and requested information for reporting progress to NSW Parliament
Page 21 CDRT Annual report 2017-2018	**SUDI unintentional bed sharing**: noting observations from our work about risks arising from unintentional bed sharing, we recommend that NSW Health, in consultation with Red nose should review advice and educational strategies, with the view to a) 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. b) Strategies targeted to young mothers including use of alternative avenues of advice through social media and parenting blogs and targeting grandmother for safe sleep education. *(Recommendation 6, Child Death Review report 2015)*	NSW Health continues to support Recommendation 6, CDRT report 2015. NSW Health has drafted a Policy Directive and Clinical Practice Guideline to replace GL2005_063 Sudden Infant Death Syndrome (SIDS) and Safe Sleeping for Infants and PD2012_062 Maternity - Safer Sleeping Practices for Babies in NSW Public Health Organisations (PHO). The revised draft Policy and Guideline aims to provide consistent information to facilitate safe sleeping messaging to expectant parents, parents, caregivers and/ or extended family members across the birth to 12 months continuum. This includes: • information regarding risk of the parent/carer unintentionally falling asleep with the baby • information provision to include not only parents but also extended family and other caregivers • risk assessment to identify vulnerable families who may need additional support. The initiatives undertaken by NSW Health commenced following previous CDRT recommendations to address the issue of unintentionally falling asleep and sharing a sleep surface with a baby: • eLearning *Safe Sleep* Module available through My Health Learning for health professionals - published in March 2017

		• *Safe Sleeping for Newborns - FAQs and Information for Professionals* - published in May 2016. The eLearning safe sleep module for health professionals and the revised policy directive (as referenced above) include advice to be given to grandmothers, young mothers and other care givers to ensure they are aware of the modifiable risk factors for safe sleep. NSW Health will liaise with Red Nose regarding opportunities for alternative media messaging.
Page 18-19 CDRT Annual report 2017-18	**SUDI Investigation:** We recommend that the NSW Government, in the context of previous CDRT recommendations and the work of Garstang et al: Consider a centralised model for SUDI response and investigation in NSW (staffed by specialist health professionals to work with police, the family, pathologists and the Coroner to respond immediately and consistently to SUDI), and Devise a joint agency policy and procedure governing the individual and coordinated roles and re4sponsibilities 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: • Expert paediatric assistance in death scene investigation and interviews with the family (noting that the investigation of any suspicious deaths would be the responsibility of police) • Specialised training and development of resources for police in SUDI investigation • Identified specialists to take 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 continues to support Recommendations 2 and 3, CDRT report 2015. In July 2019, NSW Health published the revised Policy Directive PD2019_035 Management of Sudden Unexpected Death in infancy (SUDI). The revised Policy Directive: • emphasises the need to provide parents/carers with the support they need, including medical and nursing care, social work and referral to other services such as Red Nose Grief and Loss • stipulates the Hospital is to accept and manage all episodes of SUDI whether they occur in Hospital or in the community • emphasises that all NSW Health facilities are expected to respond to a SUDI • emphasises the use of the revised SUDI medical history protocol. The Ministry of Health is working with NSW Ambulance, Forensic Medicine, NSW Health Pathology, the NSW Coroner's Office, Department of Premier and Cabinet and NSW Police through the continuation of the Cross-Agency Working Group (CAWG). The representation of families on the CAWG is currently being established for the next meeting.

	• Application and monitoring of standardised protocols for SUDI pathology, with specific requirements for standard screens in sudden unexpected infant death
	• 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
	• Multi-disciplinary review post mortem. The review should be chaired by an informed paediatrician, and involve the 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.
	• The introduction of clear procedures to ensure families are provided with:
	  ○ Appropriate advice and referral, particularly where genetic causes are indicated or suspected, and
	  ○ Ongoing contact, including for provision of grief counselling.
	
	(Recommendations 2 and 3, Child Death Review report , 2015)
		The first meeting, chaired by the Ministry, was held in July 2019 with the aim to establish a monitoring process of the actions agreed to by the NSW Government CAWG in 2017-18 (co-chaired by the Department of Premier and Cabinet and the NSW Deputy State Coroner) to:
		• increase the proportion of SUDI cases that are explained, and
		• ensure all families affected by SUDI in NSW are offered support and referral.
		The CAWG will meet quarterly.
		
		Forensic Medicine, NSW Heath Pathology have established a multi-disciplinary meeting to discuss the case prior to the post mortem results being sent to the family.
		
		Further work will be undertaken by NSW Health to determine the possibility of an early multi-disciplinary meeting, attended by all agencies involved in the first 2 weeks following the autopsy. This would include NSW Police, NSW Ambulance and NSW Health clinicians to review the adequacy and timeliness of reports provided to forensic medicine from the first responders. This will assist in ongoing monitoring regarding timeliness and quality of the information provided to Forensic Medicine following a SUDI.

Schedule: NSW Health's position regarding new recommendations made by the NSW Ombudsman in the Biennial Report of the Deaths of Children in NSW: 2016 and 2017

Reference	Recommendation	Summary of advice to date and requested information for reporting progress to NSW Parliament
Chapter 6 Section 6.7.2	**SUDI Safe sleeping in vulnerable families:** NSW Health should develop and implement strategies to promote safe infant sleeping 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. *(Recommendation 1, Biennial report of the deaths of children in NSW:2016 and 2017)*	NSW Health supports the new recommendation. NSW Health will meet with Family and Community Services representatives to discuss opportunities to work together to support families: • known to child protective services • living in rural and remote areas of NSW, and • living in areas of greatest socio- economic disadvantage.
Chapter 6 Section 6.7.4	**SUDI identification of illness in infants:** 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) *(Recommendation 2, Biennial report of the deaths of children in NSW: 2016-2017)*	NSW Health supports this new recommendation. NSW Health is in the process of contacting Red Nose to work collaboratively to promote evidence based and evaluated resources for parents and carers.

Chapter 8 Section 8.6.4	**Transport fatality crash surveillance** 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, Biennial report of the deaths of children in NSW: 2016-2017)*	Agreed in principle The Centre for Health Record Linkage (CHeReL) within NSW Health, provides health data and linkage services to Transport for NSW. Transport for NSW holds the linked dataset for their own surveillance and reporting purposes with the approval of NSW Ministry of Health but the dataset itself is not used by the Ministry. As a result any feedback on the recommendation should come from the lead Agency, Transport for NSW. NSW Health will continue to provide health data and linkage services to support the work.

red nose
saving little lives

Michael Barnes
Convenor, NSW Child Death Review Team
NSW Ombudsman
Level 24, 580 George St, Sydney

Dear Mr Barnes,

Thank you for your correspondence on 28 May 2019 seeking our response in relation to a previous recommendation made by Red Nose Australia to the Child Death Review Team (CDRT) regarding unintentional bed sharing. We trust that you will be pleased with our progress to date.

Red Nose Australia's public campaigns have and will continue to create real change in infant deaths through the translation of latest research into easily accessible education and adapting these messages to meet local community needs. This was seen with the 85% reduction in Sudden Infant Death Syndrome (SIDS) between 1989 and 2017.

However, we note that according to your report, that in the five years 2011-15, the CDRT identified that 18 infants had died in circumstances of unintentional bed sharing. In all cases, the infant was being fed on a bed (12) or lounge (6), and the adult caregiver fell asleep. The majority of infants were neonates.

Red Nose Australia agrees that safe sleep advice and education should identify and share strategies to assist parents and caregivers to avoid this devastating situation.

Your report also identified that almost one third of infants' mothers were aged 21 years or under, and noted it was critical that clear messages about safe sleep and safe environments be developed and delivered to specific high-risk populations.

This was of great concern to us. As the national lead in infant and child sleep safety, it is apparent that we need to have a greater focus on this somewhat overlooked but important topic and provide the necessary support and interventions required to all parent groups, in particular, our disadvantaged and vulnerable families.

Bed Sharing / Co-sleeping Guide for Parents

In response to the above findings, Red Nose Australia has broadened its safe sleep education suite by creating a simple, user friendly "Co-Sleeping Tool" to support all parents who co sleep; both intentionally and unintentionally. The purpose of the guide is to assist parents at their time of need, at a moment when they require quick reference. Often, this occurs in moments of desperation and extreme sleep deprivation.

Despite the vast amount of information available to parents and health professionals on our website with regard to this very important topic, we observed that the format in which it is presented is

Red Nose is dedicated to saving the lives of babies and children during pregnancy, birth, infancy and childhood and to supporting bereaved families.

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challenging and possibly overwhelming in its entirety. Red Nose Australia is looking to condense and simplify the way this information is made available.

This piece of work is an easy to read format, available to download and is printable. We will also have hard copies available for families upon request. The tone of the recommendations highlight risk minimisation strategies in the event of parents either intentionally or unintentionally co-sleeping with their baby.

Bed Sharing / Co-sleeping Guide for Healthcare Professionals

Following feedback from a wide selection of Maternal and Child Health Nurses across three municipalities in Victoria, a tool, similar to that created for parents, is being created for healthcare professionals and will include the clinical reasoning underpinning the recommended risk reduction strategies.

Strategies to Target Young Mums

The communication strategy to capture this important, vulnerable group of parents included a targeted ongoing digital communication strategy to reach new and expectant parents, including young mothers.

This involved the creation of a web subpage (https://rednose.org.au/article/co-sleeping-with-your-baby), the creation of a news article linking back to the product (https://rednose.org.au/news/accidental-co-sleeping); social media posts across Facebook, Instagram and LinkedIn; and inclusion of product link and information through targeted eDM communication channels.

Upcoming communication will include continued social and digital content, a targeted Google Adword, and written co-sleeping content linking back to the product.

We would welcome partnering with NSW to help us achieve more success in accessing this particular sub group of parents. We understand that collaboration, localisation and cultural sensitivity are the keys to success within our more vulnerable communities where the needs are more immediate and acute.

We thank the NSW Government for their past financial contributions to our safe sleeping and bereavement services and welcome any further partnership and funding opportunities to expand our reach in targeting those most at risk of SUDI.

Yours sincerely,

Keren Ludski
Chief Executive Officer
Red Nose

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Office of the Secretary

Our reference: BN-00050-2019
Your reference: ADM/2019/164

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

c/- Ms Pamela Rowley
Principal Investigation and Review Officer, NSW Ombudsman
By email: prowley@ombo.nsw.gov.au

Dear Mr Barnes

Thank you for your letter 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 confirm the response provided by Mr Martin Hoffman, then Secretary, Department of Finance, Services and Innovation, in February 2019 represents the current status of the recommendation concerning the NSW Swimming Pool Register (the Register). I have enclosed a copy of Mr Hoffman's letter for your reference.

In summary:

- some of the recommended data (the number of pools, number inspected and proportion compliant/non-compliant) was published in the 2017-18 Annual Report of NSW Fair Trading's Building Professionals Board
- in order to publish data about the reasons pool barriers fail inspections, and whether non-compliances were rectified by the owner within a reasonable timeframe will require upgrades to the Register to enable amalgamated reporting.

Enhancements to the Register, including the ability to provide amalgamated reports on a range of matters, are still being considered as part of a larger departmental information technology project.

Should your staff have any queries, please encourage them to contact Mr Dominic Wong, Manager Strategy and Industry Education, Building Professionals Board, NSW Fair Trading on 8522 7478 or by email to dominic.wong@bpb.nsw.gov.au.

Yours sincerely

Glenn King
Secretary

Date: 28/06/19

Encl. *February 2019 letter*

Finance, Services & Innovation
NSW GOVERNMENT

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Office of the Secretary

Our ref: FTMIN19/51
Your ref: ADM/2017/600

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

c/- Ms Stella Donaldson
Executive Assistant to Deputy Ombudsman and Community and Disability Services
By email: sdonaldson@ombo.nsw.gov.au

Dear Mr Barnes Michael

Thank you for inviting the Department of Finance, Services and Innovation (DFSI) to comment on the draft chapter on child drownings in the *Biennial report of child deaths in New South Wales in 2016 and 2017*.

I can confirm that DFSI has no significant issues to raise in relation to the Report. However, the attachment to this letter includes two minor suggestions for clarification as well as an update on the implementation of recommendation 10 of the *NSW Child Death Review Team Report 2015*, which was referred to in the draft chapter.

Thank you again for providing DFSI with the opportunity to comment. If you require more information, please contact Mr Dominic Wong, Manager Strategy and Industry Education, Building Professionals Board, NSW Fair Trading on 8522 7478 or dominic.wong@bpb.nsw.gov.au.

Yours sincerely

Martin Hoffman 27/2/19
Secretary

Encl.

Transport for NSW

Your ref: ADM/2019/164
Our Ref: SO19/04460

Mr Michael Barnes
NSW Ombudsman
Convenor, NSW Child Death Review Team
L24, 580 George Street,
Sydney, NSW 2000

Dear Mr Barnes

Thank you for your correspondence seeking a formal response in relation to the road safety recommendations in the *Biennial report of the deaths of children in NSW: 2016 and 2017.*

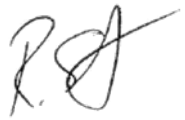
Safety is one of six customer outcomes under the *Future Transport 2056* strategy, so I am pleased to note the focus on transport safety in the report through Recommendations 3, 4, 5, 6, 7 and 8.

Transport for New South Wales supports these recommendations.

Please note that work is already underway which support the recommendations. For example, in relation to Recommendation 4, which proposes a study of child restraint practices in NSW, we have engaged Neuroscience Research Australia to conduct a study to estimate the appropriate and correct use among children 0-12 across NSW.

If you have any further questions, please contact Mr Melvin Eveleigh (Director, Safe Systems, Centre for Road Safety), on (02) 8265 6362, who is responsible for actions related to the recommendations.

Yours sincerely



Rodd Staples
Secretary

Transport for NSW
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Biennial report on the deaths of children in New South Wales: 2016-2017

Recommendations referred to Transport for NSW, and Transport for NSW comments:

Recommendation 3 – supported

3. 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).

Comment

Transport for NSW has supported the development and NSW rollout of ANCAP campaign Safer Vehicle Choices Save Lives campaign. Placement of campaign advertising in NSW has been funded by Transport for NSW which also created additional content for its Towards Zero website where NSW consumers are directed from this advertising. Further work will be carried out to enhance the content on the website during 2019, including the addition of more information on safety features.

Recommendation 4 – supported

4. 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.

Comment

Transport for NSW has engaged NeuRA to conduct a study to estimate restraint practices in terms of appropriate and correct use among children 0-12 across NSW. The study uses a multi-stage stratified random sampling used to represent the population of children in the age range. A total of 10 Local Government Areas have been selected, stratified based on ARIA (Accessibility and Remoteness Index of Australia).

Recommendation 5 – supported

5. 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.

Comment

Serious injuries and fatalities for children under 13 involved in crashes on public roads will be monitored regularly.

Recommendation 6 – supported

6. 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.

Comment

Transport for NSW already undertakes and supports a range of activities to promote information on best practice for restraining children over seven years of age. During 2019-20, 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 also create tailored content to target Aboriginal and CALD audiences on Facebook.

Recommendation 7 – Supported

7. 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.

Comment

Transport for NSW has ongoing programs to reduce the incorrect use of child restraints in motor vehicles. These programs include:

- Child Restraint Evaluation Program (CREP) where it provides independent and consistent information advice to parents and carers on the levels of child protection from injury in a crash provided by child car seats and the level of ease with which they can be used correctly.
- Contributed financially and in-kind to a study conducted by NeuRA to increase the correct and age-appropriate use of child restraints by determining their ergonomic features that will increase child comfort and hence reduce the likelihood of errors in their installation and use. The study has produced a set of guidelines which has been tested to be able to increase the correct use. Transport for NSW – through CREP – will encourage manufacturers to implement the guidelines by providing a full five star rating in ease-of-use if they implement these guidelines in their products.
- Ongoing financial and policy supervision supports for the RMS Authorised Restraint Fitting Station Scheme whereby a research study shows children whose parents used the scheme are twice as likely to be correctly restrained than other children.

Recommendation 8 – supported

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.

Comment

Transport for NSW will enhance its educational activities to promote the prevention of low-speed vehicle run over crashes involving young children by creating additional Facebook content aimed at families, further promoting driveway safety messaging through existing partnerships with the school and early childhood education sectors, and producing additional driveway safety display kits for use in local communities by Kids and Traffic (Transport for NSW's) early childhood road safety education program), local council road safety officers, and Transport for NSW road safety staff.

A number of promotional resources have already been developed to promote good practice and education for families. These include:

- Driveway Safety Campaign – this is now promoted through social media
- Road Safety A Guide For Families and Carers of Children Birth To 5 Years – includes information about driveway safety.
- It only takes a second - teddy bear poster – reminds parents and carers of the importance of close supervision of young children near driveways.
- It only takes a second - goodbye dad poster – reminds parents and carers of the importance of close supervision of young children near driveways

Attachment A:

Additional Information on current promotional activities for promoting the safe restraint of children of all ages

Centre for Road Safety website

The Centre for Road Safety website has detailed content and guidelines based on the national child restraint laws. This content is one of the top 10 most visited pages with about 19,000 page views per month.

Facebook

Posts on child restraints are published on the NSW Road Safety Facebook page, which reaches an average of 1.4 million people per week. In June 2019, Transport for NSW created a short animation the 'Five-step Test' to clearly demonstrate to parents and carers when a child is ready to move to a seatbelt.

While the laws state that children aged 7 and over are permitted to use an adult seatbelt, the Centre recommends that children aged from seven years old but under 16 years old who are too small to be restrained by a seatbelt properly adjusted and fastened should be restrained in an approved booster seat.

The Centre also recommends a suggested minimum height of 145cm for children to use an adult lap-sash seatbelt.

Child Restraint Evaluation Program (CREP)

Transport for NSW also promotes the safe restraint of children over seven years of age through the Child Restraint Evaluation Program (CREP), a consortium of government agencies and motorist organisations who share a common interest in improving safety for children travelling in vehicles. CREP publishes child restraint safety ratings and information on the Child Car Seats website where visitors can quickly find and compare more than 200 types of child restraints, including the safest booster seats for children who may be aged 7 and over but are too small to use an adult seatbelt.

Wiggles concerts

Transport for NSW has a stand at Wiggles concerts performed across NSW as part of a partnership to promote the correct use of child car seats.

Sydney Royal Easter Show

The Child Car Seats website and safe fitting and use of child car seats are promoted annually at Transport for NSW's stand at the Sydney Royal Easter Show. The stand features a child car seat display, with restraint fitting specialists on hand, who answer detailed questions from hundreds of visitors about the safe fitting of child car seats and when they should move their children to the next level of seat.

Local Government Road Safety Program

Transport for NSW commits about $6 million per year to fund the Local Government Road Safety Program. Through this program, Road Safety Officers in local councils across the state deliver a range of child car seat safety projects to the community, including child car seat fitting days, Authorised Restraint Fitting Station free voucher schemes, and local community education initiatives to promote the use of www.childcarseats.com.au.

Roads and Maritime Services (RMS) Behavioural Road Safety Program

In 2017/18:

- 981 restraints were checked at 33 Child Restraint Checking Days conducted across NSW.
- 139 child restraint presentations conducted across NSW with an audience reach of 6,433.
- 1,117 child restraint vouchers provided across NSW.
- RMS stand at Pregnancy, Babies and Children's Expo provided 3,500 resources distributed to a potential audience of 20,000.
- 41 CALD occupant restraints presentations delivered to approx. 1,000 people.

AFL Indigenous Youth Leadership Program

In 2019/20, Transport for NSW begins a new three-year indigenous program with AFL NSW/ACT that includes running leadership camps for 12-15 year olds. Several Aboriginal AFL player ambassadors will be actively involved in the camps advocating the importance of road safety. A focus on restraints will be included in workshops and educational videos will show the consequences of seatbelt misuse.

Specific events for Aboriginal communities

Transport for NSW and Roads and Maritime are involved in a range of community events including Yabun, NAIDOC Day and the Koori Knockout promoting a range of road safety messages such as restraint use.

The child car seat display will be at the NAIDOC Day event at National Centre for Indigenous Excellence on 12 July 2019 to engage with the Aboriginal Community on safe restraints for children. Specialist staff will be on hand to answer safety questions and to offer advice specific to the needs of the community.

NSW GOVERNMENT | SafeWork NSW

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Locked Bag 2906, Lisarow NSW 2252
Customer Service Centre 13 10 50
ABN 81 913 830 179 | www.safework.nsw.gov.au

Our Reference: 00582/19
Your Reference: ADM/2019/164

Mr Michael Barnes
NSW Ombudsman
By email: prowley@ombo.nsw.gov.au

Dear Mr Barnes

Thank you for your correspondence to SafeWork NSW (SafeWork) dated 19 July 2019.

SafeWork acknowledges the *Biennial Report of the deaths of children in New South Wales: 2016 and 2017* as tabled in the NSW Parliament on 25 June 2019. SafeWork NSW confirms support of recommendation nine (9) in this report, 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.*

As requested in your correspondence, this response does not detail actions planned or underway to support the recommendation. I note you will seek further details on these actions in 2020.

However, in broad terms, SafeWork administers, provides advice and enforces compliance with the *Work Health and Safety Act 2011* (the WHS Act) and the *Work Health and Safety Regulation 2017* as they relate to NSW workplaces. As such the SafeWork NSW Quad Bike Safety Improvement Program aims to reduce the unacceptable level of quad bike fatalities and serious injuries on NSW farms. The Program includes a quad bike safety rebate and training package, as well as strategies to raise awareness of the dangers of children using adult-sized quad bikes, as well as preventative measures.

SafeWork's guidelines (available online at: www.safework.nsw.gov.au/hazards-a-z/quad-bikes) state that children under 16 years of age should not be allowed to ride adult-sized quad bikes. Criminal penalties exist under the WHS Act, where a person conducting a business or undertaking fails to provide a safe system of work or provide and maintain safe plant in a work environment.

Should you have any further queries, please contact Diane Vaughan, Principal Project Manager, Quad Bike Safety Improvement Program, SafeWork NSW on 02 8867 2768 or via email diane.vaughan@safework.nsw.gov.au

Yours sincerely

Tony Williams
Executive Director, Operations
SafeWork NSW

Date: 5 August 2019

NSW GOVERNMENT | Premier & Cabinet

Ref: A3077792

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 19 July 2019 regarding two recommendations made by the CDRT in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*.

The NSW Government's position on these recommendations is as follows:

Recommendation 10 - Supported.

Recommendation 11 - Supported.

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

Yours sincerely

Amy Brown
A/Secretary
12 August 2019

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NSW GOVERNMENT | Education

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

DGL19/502

Dear Mr Barnes

Thank you for your letter of 19 July 2019 seeking a formal response to two recommendations made by the NSW Child Death Review Team in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*.

The Department of Education has reviewed the report and our response to the recommendations is attached.

Suicide prevention 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 will also continue to work with other government agencies and leading mental health organisations to support public schools in delivering best practice suicide prevention.

Yours sincerely

Mark Scott AO
SECRETARY
DEPARTMENT OF EDUCATION
5 August 2019

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

DGL19/502

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

Report Recommendations	Response and Comments
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.	**Supported** NSW Department of Education will commission an evaluation of postvention initiatives in NSW government high schools. It is timely for us to do this with the 2015 NSW Department of Education evidence-based guidelines *Responding to Student Suicide - Support Guidelines for Schools*. The Department's procedures and strategies facilitate rapid response and support to schools following student suicide that address the impact on the school community and are also aimed at preventing suicide clusters.
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.	**Supported** The Department of Education will establish an appraisal process after the suicide death of a child or young person to inform future practice and policy.

Catholic Schools NSW

From the desk of the CEO
Dallas J McInerney

Tuesday, August 6, 2019

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

Dear Mr Barnes,

RE: Response to Recommendation by NSW Child Death Review Team (CDRT) report

Thank you for your letter of 19 July 2019 and the NSW Child Death Review Team's annual report to Parliament.

Catholic Schools NSW (CSNSW) is happy to confirm its support of recommendation 13 in Chapter 11 of the "Biennial Report of the Deaths of Children in NSW: 2016 and 2017" which states that;

> "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".

CSNSW aims to take a leadership role in coordinating and representing Catholic education in NSW at a state and national level. Educating one in five NSW school students, we are particularly concerned at the prevalence of suicide as the 4th most frequent cause of death for 10-14 year olds and the 2nd most prevalent cause of death for children aged 15-17 years.

CSNSW has existing mechanisms which support student wellbeing and works with Catholic school agencies (these include diocesan offices as well as stand-alone 'Independent' Catholic schools) on these matters.

We look forward to providing additional information as required about the way in which we intend to implement the recommendation, incorporating our existing mechanisms.

If you have any further questions please do not hesitate to be in touch with my office.

Yours Sincerely,

Dallas Mcinerney
Catholic Schools NSW

8/viii/19

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empowering
independent
education

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Your reference: ADM/2019/164

15 August 2019

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

SUBJECT: AISNSW response to *Biennial report of the deaths of children in NSW: 2016 and 2017*

Dear Mr Barnes,

Thank you for your letter of 19 July 2019 seeking a formal response from the Association of Independent Schools of NSW (AISNSW) to recommendation 14 of 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 supports recommendation 14 in its entirety. AISNSW provides both proactive and responsive support for schools through a systematic approach that is multi-faceted, coordinated and sensitive to each school's individual context. Informed by best-practice, these approaches are focused on supporting schools with the establishment of sound whole-school processes for wellbeing, mental health and suicide prevention.

I note your intention to publish this correspondence in full in your October 2019 report, and your intention to seek information in mid-2020 about actions to implement this recommendation.

Yours sincerely

Dr Geoff Newcombe AM

Chief Executive

Child Death Review Team
NSW Ombudsman
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