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New South Wales

NSW Child Death Review Team
Annual Report 2020-21

nsw cdrt
child death review team

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26 October 2021

The Hon Matthew Mason-Cox 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 2020-21

As Convenor of the NSW Child Death Review Team (CDRT), I am pleased to present the NSW Child Death Review Team Annual Report 2020-21 for tabling in Parliament.

This report is made under s34F of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. It details the activities of the CDRT and progress of its recommendations.

I recommend that this report be made public immediately.

Yours sincerely

Paul Miller

Convenor, NSW Child Death Review Team
NSW Ombudsman

Contents

About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during the period 1 July 2020 to 30 June 2021.

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

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

The report is arranged in the following chapters:

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

1. The NSW Child Death Review Team

1.1 Who we are

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

CDRT membership is prescribed by the Act. Members are:

- The NSW Ombudsman, who is the Convenor of the CDRT
- The NSW Advocate for Children and Young People
- The Community and Disability Services Commissioner
- Two persons who are Aboriginal persons
- Representatives from NSW Government agencies:
    - NSW Health
    - NSW Police Force
    - Department of Communities and Justice[1] (two representatives, one in respect of the *Children and Young Persons (Care and Protection) Act 1998*, and one in relation to the *Disability Inclusion Act 2014*)
    - Department of Education
    - Department of Justice[2]
    - Office of the NSW State Coroner
- Experts in health care, research methodology, child development or child protection, or persons who because of their qualifications or experience are likely to make a valuable contribution to the CDRT.

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

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

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

[2] Ibid.

1.2 CDRT members at 30 June 2021

Ex officio members

Mr Paul Miller (Convenor)
NSW Ombudsman
Community and Disability Services Commissioner

Ms Zoe Robinson
NSW Advocate for Children and Young People

Agency representatives

Detective Superintendent Danny Doherty
Commander Homicide Squad, State Crime Command
NSW Police Force

Ms Eloise Sheldrick (on leave)
Coordinator and Assistant Coroner, Coronial Information and Support Program
Coroner's Court of New South Wales

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

Mr Ben Spence
Executive District Director, Hunter & Central Coast District
District and Youth Justice Services
Department of Communities and Justice

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

Mr Matthew Karpin
Director, Criminal Law Specialist, Policy and Reform Branch
Department of Communities and Justice

Independent experts

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

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

[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.

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

Dr Susan Arbuckle
Paediatric and Perinatal Pathologist
The Children's Hospital at Westmead

Dr Isabel Brouwer
Statewide Clinical Director
Department of Forensic Medicine

Dr Luciano Dalla-Pozza
Head of Department (Cancer Centre for Children), Senior Staff Specialist (Paediatric Oncology)
The Children's Hospital at Westmead

Dr Bronwyn Gould
General Practitioner

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

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

Ms Catherine Lourey
Commissioner
Mental Health Commission of New South Wales

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

1.3 Previous members (1 July 2020 to 30 June 2021)

Mr Michael Barnes (to August 2020)
NSW Ombudsman

Assistant Commissioner Scott Cook (to May 2021)
Police Prosecutions and Licensing Enforcement Command
NSW Police Force

Ms Lisa Alonso Love (to June 2021)
Executive Director Learning and Wellbeing, Educational Services
Department of Education

1.4 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 2020-21 include:

- Professor Les White, former NSW Chief Paediatrician and CDRT member for NSW Health
- Dr Lorraine du Toit-Prinsloo, Senior Staff Specialist, Clinical Training Coordinator, Forensic Medicine Newcastle
- Ms Kyra Parry-Williams, Acting Coordinator, Coronial Information and Support Program, Coroner's Court of New South Wales
- 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
- Dr Fadwa Al-Yaman, Group Head, Australian Institute of Health and Welfare
- Dr Prem Thapa, Senior Project Manager, Australian Institute of Health and Welfare
- Ms Tracy Dixon, Unit Head, Australian Institute of Health and Welfare

Chapter 4 includes details of researchers currently undertaking projects for the CDRT.

2. Our functions

Under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act), 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 that may assist in preventing or reducing the likelihood of child deaths.

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

- Maintain a register of reviewable deaths
- Monitor and review 'reviewable' deaths
- Undertake, alone or with others, research that aims to help prevent or reduce, or remove risk factors associated with reviewable deaths that are preventable.
- Make recommendations as to policies and practices for implementation by government and non-government service providers to prevent or reduce the likelihood of reviewable child deaths.

2.1 Reporting to NSW Parliament

The CDRT reports directly to the NSW Parliament, with oversight by the Parliamentary Committee on the Ombudsman, the Law Enforcement Conduct Commission and the Crime Commission. There are three provisions in the Act under which the CDRT is required to report to Parliament:

- The **annual report** (s 34F), which details the activities of the CDRT and progress of its recommendations. This is the annual report for 2020-21.
- 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 provide information on the results of research undertaken in the exercise of our research functions. The CDRT may report to Parliament at any time and is expected to report on its research at least once every three years. Details of recent and current research are provided in Chapter 4.

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

Biennial reports, and reports by the Ombudsman of reviewable deaths of children are available at: https://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths

Research reports published by the CDRT are available at: https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/child-death-review-team

Since 2019, the CDRT biennial report and the Ombudsman's biennial report of reviewable child deaths have been combined into one report. The focus of both functions is to help prevent the deaths of children. Combined reporting allows us to present an integrated report that examines all child deaths in NSW, and the contexts in which the deaths occur, in a way that focuses on factors and whole of population measures for prevention.

The most recently tabled biennial report (August 2021) is available at: https://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths/biennial-report-of-the-deaths-of-children-in-new-south-wales-2018-and-2019-incorporating-reviewable-deaths-of-children

2.2 Meetings of the CDRT

The CDRT met formally on four occasions in 2020-21: September 2020; December 2020; March 2021; and June 2021. All meetings were held via an online platform due to restrictions arising from the COVID-19 pandemic.

Planning forums

The CDRT meets every three years to form a strategic action plan. In 2020-21, we continued to progress agreed strategies in the CDRT's Strategic Priorities Plan 2019-2022. This plan, and progress against actions, is included at Appendix 1.

2.3 CDRT Secretariat

The CDRT's day-to-day work is supported by staff of the Death Reviews unit in the NSW Ombudsman's Office. During the 2020-21 period, this unit comprised 10-12 staff. The unit is also responsible for the Ombudsman's child death review function, as well as the Ombudsman's separate functions of reviewing certain deaths of people with a disability who were living in supported group accommodation. Work undertaken by staff to assist the CDRT includes:

- Registration of individual deaths. On average, approximately 450-500 children die in NSW each year.
- Gathering relevant information and records from stakeholders and service providers.
- Recording information in the Register of Child Deaths and analysing and reviewing that information.
- Identifying systemic issues and providing strategic advice to the CDRT.
- Coordination, oversight and completion of research and other projects to support the work of the CDRT.
- Preparing statutory reports (annual, biennial, and research).
- Monitoring recommendations from previous reporting periods.
- Performing secretariat functions for the CDRT.

The CDRT and COVID-19

We are not aware of any child who died as a direct result of acquiring COVID-19 in NSW. At this stage, we have also not identified any deaths of children due to causes that have been attributed indirectly to COVID-19-related issues.

We are aware, however, that concerns have been raised at various time about the potential mental health impacts of COVID-19 related public health measures on children as well as potential impacts of COVID-19 on the timely access to diagnosis or treatment services for non-COVID-19 related conditions. We will continue to monitor child deaths and actively consider whether there is any possible direct or indirect association with COVID-19, or actions taken in response to it.

The members of the CDRT acknowledge those families and other loved ones who have had to deal with the death of a child or young person during these difficult times, aware that circumstances, including limits imposed at various times in NSW on the number of mourners at funerals and restricted visiting in hospitals, state border restrictions, and 'hotspot' lockdowns, have added to their stress and grief.

2.4 CDRT Charter and Code of Conduct

In August 2020, we engaged a consultant, Cultural Perspectives, to develop a new statement of purpose and vision, service charter, and code of conduct for the CDRT.

In September 2020, members participated in a focused workshop and a process of further consultation and feedback followed which produced a draft Charter and Code of Conduct. The final documents were endorsed by the CDRT in December 2020.

The Charter and Code of Conduct can be accessed at: https://www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/child-death-review-team

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

Our vision is:

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

Our purpose is:

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

We work to achieve our vision and purpose through the clear articulation of strategic priorities that are designed to build, enhance, collaborate, and expand initiatives and strategies that result in the increased safety and wellbeing of children and the elimination of preventable deaths.

3. Reporting of child deaths

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

The CDRT's *Biennial report of the deaths of children in New South Wales: 2018 and 2019* was tabled in August 2021. An overview of its findings and observations will be included in the next annual report.

3.1 Recommendations

Over the past 12 months, the CDRT has been monitoring 11 recommendations made to various agencies in relation to SUDI (3), drowning (1), transport-related fatalities (3), and suicide (4). Detailed information from agencies about actions they are taking to implement these recommendations is included later in this report in Chapter 7.

4. Research to help reduce child deaths

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

The Act anticipates that the CDRT will table a research report in Parliament on a triennial basis, with reasons required to be given if such a report has not been presented within the previous 3 years.

In 2020-21, we did not table any reports from research projects; however, several research projects are currently underway. Three of these projects are discussed below.

4.1 Research in progress

Social determinants and early childhood mortality

In 2019, we commissioned the Australian Institute of Health and Welfare (AIHW) to conduct a research project using data linkage: 'Analysing the effects of antenatal care, birth conditions and socioeconomic status on early childhood mortality'.

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

The linked data includes information from the NSW Register of Child Deaths, data from Births Deaths and Marriages, and NSW Health Perinatal Data Collection, and the AIHW National Death Index. It also includes some selected area-level data derived from the 2011 and 2016 Census based on the usual place of residence.

The project has three main components: a) summary comparative analysis of the characteristics of the children who have died and who survived to specific ages by birth cohort; b) logistic regression modelling of the risk of death at an individual child level; and c) analysis of all child deaths under five years for the full set of children in the CDRT records.

At the time of writing, data linkage and initial analyses have been completed, and preliminary high-level findings identified. Work is underway to undertake final analyses and prepare a report for the NSW Parliament about the project. We aim to publish the results of this research in early 2022.

Review of infant deaths associated with hypoxic-ischemic encephalopathy (HIE)

Our work on this research project continues. Its aim is to identify opportunities to reduce potentially preventable deaths of newborn infants with asphyxia-related causes such as HIE.

The work involves review of newborn infant deaths over the four-year period from 2016 to 2019, considering issues such as the level of monitoring of women in labour, recognition of abnormal traces via monitoring, and the timeliness and appropriateness of decision-making in relation to women at risk.

The project is being led by a member of the CDRT who will oversee the key findings and outcomes of the project. An experienced clinical midwife consultant has been recruited to undertake a detailed case review of 101 neonatal deaths in NSW with HIE that met the inclusion criteria. The reviews will be

synthesised into a data and thematic analysis of key issues which identify strategies and recommendations to reduce potentially preventable HIE infant deaths in the future.

We aim to publish the results of this research in early 2022.

Review of the suicide deaths of Aboriginal children and young people

Aboriginal and Torres Strait Islander children and young people are over-represented in suicide deaths of children and young people aged 10-17 years. Over the 2011-2020 period, the NSW child death register recorded the deaths by suicide of 238 children and young people aged 10-17 years, including 43 (18%) who were identified as being from an Indigenous background.

The primary aim of this project is to identify opportunities for preventing and reducing the suicide deaths of Aboriginal and Torres Strait Islander children.

The project will also add to knowledge and contextual understanding of:

- Factors that may contribute to suicide risk and interventions – programs, agencies, organisations – that may have a positive impact on wellbeing and suicide prevention for Aboriginal and Torres Strait Islander children
- Factors that are unique in consideration of strategies to prevent suicide of Aboriginal and Torres Strait Islander children

The project has four main components: a literature and policy review; a service mapping exercise; detailed case review of the Aboriginal and Torres Strait Islander children and young people who died by suicide in the period 2011-2020; and a consultation process including Aboriginal community-controlled organisations.

The project is being led by Aboriginal members of the CDRT. The Sax Institute has been engaged to complete the literature/policy review and service mapping components of the project. We have also engaged the Ngarruwan Ngadju First Peoples Health and Wellbeing Research Centre to provide expert advice for the review.

We aim to complete this work in 2022.

5. Other activities

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

5.1 National child death review group

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

On 18 and 20 May 2021, and in the context of COVID-19 travel restrictions, we hosted the group's first virtual annual conference.

The first day of the conference was devoted to presentations delivered by a range of academics and national experts. Topics included:

- Indigenous Data Sovereignty and data governance
- Evidence from linked data studies related to Aboriginal child injury
- Processes undertaken to achieve a minimum national data set on intimate partner homicide
- Coding child deaths as part of the National Mortality Dataset
- An overview of the National Children's Commissioner's priorities and key activities.

The second day of the conference was a meeting attended by members of the group's Secretariat. The meeting included focused contributions from each jurisdiction, discussion about national data collection, a conversation with the National Children's Commissioner, and planning for 2022. The group agreed that NSW would again convene the national conference in 2022.

We received excellent feedback from those who attended all or parts of the conference, and it was generally noted that an online conference offered greater opportunities for participation and the sharing of expertise among professionals. Planning is now underway for the 2022 conference.

Further information about the group and its members is available on our website: https://www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/child-death-review-team/australian-and-new-zealand-child-death-review-and-prevention-group

5.2 Injury prevention group

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

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

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

The group is supported by the Office of the NSW Advocate for Children and Young People. Members of the CYPIP are drawn from a cross section of academia, government, and non-government organisations. The CYPIP seeks to build on work already done and to utilise recent research into the prevalence of unintentional injury to children and young people in NSW.

6. Disclosure of information

6.1 Disclosures 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 2020-21, we made one disclosure under s 34L (1) (b): in September 2020, we provided aggregate information to Professor Heather Jeffery about infant deaths classified as SUDI over the past 10 years, including details about the number of deaths where a SUDI medical history was completed for deaths during the five-year period 2014-2018. This information was provided for research into SUDI medical history-taking by paediatricians in NSW.

6.2 Other information disclosures

Under section 34D (3) of the Act, the Convenor may enter into an agreement or other arrangement for the exchange of information between the CDRT and a person or body having functions under the law of another State or Territory that are substantially like the functions of the CDRT, relevant to the exercise of the CDRT's functions and those of the interstate body. The CDRT currently has formal agreements in place with the Australian Capital Territory (ACT) and Western Australia, and provides information to other states and territories on a case-by-case basis.

In this context, we provided information to agencies in Queensland, Northern Territory, Victoria, and the ACT:

- In July 2020, we provided the Queensland Family & Child Commission (QFCC) with de-identified aggregate data of deaths of children who died in NSW in 2018 by age, gender, Indigenous status and reporting category. In May 2021, we also provided information about the number of children who died in NSW due to heat stress associated with being left in a vehicle over the period 2016-2020.
- In July 2020, we provided the Northern Territory Child Death Review & Prevention Committee with de-identified data relating to the deaths of children in NSW in 2019 who were residents of the Northern Territory.
- In August 2020, we provided the Victorian Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) with de-identified data relating to the deaths of children in NSW in 2019 who were residents of Victoria.
- In February 2021, we provided the ACT Children and Young People Death Review Committee (CYPDRC) with information about the deaths of children in NSW in 2020 who were residents of the ACT. In March 2021, we provided the ACT CYPDRC with case information in accordance with our Information Exchange Agreement.

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

- The *Coroners Act 2009* (section 24) outlines the Coroner's jurisdiction concerning the deaths of children and disabled persons. In February 2021, we provided information to the Coroner in

relation to child deaths under section 34L (1) (c) (iii) of CS CRAMA for inclusion in the Chief Magistrates Annual Report 2020. The State Coroner also sought, and we provided, individual case reviews for three children in accordance with section 34L.

- In March 2021, as part of an infectious diseases data exchange agreement with NSW Health, we provided identified data to NSW Health in relation to children who died from infectious diseases in NSW in 2019, and any additional cases not previously reported in 2017 and 2018. In April 2021, we provided further data to NSW Health about children who died from infectious diseases in NSW in 2020.

7. Our recommendations

One of the functions of the CDRT is to make recommendations arising from our work as to legislation, policies, practices, and services that could be implemented by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.

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

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

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

As present, we have 11 open recommendations relating to Sudden Unexpected Death in Infancy (SUDI), private swimming pool regulation, road safety (safer vehicle choices, child seatbelt and restraint practices, and quad bikes), and suicide prevention.[5] These recommendations are detailed below, along with a report on the status of each recommendation.

Agency correspondence is provided in full at appendix 2.

7.1 Progress on recommendations

Sudden Unexpected Death in Infancy (SUDI)

Our recommendation: SUDI investigation

Recommendation 3, Child Death Review Report 2015 (published November 2016)

This recommendation originally comprised seven components. We ceased monitoring all but the following two proposals in 2020, as detailed below.

We recommended that the NSW Government, in the context of previous CDRT recommendations and the work of Garstang et al:[6]

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:[7]

[5] In addition to the 11 recommendations monitored by the CDRT, the Ombudsman is monitoring a small number of recommendations (2) that relate to reviewable child deaths.

[6] Garstang J., Ellis C., & Sidebotham P. (2015). Reporting to Sudden Unexpected Death in Infancy (SUDI): A review of the evidence. Research compiled for NSW Kids and Families, through the Sax Institute.

[7] Originally this recommendation listed seven elements – only two of these elements remain open.

(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.

(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.

Why we made the recommendation

In 2016, the CDRT observed that a cause of death was only able to be determined in approximately 25% of cases where an infant died suddenly and unexpectedly. Identifying a cause of death is important for several 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 to help prevent future deaths.

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

To what extent has the recommendation been implemented?

As noted, our original recommendation included seven elements aimed at improving the investigation of SUDI. The NSW Government supported the recommendation, and established a cross-agency working group (CAWG) under the lead of the Department of Premier and Cabinet (DPC) to develop strategies to address the issues identified. Responsibility for management of the CAWG and implementation of the recommendation was transferred to NSW Health in July 2019.

In October 2020, noting progress made in a number of key areas, we accepted the intent of elements (a), (b), (d), (f) and (g) of this recommendation had been met. We reported we would continue to monitor elements (c) and (e).

(c) SUDI medical history

In July 2019, NSW Health published a revised policy directive relating to the management of SUDI, including a revised SUDI medical history protocol.[8] Completion of the infant medical history is mandatory, and it is a requirement to provide a copy of the infant's health care record to NSW Health Pathology Forensic Medicine within 24 hours of the infant's death.

In November 2019, the State Coroner released findings of an inquest into the sudden and unexpected deaths of two infants.[9] One of the Coroner's recommendations was that NSW Health implement their proposed audit of the revised medical history form over a period of 12 months, and that it take steps to ensure the SUDI medical history form is provided to the case forensic pathologist in a timely manner.

In July 2020, NSW Health advised us that the Coronial inquest findings aligned with aspects of the CDRT's recommendations and was also shaping the work of the CAWG. NSW Health further acknowledged that additional work was required to ensure the SUDI medical history is completed as required and provided

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

[9] Coroners Court NSW 2020. Inquest into the deaths of Kayla EWIN and Iziah O'SULLIVAN (nsw.gov.au) accessed 15 September 2021.

to Forensic Medicine in a timely manner. NSW Health noted that the CAWG continues to support agencies to improve systems for medical history collection.

(e) Conduct of SUDI post-mortems

In December 2018, DPC advised that, against a background of national and international workforce shortages and training issues regarding paediatric pathologists, 'Forensic Medicine is working with NSW Health Pathology on ways to consult with paediatric pathologists' when conducting SUDI post-mortems.

In July 2020, NSW Health confirmed that in NSW post-mortem examinations on infants are completed by forensic pathologists, with selective involvement of paediatric pathologists, and that there is a shortage of paediatric pathologists in NSW and Australia which limits access to this resource. NSW Health further advised that genetic testing will be conducted in SUDI cases at the discretion of clinical paediatric specialists and/or the forensic pathologist involved in a specific investigation.

In October 2020, we reported that there did not appear to have been any further progress in relation to DPC's advice about consultations with paediatric pathologists, other than in relation to genetic testing. We also noted that NSW Health Pathology were in the process of finalising a new SUDI post-mortem protocol, and that work on this protocol had been underway for some time.

Our assessment of progress

NSW Health's revised policy relating to the management of SUDI includes a new SUDI medical history protocol. During the 12 months to 30 June 2021, the period covered by this report, the new SUDI policy was in place. Our review of SUDI matters during this period showed that there continued to be a significant number of SUDI cases where a medical history was not taken. We acknowledge the likely time lag between the release of the policy and evidence of any change in the comprehensiveness of SUDI medical histories taken.

Given the policy change, and considering NSW Health's proposed audit of its revised SUDI medical history form, in August 2021, we reported we would cease monitoring our previous recommendation regarding SUDI medical histories, and instead recommend:[10]

> That NSW Health complete a detailed audit of compliance with the revised SUDI medical history protocol. The audit should include information and analysis about:
>
> a. The number of infants presented to emergency departments following their sudden and unexpected death.
> b. The number of medical history interviews conducted in response to these deaths.
> c. An assessment of whether the intent of the policy directive has been met and is reflected in the information gathered.
> d. Information about the position of the health professional who completed the interviews, the location of the health facility, and the timing of the interview in relation to the death incident.
> e. Whether the information gathered in the interview was provided to Forensic Medicine, and the timeliness of this (within 24 hours of the infant's death).
> f. Where SUDI medical history interviews are not conducted, whether relevant staff are aware of health's policy, and reasons why the interview was not completed.

[10] NSW Child Death Review Team (2021). Biennial report of the deaths of children in New South Wales: 2018 and 2019. NSW Ombudsman, Sydney.

g. Details about any strategies or outcomes arising from the audit.

NSW Health should provide an audit plan and timeframes to the CDRT by 17 December 2021.

We will be seeking advice from NSW Health about its acceptance of, and progress to implement, our new recommendation.

In relation to the conduct of SUDI post-mortems, we acknowledge NSW Health Pathology is in the process of finalising a new protocol for SUDI post-mortems. We will continue to monitor this element, pending release of the protocol.

Our recommendation: safe sleeping in vulnerable families

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

We recommended that:

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

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

Why we made the recommendation

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

NSW Health supported the recommendation.

To what extent has the recommendation been implemented?

From 1 January 2019, NSW Health's *Baby Bundle* – a bag containing items to support the health, development and wellbeing of babies born in NSW, including reducing the risk of SUDI (a baby safe sleeping bag) and safe sleep information – has been given to parents and caregivers of newborn babies when discharged from hospital.

In November 2019, NSW Health met separately with the Department of Communities and Justice (DCJ) and Red Nose, and then hosted a meeting between both agencies to discuss opportunities for the two agencies to work together to support vulnerable families.

In July 2020, NSW Health advised that subsequent meetings planned for March 2020 were delayed and would be rescheduled. As at July 2021, the planned meetings to receive an update from both agencies have been further delayed given the impact of the response to COVID-19.

In September 2021, NSW Health advised that it had published a revised *Recommended Safe Sleep Practices for Babies* Guideline,[11] which contains information about strategies to support families. NSW Health noted that all carers should receive written, culturally appropriate, safe sleeping information about recommended safe sleep practices, and that a Safe Sleeping Recommendations information flyer has been developed for parents and to support discussions by clinicians with parents. The information flyer is available on the health website in 21 languages.

NSW Health also advised that its resources have been updated to reflect the revised Guideline, including the Aboriginal Maternal Infant Health Services (AMIHS) Strong Women, Strong Babies pregnancy diary; AMIHS/Building Strong Foundations Safe Sleeping for Your Baby brochure; and My Personal Health Record (the Blue Book).

Our assessment of progress

We acknowledge the initiatives noted above. We will continue to monitor the development and implementation of strategies that specifically focus on and target safe infant sleep practices in vulnerable families – those known to child protection services, living in remote areas, and living in the most disadvantages areas of the state.

Our recommendation: identification of illness in infants

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

We recommended that:

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

Why we made the recommendation

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

While there are several resources available to assist parents, primarily website based, that provide guidance on illness in infancy, we considered more could be done to actively support carers to identify and respond to illness in infants.

NSW Health supported this recommendation.

To what extent has the recommendation been implemented?

In August 2019, NSW Health provided initial advice that it was in the process of contacting Red Nose[12] to work collaboratively to promote evidence-based and evaluated resources for parents and carers.

[11] NSW Health, GL2021_013, Recommended Safe Sleep Practices for Babies Guideline, published 27 July 2021. This guideline replaces Babies – Safe Sleeping Practices (PD2019_038). Accessed 1 October 2021 at https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2021_013

[12] Red Nose is an Australian organisation 'dedicated to saving little lives during pregnancy, infancy and early childhood, and supporting anyone impacted by the death of a baby or child'. See https://rednose.org.au/

In its July 2020 update, NSW Health provided a summary of existing available resources, such as the Health Direct website, and information and linkages to resources available via the Blue Book.

Our assessment of progress

Preceding infectious illness continued to be factor present in a substantial proportion of the infant deaths in 2018 and 2019 that were classified as SUDI. Our recommendation has not been implemented and we will continue to monitor this recommendation.

Drowning: private swimming pools

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

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

We recommended that the Office of Local Government should:

Publish annual data from its analysis of the swimming pool register, including but not limited to:

a. the number of pools registered

b. the number of pools that have been inspected

c. the proportion of inspected swimming pools that were deemed non-compliant with the Act at the time of inspection

d. the main defects identified at the time of inspection, and

e. **whether or not owners have rectified defects within a reasonable period of time**.

Why we made the recommendation

Pool inspection and compliance with legislation is managed within local government areas. The *Swimming Pools Regulation 2018*[13] requires local councils to report publicly on the number of inspections carried out, the proportion that were deemed non-compliant with legislation, details of the defects identified, and whether owners rectified defects within a reasonable period of time.

While some information about swimming pool safety and inspection is published in annual reports of local councils and the Building Professionals Board, the information that is currently published is not comprehensive or consistently provided by each council. We consider there should be open and regular public reporting on key aspects of swimming pool regulation, and in particular, the outcomes of the regulatory regime for swimming pool safety and inspection.

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

The Swimming Pool Register is currently managed by NSW Fair Trading within the Department of Customer Service (DCS).

To what extent has the recommendation been implemented?

In June 2020, DCS advised us that the Swimming Pool Register cannot currently provide an amalgamated report of the reasons pool barriers fail inspections, and whether non-compliances were rectified by owners within reasonable timeframes. Planned upgrades to the Register are required and will not be available until 2021.

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

In September 2021, DCS advised that upgrades to the Pool Register are now planned for 2022, not 2021.

Our assessment of progress

To date, our recommendation has not been implemented. The information that is currently published is not comprehensive or consistently provided by each council. We believe it should be.

In August 2021, we reported we are continuing to monitor this issue and report on the extent of publicly accessible data on the effectiveness of the regulatory regime. Considering advice from DCS about its planned upgrades, we amended our recommendation:[14]

> The Department of Customer Service, in its planned upgrade of the Swimming Pool Register, ensure its collection and reporting capability allows for public amalgamated reporting of compliance data relating to the key aspects of swimming pool regulation, including the reasons pool barriers fail inspections, and whether non-compliances were rectified by owners within reasonable timeframes.

Transport-related fatalities

Our recommendation: safer vehicle choices

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

We recommended that:

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

Why we made the recommendation

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

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

Transport for NSW (TfNSW) supported the recommendation.

To what extent has the recommendation been implemented?

In June 2020, TfNSW advised steps to implement this recommendation were underway:

- NSW consumers are directed to the Towards Zero website from advertising associated with the *Safer Vehicle Choices Save Lives* campaign.

[14] NSW Child Death Review Team (2021). Biennial report of the deaths of children in New South Wales: 2018 and 2019. NSW Ombudsman, Sydney.

- additional content aimed at younger drivers is being developed for publication on the Towards Zero website.
- in future, the ANCAP website will enable price range car searches, similar to the '*howsafeisyourcar*' website.

In July 2021, TfNSW advised the Centre for Road Safety has been working with ANCAP and the Vehicle Safety Research Group to develop a website that will allow consumers to search vehicles within a price range, providing the most appropriate safety rating for that vehicle. Once launched, TfNSW will promote this website, particularly to young drivers. In the interim, the Centre for Road Safety has been promoting the '*howsafeisyourcar*' website, including linking to it from the Towards Zero website. While operated by the Victorian-based Transport Accident Commission, the website provides a user-friendly interface for drivers to search for safety ratings for new and used vehicles.

Our assessment of progress

We acknowledge progress has been made to implement this recommendation.

Considering TfNSW's advice, in August 2021, we amended our recommendation:[15]

> Transport for NSW (Centre for Road Safety) include in its proposed website to allow consumers to search vehicles within a price range and by safety rating, a page targeted at young drivers. The website should be promoted directly to young drivers through a focused campaign.

Our recommendations: child restraints and seatbelts

Recommendation 4, Biennial report of the deaths of children in NSW: 2016-17 (published June 2019)

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

Transport for NSW should undertake a study of child restraint practices in NSW. The study should have a particular focus on areas of socio-economic disadvantage and those outside major cities (recommendation 4).

Why we made the recommendation

In 2019, we released a report detailing our findings from a review of the deaths of 66 children who died as passengers in NSW during the period 2007-2016.[16] The review found that just over half the children who died were not properly restrained in the vehicle at the time of the crash, and that correct use of a restraint or seatbelt may have prevented almost one in three of the deaths that occurred.

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

- Children who lived in the lowest socio-economic areas of NSW
- Crashes that occurred outside of major cities, and/or on high-speed roads, and
- Aboriginal and Torres Strait Islander children.

[15] NSW Child Death Review Team (2021). Biennial report of the deaths of children in New South Wales: 2018 and 2019. NSW Ombudsman, Sydney.

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

Transport for NSW (TfNSW) supported the recommendation.

To what extent have the recommendations been implemented?

In June 2020, TfNSW advised it had engaged Neuroscience Australia (NeuRA) to conduct a study to estimate child restraint practices in NSW across 10 selected Local Government Areas.

In July 2021, TfNSW advised that NeuRA's report has recently been finalised, but was not fully completed due to disruptions as a result of bushfires and COVID-19 restrictions. TfNSW advised it was not possible to resume the survey because too much time had passed in between the data collection points. TfNSW further advised that it considers research referred to in NeuRA's report has arisen from an approach by NeuRA in June 2021 to the Minister for Transport and Roads office seeking a new study focused on regional areas, intended to close off some of the gaps due to disruption to the previous study and to provide additional insights. At the time of writing, TfNSW has not been advised by the Minister's office to engage NeuRA and has not yet commissioned this work.

Our assessment of progress

We acknowledge the work that has been undertaken to date, and note the original study was not able to be fully completed due to circumstances outside of TfNSW's control. We will therefore continue to monitor this recommendation, pending further advice about a new study.

Our recommendation: quad bikes

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

We recommended that:

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

Why we made the recommendation

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

SafeWork supported this recommendation. SafeWork NSW currently sits within the Department of Customer Service (DCS).

To what extent has the recommendation been implemented?

In April-June 2020, SafeWork ran a child safety campaign – consisting of print, radio and digital regional advertising – which featured a key message *'It's not worth your child's life. Just say no to them riding adult quad bikes*'. The post campaign survey noted a shift in attitudes of farmers surveyed, with 64% agreeing with the impact statement 'children under 16 should not be allowed to ride an adult sized quad bike' – a substantial increase from previous survey results.

SafeWork NSW has also re-organised and updated the information that is available on its website regarding quad bike safety and children. The website includes information that reinforces the risk of injury and death associated with children using quad bikes, and that children under 16 years should not be riding adult quad bikes, even as passengers. The website also provides safety tips such as removing keys from machinery and vehicles when they are not in use.[17] [18] [19]

A Quad Bike Safety Improvement Program webinar is accessible from the SafeWork website that includes child safety content.

In September 2021, DCS further advised that SafeWork had launched its Virtual Farm Safety Experience in 2020. This free online education tool includes child safety information, as well as the use of a child avatar to reinforce messaging. DCS also advised that during December 2020 and April 2021, SafeWork ran targeted social media campaigns for visitors to farms during the school holiday period. SafeWork has also promoted child safety at events such as the 2021 Sydney Royal Easter Show and will continue to do so at future agricultural field days and farm safety events.

Our assessment of progress

We acknowledge and commend SafeWork for the positive initiatives noted above.

SafeWork NSW has significantly improved the visibility and impact of its messaging in relation to quad bikes and child safety on its website. There is specific and impactful information available on multiple pages of its website, and the messaging across all platforms – website, social media, and event promotion – is clear and unambiguous. SafeWork NSW has also ensured both its webinar and Virtual Farm Safety Experience are free eligible events to access the Quad Bike Safety Rebate.

We are satisfied that the intent of this recommendation has been met and will no longer monitor this recommendation.

Suicide deaths

Our recommendations: focused prevention plan, managing and containing risk

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

We recommended that:

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

a. **universal strategies that promote wellbeing in children and young people**
b. **early intervention designed to arrest emerging problems and difficulties**
c. **the provision of targeted, sustained and intensive therapeutic support to young people at high risk – including strategies for reaching those who are hard to engage.**

[17] Quad bikes and side-by-side vehicles | SafeWork NSW accessed 13 September 2021

[18] Quad Bike safety | SafeWork NSW accessed 13 September 2021

[19] Child safety | SafeWork NSW accessed 13 September 2021

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

Why we made the recommendations

Our work has shown that, unlike other causes and circumstances of death, the suicide rate for young people aged 10-17 years has increased over the past decade, and that school-aged young people have particular vulnerabilities and needs that should be considered in suicide prevention strategies. We observed that NSW generally has good systems for identifying young people who are at risk of suicide or who are dealing with mental health problems, but that intervention – once a problem is identified – can be episodic and fragmented. Identification of suicide risk must be supported by effective strategies to manage and contain risk to prevent suicide.

We also observed that in NSW, demand for access to developmentally appropriate specialist mental health services for children and young people regularly outstrips the capacity to supply timely services. The *Strategic Framework for Suicide Prevention in NSW 2018-2023* supports whole of government suicide prevention activity across all NSW communities.

The NSW Government supported both recommendations.

To what extent have the recommendations been implemented?

In June 2020, the Department of Premier and Cabinet (DPC) advised it was considering how best to act in the context of the Framework and *Towards Zero Suicides* Premier's Priority. DPC noted that NSW Health would be taking the lead on behalf of the NSW Government for future updates.

Towards Zero Suicides is an $87 million investment over three years from 2019-20 in new suicide prevention initiatives that address priorities in the Framework and contribute to the Premier's Priority to reduce the suicide rate by 20 per cent by 2023.

In September 2021, NSW Health advised that implementation of the *Towards Zero Suicides* initiatives is well underway and includes a range of activities relevant to children and young people. For example:

- A Youth Aftercare Pilot program based in three regional and metropolitan sites is providing community-based supports for children and young people and their families following self-harm, suicidal ideation, or a suicide attempt. The program receives funding from the Commonwealth Health Innovation Fund and NSW Health as part of the *Towards Zero Suicides* initiatives.
- $6 million has also been provided to key organisations including Headspace and Lifeline to establish and coordinate 12 Community Wellbeing Collaboratives in communities assessed as high risk.
- The recently commissioned Community Response Package for Young People will see the Community Managed Organisation, Wellways, deliver local and state-wide social media campaigns to build awareness of support pathways available to young people.
- The Community Gatekeeper Training initiative – 13 organisations funded over three years, from 2019-20, to train key community members in suicide awareness and response skills. Four of the 13 organisations are specifically targeting young people.

NSW Health also advised that the *NSW School-Link Action Plan 2020-2025* was released in 2020.[20] It aims to facilitate early identification of and timely access to specialist mental health services and supports

[20] At the time of writing, NSW Health's website only includes a link to the NSW School-Link Strategy and Action Plan 2014-2017, not the 2020-2025 plan. Accessed 5 October 2021 at: https://www.health.nsw.gov.au/mentalhealth/Pages/services-camhs.aspx#school

suicide prevention and postvention in school communities. In addition, the NSW *Getting on Track in Time - Got It!* program embeds social emotional wellbeing programs in select primary schools across NSW.

Our assessment of progress

We acknowledge the NSW Government's investment in suicide prevention initiatives, and that these initiatives include specific measures targeted to school-aged children and young people.

Recommendation 10

NSW Health's advice about current programs address aspects of our recommendation. However, we remain concerned about the number of child and adolescent mental health workers available to deliver interventions, particularly in regional areas.

We also note that some initiatives are co-funded by the Commonwealth and NSW Government – for example, the Youth Aftercare Pilot. It is unclear if initiatives like this, and the Community Wellbeing Collaboratives, will be expanded to all regions of NSW if successful, and how sustainability will be ensured.

For these reasons, we will continue to monitor recommendation 10.

Recommendation 11

While acknowledging the value of program examples highlighted by NSW Health, it is our view that current initiatives do not address gaps in the delivery of appropriate specialist mental health services for children and young people. The emphasis of initiatives is largely on the identification of risk, not the management of risk.

We will therefore continue to monitor recommendation 11.

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

Recommendation 12, Biennial report of the deaths of children in NSW: 2016-2017 (published June 2019)

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

The NSW Department of Education should evaluate postvention initiatives in NSW government high schools, particularly the effectiveness of such initiatives in preventing suicide clusters.

Why we made the recommendation

This recommendation was made against the background of findings and observations made by the NSW Parliamentary Committee on Children and Young People inquiry into prevention of youth suicide,[21] a review undertaken for the CDRT by the Australian Institute for Suicide Research and Prevention (AISRAP) of evidence-based prevention and postvention strategies and existing youth suicide prevention strategies,[22] and our ongoing work in reviewing the suicide deaths of school-aged children and young people in NSW.

[21] Joint Committee on Children and Young People 2018, Prevention of youth suicide in New South Wales, NSW Parliament, Sydney.

[22] 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.

Together, this work suggested suicide prevention activities in schools 'lacked coordination and consistency',[23] and that of the very limited literature and research addressing the topic of prevention of suicide clusters and specific postvention activities, no study has evaluated the overall effectiveness of these strategies in preventing future clusters.[24]

Suicide prevention and intervention strategies should be subject to ongoing monitoring and evaluation, and our recommendation aims to address this gap.

The Department of Education supported this recommendation.

To what extent have the recommendations been implemented?

In June 2020, the Department of Education advised it had engaged Orgyen (partnering with EveryMind) to conduct an evaluation of postvention initiatives in NSW Government high schools. The department's advice provided details of the evaluation framework, which included benchmarking current responses against best practice approaches and mapping postvention activities, programs, and staff training.

In September 2021, we received advice the evaluation was complete. The Department of Education stated Orgyen's evaluation found the department's postvention guidelines met a high standard for implementation and application as part of the coordinated response to a student suicide. The department also advised the evaluation included some recommendations to further enhance postvention initiatives in secondary schools, and that it is progressing work on these recommendations. They include updating the guidelines to strengthen culturally safe practice when engaging with Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities. Guidance on managing social media after a suicide death will also be strengthened. The department is working with Orygen and EveryMind to update training for school wellbeing staff in postvention.

Our assessment of progress

The Department of Education has advised the evaluation of postvention initiatives has been completed, and that it is working to implement recommendations arising from the evaluation. We will seek a copy of the evaluation.

Our recommendation: the role of schools – review following suicide

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

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

Why we made the recommendation

Schools are a critical part of the service systems for identifying and intervening early to prevent suicide of school-aged children and young people. The NSW Department of Education does not currently have a process to undertake systems review of suicide deaths of students. Learning from missed opportunities and using that understanding to frame future practices and policy is critical to inform work with

[23] As before, Parliamentary Inquiry into the prevention of youth suicide in NSW.

[24] AISRAP review, 2019

vulnerable young people and should be a key strategy in improving the capacity of agencies to develop effective prevention strategies.

The Department of Education supported this recommendation.

To what extent has the recommendation been implemented?

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

In September 2021, the department advised Orygen had completed the literature review, and that it found that there is currently no precedent for a formal death review process in Australian secondary schools or educational institutions following a student death by suicide. The Department of Education further advised that Orygen's review identified a number of challenges and risks exist in a formalised death review process for suicides within a local school environment.

The Department of Education has established a pilot of four new Psychology and Wellbeing Services Coordinator roles to strengthen support to schools in suicide prevention and postvention. The department has advised it will systematically review internal incident data and consider the presence of known risk factors on an annual basis, with a view to using this information to strategically target intervention and preventative programs. The department will also continue to review the latest evidence as well as findings from the CDRT to inform policy and practice improvements.

Our assessment of progress

We note the completion of the Orygen review, and will seek a copy of this review to understand the risks of an internal departmental review.

7.2 NSW Ombudsman recommendations: reviewable child deaths

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

Appendix 1: CDRT Strategic Priorities Plan 2019-2022

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 work on actions agreed in our Strategic Priorities Plan 2019-22.

Meeting our priorities

The table below details progress against key strategic priorities as of 30 June 2021.

PRIORITY	STATUS	COMMENTS
Building on our work		
Using our data, between July 2019 and June 2022 we will:		
Identify relevant external datasets and strategies to link with our data	Ongoing	As part of the AIHW data linkage project, detailed in Chapter 4, key external datasets were identified and linked with the NSW Child Death Register.
Use data linkage in a major project	Completed	As detailed in Chapter 4, AIHW completed data linkage between BDM, perinatal, AIHW, and CDRT datasets for the social determinants in early childhood mortality research project.
Build dashboards to provide timely and relevant data	In progress	Work has been undertaken by the NSW Ombudsman's office to develop our capacity to produce automated, interactive dashboards for data visualisation.
Work with external stakeholders to promote the Register and patterns and trends identified	In progress	Since completing a design review of the Register in 2018, we have shared information about the Register and our data dictionary with various interstate stakeholders, including technical information about our analytic processes to identify patterns and trends.
Between July 2019 and June 2022, our priorities will be to actively monitor:		
Outcomes from the Cross Agency Working Group (SUDI) towards achieving improved investigation and response to sudden and unexpected deaths of infants	Progressed	We continue to monitor two of the seven issues which were the subject of a recommendation. Chapter 7 details the status of our recommendations and actions taken by agencies to progress them.

The development and implementation of strategies to improve the correct use of child restraints and seatbelts in NSW, particularly how strategies are targeted to vulnerable communities	Partially completed in 2020	We continue to monitor one of the four issues which were the subject of recommendations. Chapter 7 provides full details of agency progress.
The development of a suicide prevention plan which includes specific measures targeted to preventing suicide in school-aged children	Progress	We are continuing to monitor this issue. Chapter 7 provides full details of agency progress.
The implementation of measures in public, Catholic and independent schools to ensure suicide deaths are subject to review to inform practice and postvention	Partially completed in 2020	Actions taken by Catholic and independent schools are documented in the CDRT's previous annual report. We continue to monitor measures in public schools. Chapter 7 provides full details of the government agency's progress.
Research and projects		
Over the three-year period, we will produce reports on our work and table these in Parliament:		
CDRT Annual Report 2018-19	Completed 2019	Tabled 31 October 2019
CDRT Annual Report 2019-20	Completed 2020	Tabled 27 October 2020
CDRT Annual Report 2020-21	In draft	To be tabled 26 October 2021
Biennial child death review report – deaths in 2018 and 2019	In final draft	To be tabled 24 August 2021
Biennial child death review report – deaths in 2020 and 2021	Pending	
Between July 2019 and June 2022, we will:		
Undertake at least one major research project and table this in Parliament. The research will focus on analysis of the effects of social determinants on early childhood mortality/risk of child death	Progressed	As detailed in Chapter 4, work on this project is well underway.
Undertake and report on at least three detailed group reviews, which will examine data held in the Register of Child Deaths relating to: ○ Asphyxia-related deaths of newborn infants	Progressed	As detailed in Chapter 4, projects relating to deaths of newborns associated with HIE, and the suicide deaths of Aboriginal children and young people, are well underway.

○ Deaths of Aboriginal and Torres Strait Islander children ○ The role of young drivers in fatal motor vehicle crashes		Work in relation to the young driver project has been placed on hold, pending capacity.
Engagement and promotion		
Between July 2019 and June 2022, our priorities will be to:		
Develop a communications plan for the CDRT	Deferred	As an outcome of a workshop in June 2020, the CDRT decided to focus instead on developing its Charter and Code of Conduct. This work is detailed further in Chapter 2.
Prepare and promote fact sheets to highlight potentially avoidable child death and share evidence-based prevention strategies	Pending	
Work with the State Coroner's office, NSW Health Pathology's Forensic Medicine, and other key stakeholders to promote a revised SUDI classification	Progressed	In 2019, the NSW Coroner's office adopted the CDRT's SUDI classification. Since then, the classification has been revised and plans are now being developed to hold information sessions with relevant coronial staff to facilitate implementation of the revised version.
Work with stakeholders to promote the findings and recommendations arising from our report 'The role of child restraints and seatbelts in passenger deaths of children aged 0-12 years in NSW'	Progressed	We continue to actively monitor one recommendation arising from this report, discussed in Chapter 8. We have also engaged with NSW Police in relation to an initiative arising from this work.
Lead the Australia and New Zealand Child Death Review and Prevention Group, with a focus on engaging all jurisdictions in determining forward priorities and working with states to implement a future work agenda	Progressed	We hosted the group's annual two-day conference in May 2021. Work is underway to prepare for the 2022 conference.
Exploring new opportunities		
Between July 2019 and June 2022, our priorities will be to:		
Include data linkage in one major project, to shift our work towards predictive analysis	Completed	As discussed in Chapter 4, data linkage has been used in the CDRT's project to examine social

		determinants in early childhood mortality.
Include analysis of injury data in our review of young driver deaths	Pending	
Include analysis of injury data (intentional self-harm) in our review of suicide deaths of Aboriginal children and young people	Pending	
Review progress of recommendations from the Senate Select Committee Inquiry into Stillbirths in Australia (finalised in December 2018). The CDRT will consider the need for further work in linking perinatal deaths and stillbirths	Pending	

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