nsw cdrt child death review team

Ombudsman New South Wales

NSW Child Death Review Team Annual Report 2021-22

25 October 2022

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

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

The CDRT wish to convey their sincere condolences to the families and friends of the infants, children and young people in NSW who have died. It is the CDRT's foremost responsibility to learn from these deaths and to use that knowledge to make a difference.

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25 October 2022

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 2021-22

As Convenor of the NSW Child Death Review Team (CDRT), I present the NSW Child Death Review Team Annual Report 2021-22 for tabling in Parliament.

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

I recommend that this report be made public immediately.

Yours sincerely

Paul Miller

Convenor, NSW Child Death Review Team
NSW Ombudsman

Contents

Appendices

About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during the period 1 July 2021 to 30 June 2022.

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 – contains an overview of the biennial report of child deaths in 2018 and 2019.
- Chapter 4: Research to help reduce child deaths – details research projects to meet the CDRT's purpose and functions.
- Chapter 5: Other activities – notes some of the other work the CDRT is engaged in.
- Chapter 6: Disclosure of information – details information disclosures as prescribed in the Act.
- Chapter 7: CDRT recommendations – summarises responses by agencies to CDRT recommendations, and their progress towards implementation.
- Appendices: progress in relation to current strategic priorities, and agency correspondence regarding recommendations.

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. The CDRT's purpose is to prevent or reduce the deaths of children in NSW through the exercise of its functions under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act).

CDRT membership is prescribed by the Act. Members are:

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

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

The CDRT must have at least 17 members. The CDRT must elect one member to be the Deputy Convenor, who may undertake some of the roles of the Convenor in his or her absence, including chairing of meetings.

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

1.2 CDRT members at 30 June 2022

Ex officio members

Paul Miller (Convenor)
NSW Ombudsman

Monica Wolf
Community Services Commissioner/Chief Deputy Ombudsman

Zoë Robinson
NSW Advocate for Children and Young People

Agency representatives

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

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

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

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

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

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

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

Expert members

Professor Kathleen Clapham (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

Professor Ngiare Brown
Director and Program Manager
Ngaoara Child and Adolescent Wellbeing

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

Dr Bronwyn Gould AM
General Practitioner

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

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

Professor Ilan Katz
Professor Social Policy Research Centre
University of NSW

Catherine Lourey
Commissioner
Mental Health Commission of New South Wales

1.3 Expert advisers

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* 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 2021-22 include:

- Dr Fadwa Al-Yaman, Group Head, Indigenous Disease, Australian Institute of Health and Welfare
- Tracy Dixon, Unit Head, Indigenous Burden of Disease, Australian Institute of Health and Welfare
- Dr Prem Thapa, Acting Unit Head, Research Modelling, Australian Institute of Health and Welfare
- Marlene Longbottom, VC Post-Doctoral Research Fellow, Ngarruwan Ngadju First People Health and Wellbeing Research Centre, Australian Health Services Research Institute, University of Wollongong
- Dr Lorraine du Toit-Prinsloo, Senior Staff Specialist, Clinical Training Coordinator, Forensic Medicine Newcastle
- Professor Les White, former NSW Chief Paediatrician and CDRT member for NSW Health
- Maryann Wood, Lecturer, School of Public Health and Social Work, Queensland University of Technology

2. CDRT functions

Under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act), the CDRT's 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 to prevent or reduce 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 and 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, and
- Make recommendations 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 2021-22.
- The **biennial child death review report** (s 34G), which consists of data collected and analysed in relation to child deaths. The most recent biennial report covering deaths of children that occurred in 2018 and 2019 was tabled in Parliament in August 2021.
- **Other reports** (s 34H), which provide information on the results of research undertaken in the exercise of the CDRT's research functions. The CDRT may report to Parliament at any time and is expected to report on its research at least once every three years. Details of recent and current research are provided in Chapter 4.

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.

All reports are available on the NSW Ombudsman website: www.ombo.nsw.gov.au

2.2 Meetings of the CDRT

The CDRT met formally on four occasions in 2021-22: September 2021, November 2021, February 2022, and May 2022. 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 2021-22, it 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.

Over the period February to June 2022, the CDRT developed a new Strategic Priorities Plan 2022-2025. Work on this plan will commence on 1 July 2022.

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 2021-22 period, this unit comprised 10-12 staff. The team is also responsible for the Ombudsman's reviewable child death function.

Work undertaken by staff to assist the CDRT includes:

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

Financial costs associated with the work of the CDRT are reported in the Ombudsman Annual Report. Some CDRT members receive sitting fees in accordance with the NSW Government Boards and Committee Guidelines.

2.4 CDRT Charter and Code of Conduct

The CDRT Charter and Code of Conduct can be accessed at: https://www.ombo.nsw.gov.au/about-us/what-we-do/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.

The CDRT's vision is:

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

The CDRT's purpose is:

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

The CDRT works to achieve its 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.

The CDRT adheres to a Code of Conduct which outlines the CDRT scope, purpose and values, requirements of members, and other matters such as conflict of interest, confidentiality, and privacy.

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 this report is presented below.

3.1 Deaths of children in NSW in 2018 and 2019

The report concerns the deaths of 989 children who died in NSW in 2018 and 2019. It also provides information about trends in child mortality over time.

The report examines the underlying risk factors that may have contributed to preventable deaths and seeks to identify actions that can and should be done to prevent or reduce the deaths of children in NSW in the future.

3.2 Overview of key observations

Trends

Overall, infant and child mortality rates in NSW have declined, in both natural and injury-related causes.

During the 15-year period from 2005 to 2019, the mortality rate for infants (aged less than one) declined by 30%, from 4.7 to 3.3 deaths per 1,000 live births. For children aged 1-17 years, the mortality rate declined by 26%, from 15.4 to 11.4 deaths per 100,000 children.

However, certain children have higher mortality rates than others, including:

- those living in the most disadvantaged areas of NSW
- those living in regional and remote areas
- Aboriginal and Torres Strait Islander infants and children, and
- those in families with a child protection history.

Unlike other causes of death, the rate of suicide among children aged 10 to 17 years in NSW has significantly increased over the past 15 years. In 2018 and 2019, suicide was the leading cause of death for young people aged 15 to 17 years.

Deaths of infants aged less than one in 2018 and 2019

- More than half (61%, 599) of the infants and children who died in NSW were infants (that is, aged under one).
- Most infant deaths were due to natural causes (86%, 517) and occurred in the first 28 days of life (75%, 446).
- Other infant deaths were due to injury (1.5%, 9), or the cause was undetermined (4.3%, 26), or still under investigation (7.8%, 47).

Figure 1. Infant mortality rate by demographics, NSW 2018-2019

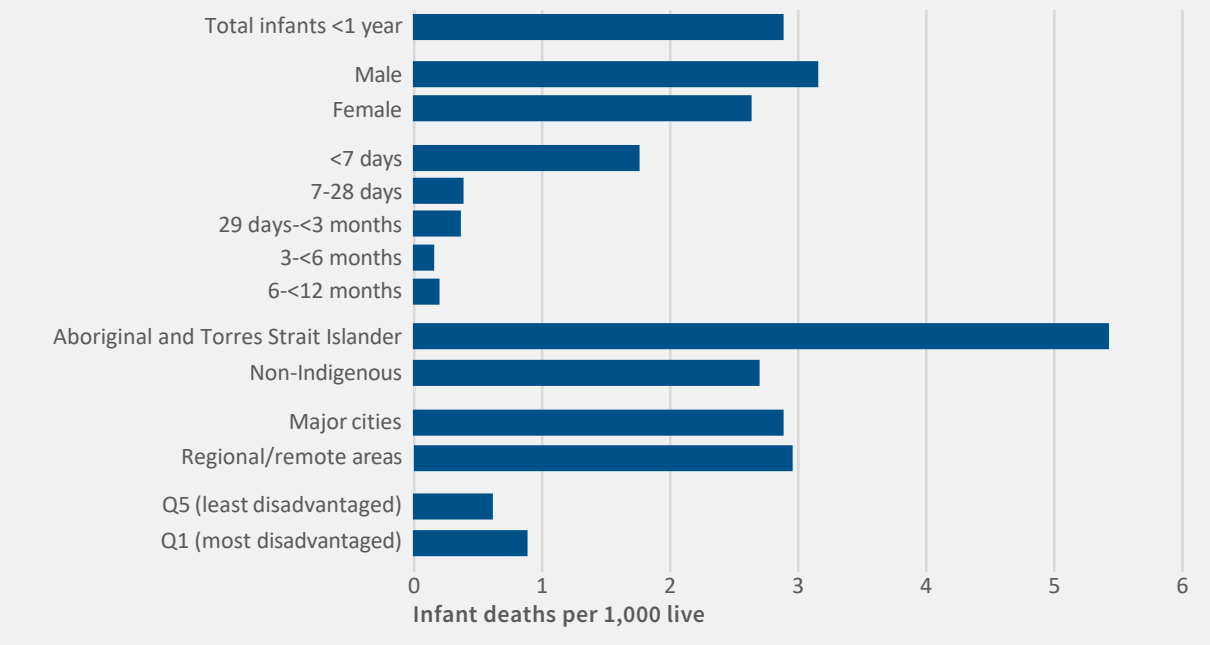
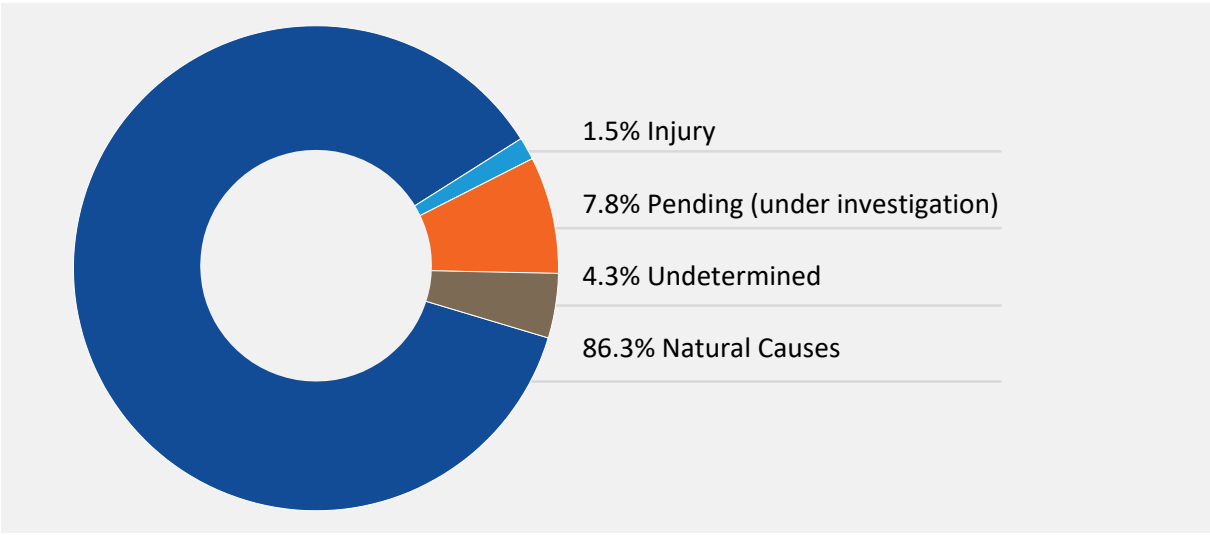


Figure 2. Proportion of infant deaths by causes of death, NSW 2018-2019



Deaths of children aged 1-17 years in 2018 and 2019

- Just over one-third (39%, 390) of the total number of infants and children who died in NSW were aged 1-17 years.
- Just over half (52%, 204) of these children died from natural causes. Other child deaths were due to injury (39%, 151), or were still under investigation.
- Young people (aged 15-17 years) had the highest mortality rate, followed by children aged 1-4 years.
- In contrast to the longer-term decline in the mortality rate, the rate of suicide among children aged 10-17 years increased by 47% over the past 15 years.

Figure 3. Child mortality rate (aged 1-17 years) by demographics, NSW 2018-2019

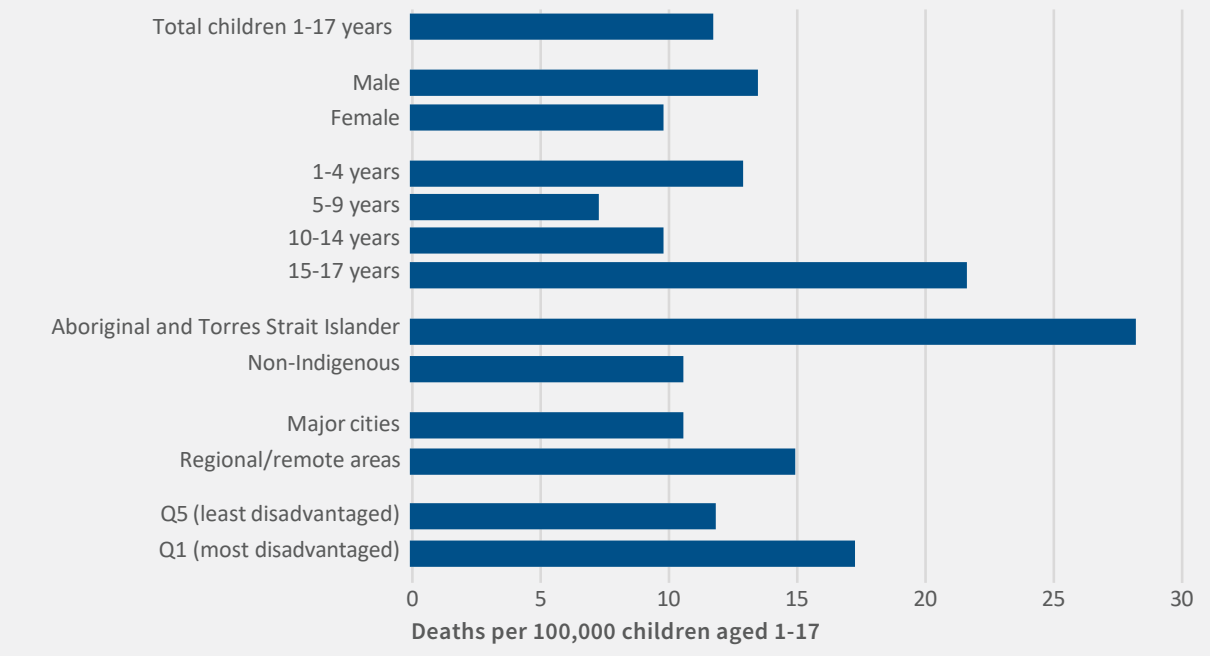
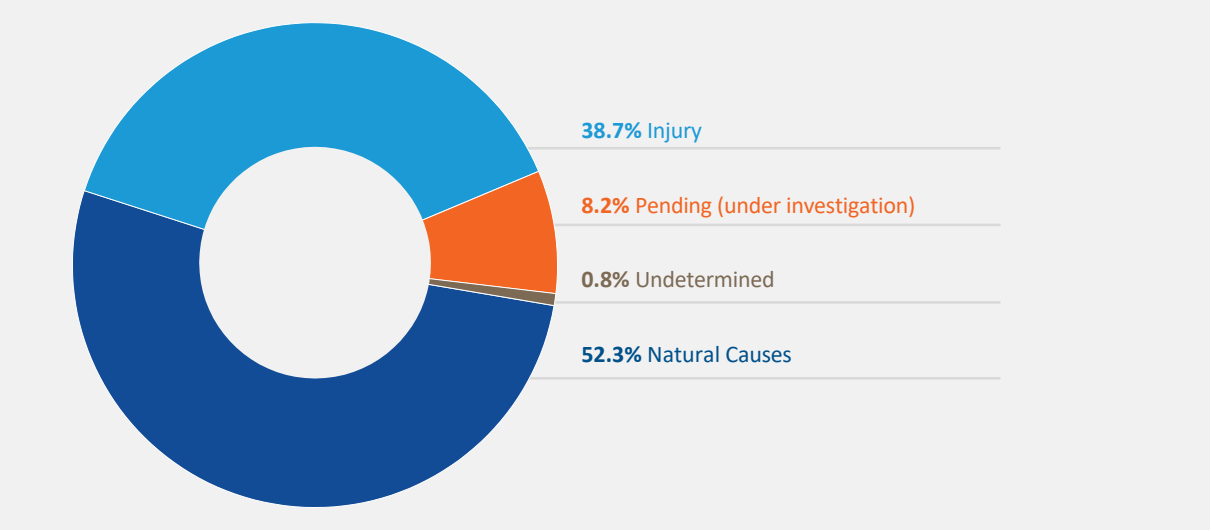


Figure 4. Proportion of children (aged 1-17 years) deaths by causes of death, NSW 2018-2019



Leading causes of death

The leading cause of death over the past five years differed according to age:

- For infants: the leading cause of death was perinatal conditions.
- For children aged 1-4 years, 5-9 years, and 10-14 years: the leading cause of death was cancers and tumours.
- For young people aged 15-17 years: the leading cause of death was suicide.

Table 1. Top 5 leading causes of death for infants and children by age group, NSW 2018-2019

	1st	2nd	3rd	4th	5th
Under 1 year	Perinatal	Congenital	Cancers and tumours	Endocrine	Nervous system
1-4 years	Cancers and tumours	Nervous system	Respiratory system	Congenital	**Transport**
5-9 years	Cancers and tumours	Respiratory system	Congenital	**Transport**	Nervous system or endocrine
10-14 years	Cancers and tumours	**Transport**	Nervous system	**Suicide**	Congenital or endocrine
15-17 years	**Suicide**	**Transport**	Cancers and tumours	Nervous system	Circulatory system

Deaths from natural causes

In 2018 and 2019, 721 infants and children died from natural causes in NSW. Nearly three-quarters (72%, 517) were infants. The highest risk of infant mortality is among infants born prematurely, particularly those born at less than 24 weeks gestational age.

Natural cause mortality rates are declining. Over the 15-year period 2005-2019, there have been significant declines in natural cause deaths for both infants (mostly driven by a significant decrease in perinatal conditions) and other children in NSW.

Figure 5. Natural cause infant mortality rate by year, NSW 2005-2019

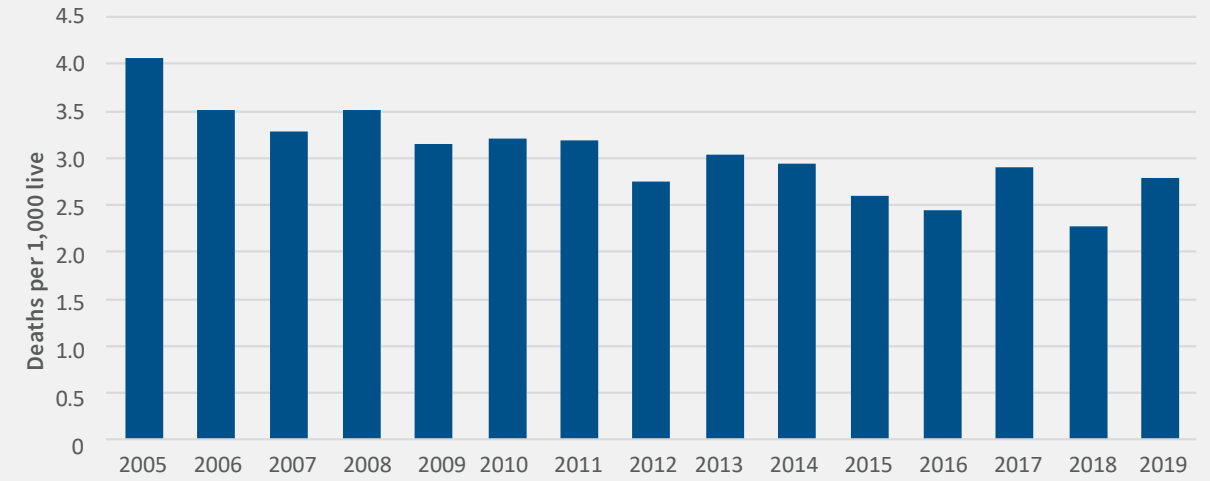
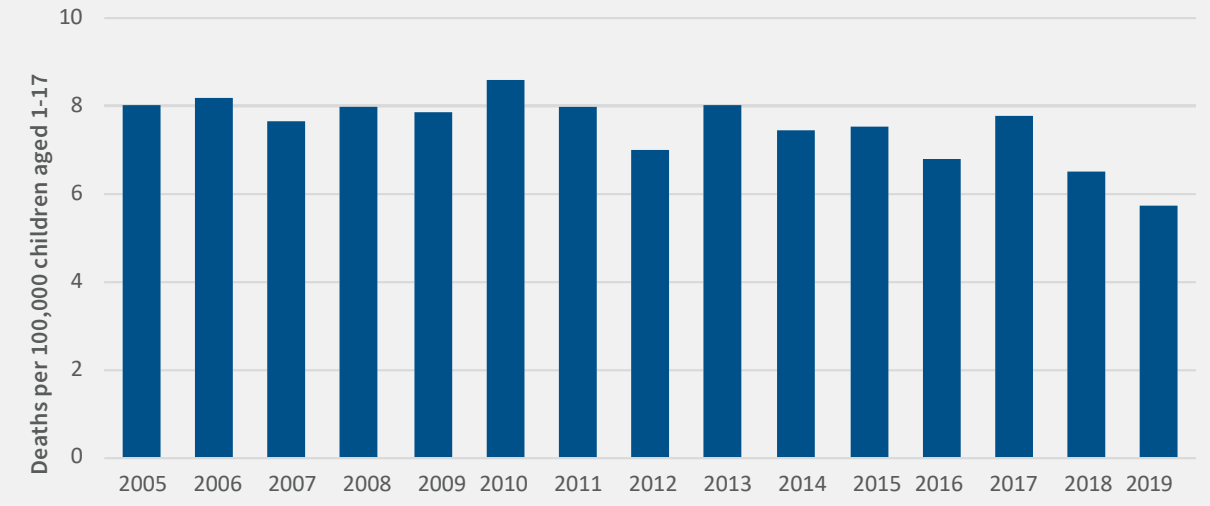


Figure 6. Natural cause child mortality rate (aged 1-17 years) by year, NSW 2005-2019



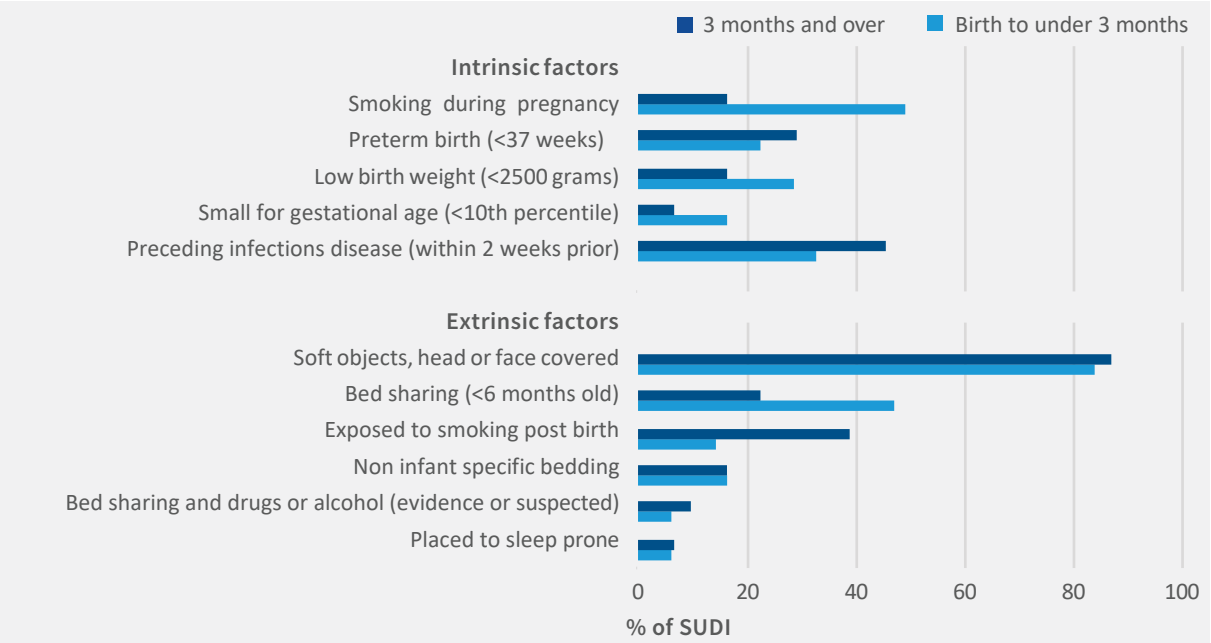
Sudden Unexpected Death in Infancy (SUDI)

In 2018 and 2019, 80 infant deaths were classified as SUDI.

Most infants who died suddenly and unexpectedly were less than three months of age. The majority of infants were exposed to at least one avoidable risk, including tobacco smoke and objects or bedding that posed a risk of suffocation in their sleep environment.

Infants from families known to child protection authorities, and those who lived in the most disadvantaged areas of NSW, were over-represented in SUDI. Targeted interventions by frontline agencies need to focus on disadvantaged and vulnerable families. We are currently monitoring a recommendation in relation to this issue (see discussion in Chapter 7).

Figure 7. Key reported factors identified for SUDI by age group, NSW 2018-2019



Injury-related deaths overview

In 2018 and 2019, 160 infants and children died from injury-related causes in NSW.

Injury-related deaths have decreased in NSW, except for suicide.

Young people aged 15-17 consistently had the highest injury-related mortality rate from injury-related deaths of any age group, with suicide and transport fatalities accounting for most deaths.

Deaths from injury-related causes also include poisoning, falls, fire, being struck by an object, and accidental threats to breathing.

Figure 8. Injury-related child mortality rate (aged 0-17 years) by gender and age group, NSW 2005-2019

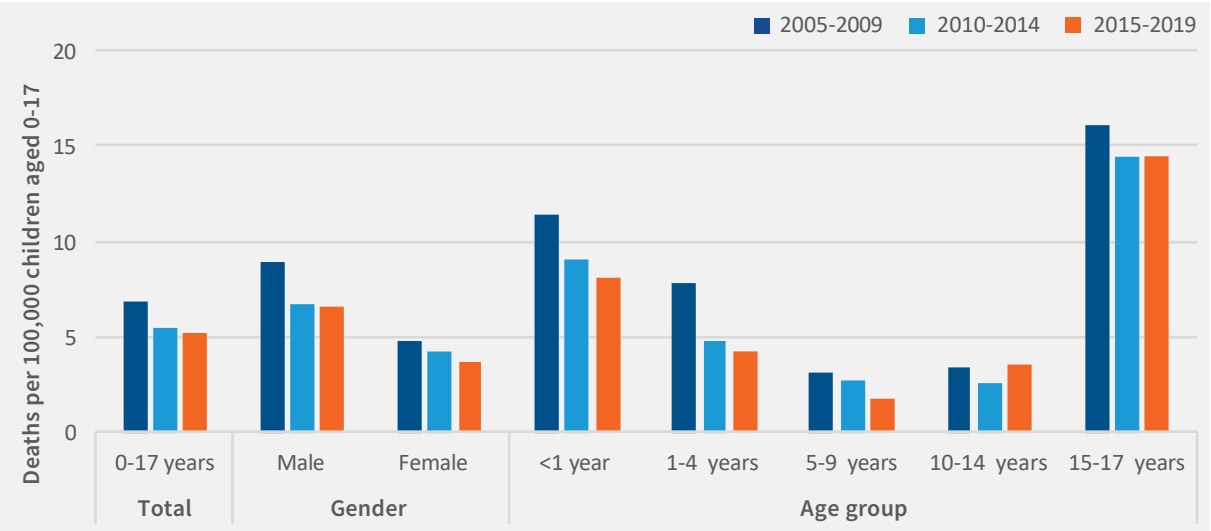
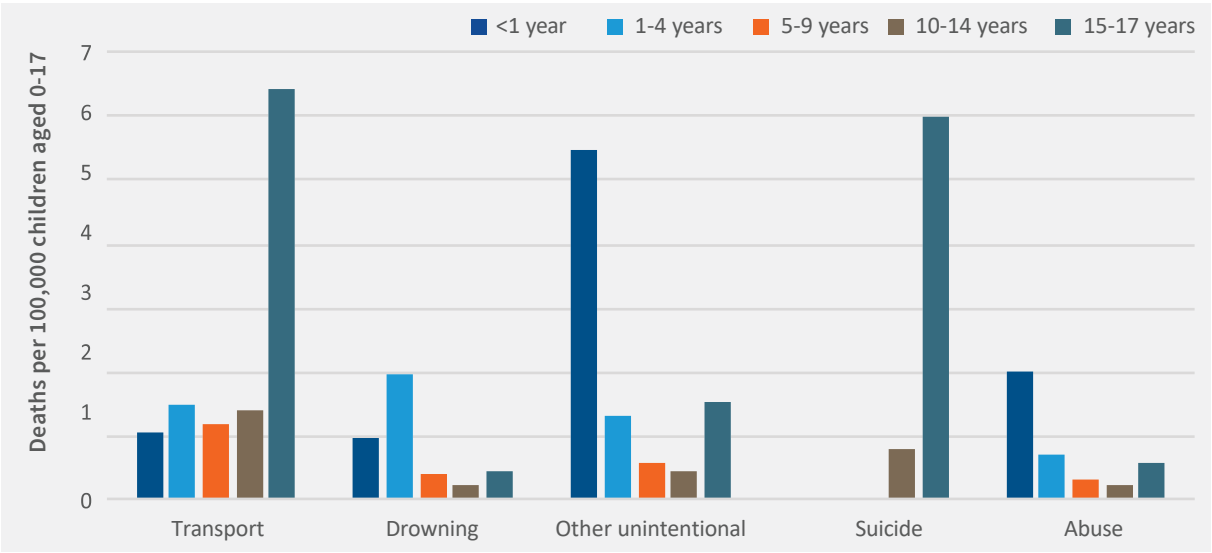


Figure 9. Injury-related child mortality rate (aged 0-17 years) by age group and cause, NSW 2005-2019



Transport

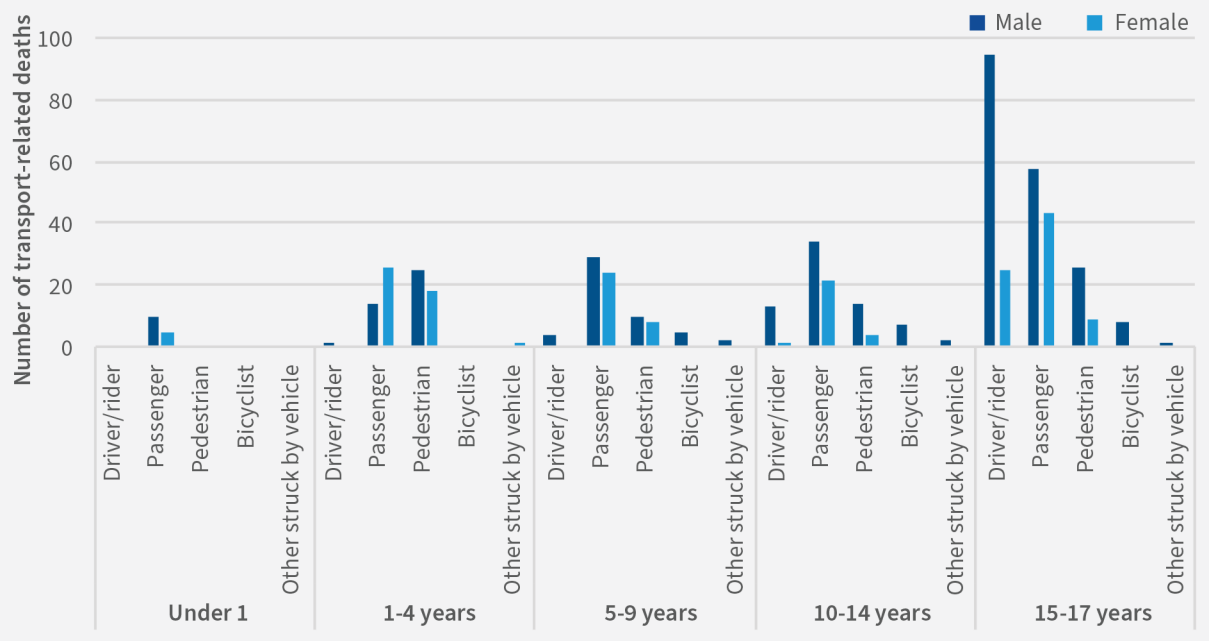
In 2018 and 2019, 54 infants and children died in transport fatalities in NSW.

Males, young people aged 15-17, those living in regional or remote areas of NSW, and those from the most disadvantaged areas, were more likely to die in a transport-related incident than other children.

Unsafe driver behaviours – such as speeding, alcohol and drug use, and reckless driving – remain the key contributing factor in transport fatalities, especially in combination with driver inexperience. In 2018 and 2019, more than half the 'at-fault' drivers were young novice drivers.

The majority of child deaths in motor vehicle incidents involved older, less safe vehicles. Seatbelts and child restraints can prevent the deaths of children in vehicle crashes.

Figure 10. Number of transport-related deaths of children 0-17 years by nature of incident, age and gender, NSW 2005-2019



Drowning

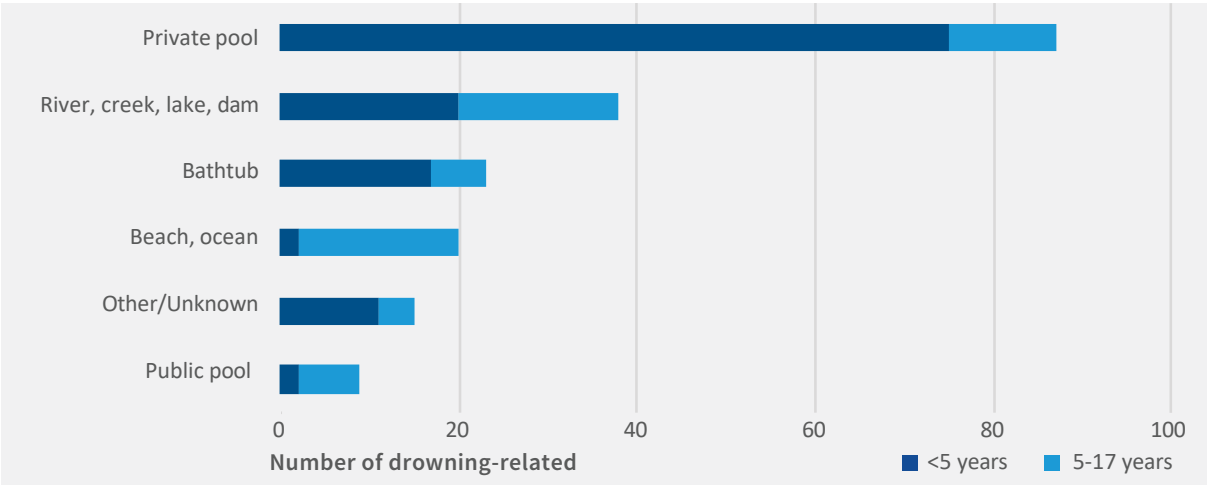
In 2018 and 2019, 12 infants and children died by drowning in NSW.

Drowning remains the leading cause of unintentional injury-related death for children aged 1-4 years in NSW. Most drownings of children this age occurred in private swimming pools. These fatalities often result from a chain of events – a faulty pool gate left unsecured, a carer distracted with household chores or attending to other children, unclear delegation for supervision, and/or a child able to leave the house unseen. Compliance with child safety barrier fencing requirements is essential.

Constant and arms-length supervision of infants and very young children in bathtubs is also vital.

For older children, most drowning incidents occurred in natural bodies of water such as beaches, rivers, and lakes. Other factors come into play in these drowning fatalities, such as a lack of experience in assessing or paying heed to danger.

Figure 11. Number of drowning-related deaths among children by location and age group, NSW 2005-2019

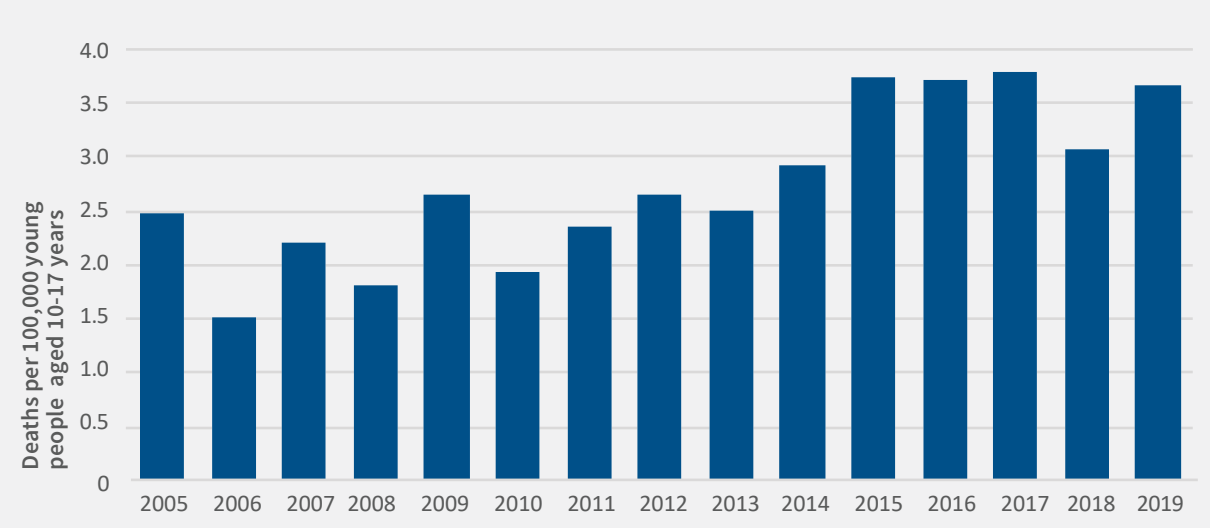


Suicide

In 2018 and 2019, 51 children died by suicide in NSW.

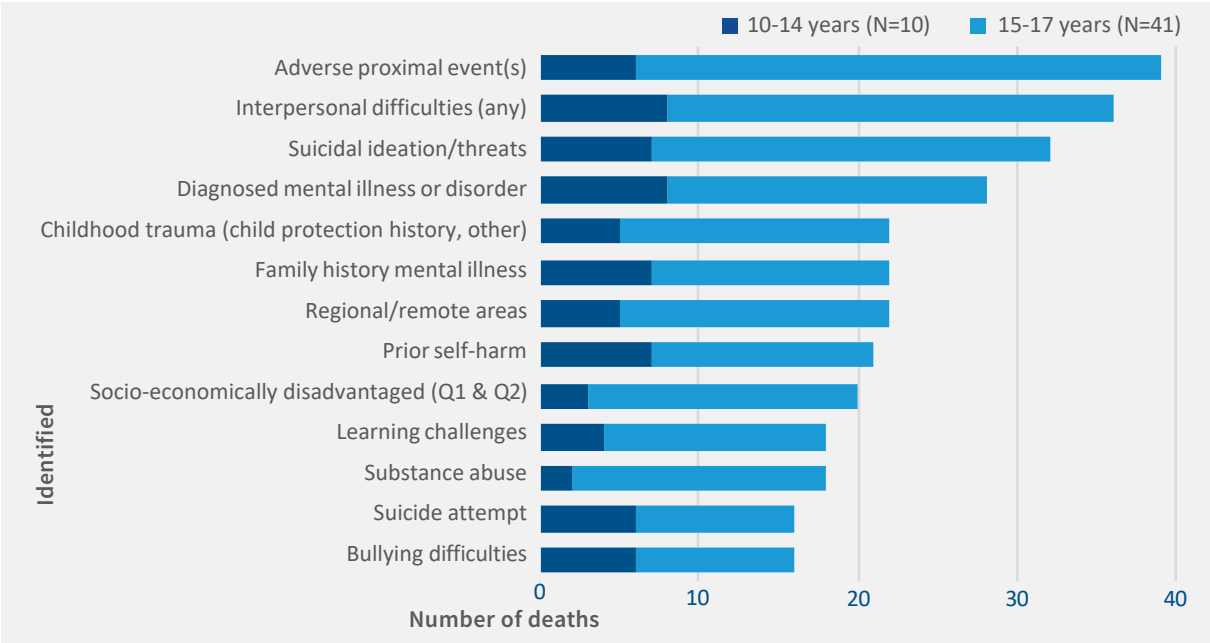
Aboriginal and Torres Strait Islander children have a much higher rate of suicide than non-Indigenous children. More males than females die by suicide, and this gender gap has increased in the last 5 years.

Figure 12. Suicide rate among young people (aged 10-17 years) by year, NSW 2005-2019



No single factor or combination of factors can predict suicide – there are a range of individual, family, school and peer factors, and other demographic factors that are associated with suicide risk. A sustained, coordinated approach to responding to risk, timely access to appropriate services, and strategies to address emerging mental health concerns are crucial to reducing the rate of suicide.

Figure 13. Number of suicide deaths among young people aged 10-17 years by selected factors and age group, NSW 2018-2019



Abuse and neglect

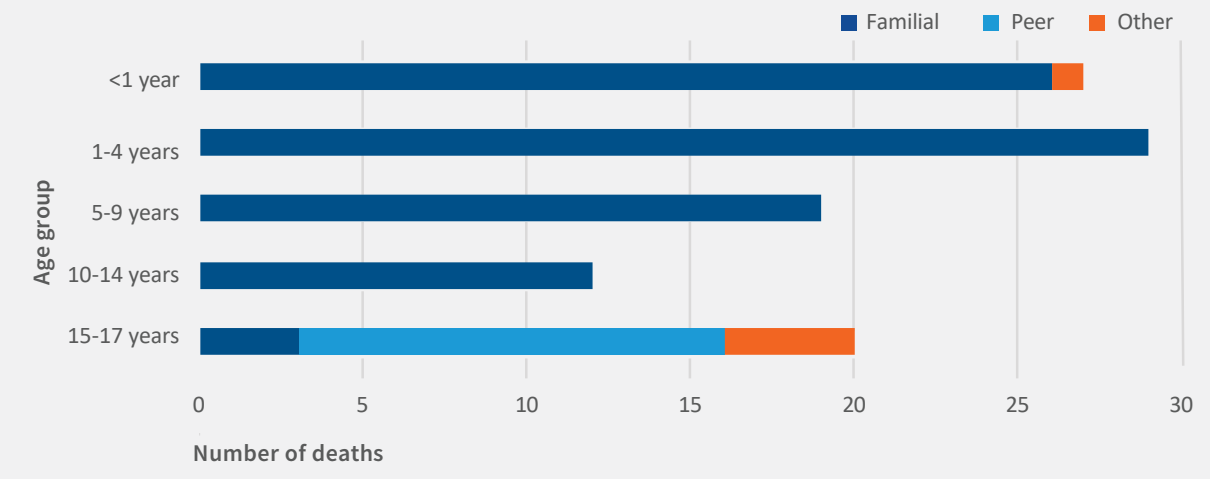
In 2018 and 2019, 19 infants and children died in circumstances of (or suspicious of) abuse or neglect in NSW.

Most of the infants and children who died were from families known to child protection authorities. Well-recognised child protection issues – including family violence and relationship breakdown, parental mental illness, and parental alcohol and drug abuse – were often present in families where children died in circumstances of abuse or neglect.

Children under 5 years are the most vulnerable to fatal abuse and neglect – they accounted for more than half of all abuse and neglect-related deaths in the 10-year period.

More still needs to be done by agencies to address practice and systems issues to ensure better protection of children and improved support of vulnerable families. Key issues include case coordination, collaboration and information sharing, and the premature closure of high-risk cases. These issues are being monitored by the NSW Ombudsman, and are discussed further in the combined biennial report.

Figure 14. Abuse and neglect-related deaths among children aged 0-17 years by the relationship of person causing harm to child, NSW 2010-2019



3.3 Recommendations

Based on the data collected and analysed in relation to child deaths over the two-year period, the CDRT made three new recommendations in its *Biennial report of the deaths of children in New South Wales: 2018 and 2019* (tabled in August 2021).[1] They related to:

- an audit of the revised SUDI medical history protocol by NSW Health
- content on Transport for NSW Centre for Road Safety's proposed website providing guidance for young people to purchase safe cars, and
- public reporting of swimming pool compliance data by the Department of Customer Service.

Information about agency responses to these recommendations is included later in this report (Chapter 7). The chapter also includes detailed information from agencies about their actions to implement eight previous recommendations currently being monitored by the CDRT. These eight recommendations relate to SUDI prevention (3), road safety (1), and suicide prevention (4).

[1] The biennial report also included four recommendations made by the NSW Ombudsman in relation to reviewable child deaths

4. Research to help reduce child deaths

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

The *Community Services (Complaints, Reviews and Monitoring) Act 1993* (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 2021-22, the CDRT did not table any reports from research projects. However, several research projects are nearing completion, and it anticipates at least one of these reports will be tabled in the 2022-23 financial year. Three key projects are discussed below.

4.1 Research in progress

Linking data on social determinants and early childhood mortality

In 2019, the CDRT commissioned the Australian Institute of Health and Welfare (AIHW) to conduct a research project using data linkage, 'Analysing the effects of birth conditions and socio-economic status on early childhood mortality in NSW using linked data'.

The project links to previous work commissioned from the AIHW by the CDRT – Spatial analysis of child deaths in New South Wales (April 2018) – that 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 socioeconomic status and the risk of child death has been well established, questions remain about the factors underpinning this relationship.

The aim of the current project is to identify and quantify the role of key risk factors behind child mortality in NSW at specific ages (grouped into two cohorts, under one year and between ages 1 and 4) for all children born in NSW between 2005 and 2018. The project also involves a separate analysis for Aboriginal and Torres Strait Islander children.

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

At the time of writing, a report of the AIHW analysis and findings is in the final stages of preparation. We previously reported that we were aiming to publish the results of this research in early 2022. We now anticipate the report will be tabled in the NSW Parliament in late 2022 or early 2023.

Severe perinatal brain injury among infant deaths in NSW

In 2017 the CDRT commenced a project reviewing neonatal deaths over a four-year period (2016-2019). Work on the project progressed, and in 2021 the CDRT engaged an experienced clinical midwife consultant to undertake a detailed case review of 101 neonatal deaths in NSW over the four-year period.

The aim of this research project is to identify opportunities to reduce potentially preventable deaths of newborn infants with asphyxia-related causes such as hypoxic-ischemic encephalopathy. The project considers 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 individual case reviews have been completed and a thematic analysis of key issues and observations is underway. At this stage we anticipate being able to table a report in the NSW Parliament in early 2023.

Review of the suicide deaths of Aboriginal children and young people

Aboriginal and Torres Strait Islander children and young people are over-represented in suicide deaths of children and young people aged 10-17 years. Over the ten-year period 2011-2020, the NSW child death register recorded the deaths by suicide of 238 children and young people aged 10-17 years, of whom 44 (18%) were identified as being of First Nations 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 team is led by Aboriginal members of the CDRT, who are acting as project sponsors overseeing the key findings and outcomes of this work. The CDRT has also engaged a Post-Doctoral Research Fellow from the Ngarruwan Ngadju First People Health and Wellbeing Research Centre at the University of Wollongong as an expert adviser for the review.

The project has four main components, including a literature and policy review, and service mapping (both completed by the Sax Institute), detailed case reviews of 44 Aboriginal and Torres Strait Islander children and young people who died by suicide in the ten-year period (completed by Ombudsman review staff and expert advisers), and a consultation process including with Aboriginal community-controlled organisations.

At the time of writing, preparation of a thematic review and issues analysis based on the case reviews and comparative data analysis is underway to determine critical risk, intervention, and protective factors. A consultation process will then be undertaken, and a final report prepared presenting key observations and findings. We anticipate this report will be tabled in Parliament by the end of 2023.

5. Other activities and information

In addition to the CDRT's review and research work, the Team is also involved in a range of other activities that ensure it engages in discussions with similar teams across Australia, keeps its knowledge current, and helps with its efforts to prevent future deaths of children. One of these activities is discussed below.

5.1 COVID-19

During the period March 2020 to June 2022, seven deaths of children were registered in NSW where COVID-19 was listed as an indirect or direct cause of death.

In addition to registering COVID-19 related deaths, the CDRT continues to seek to identify and consider issues related to COVID-19 that may be identified in individual deaths. We will report about these issues in the next biennial report.

5.2 National child death review group

NSW continued to have responsibility for convening the Australian and New Zealand Child Death Review and Prevention Group (ANZCDR&PG) in 2021-22. 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 event 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 17 May 2022, the CDRT and NSW Ombudsman hosted the group's second virtual annual conference.

The first day of the conference involved presentations delivered by a range of academics and experts on topics associated with this year's theme – 'The Discipline of Death Review'. Presenters included:

- The Director of the National Center for the Review and Prevention of Child Deaths USA, translating the Center's experience building a national data set into project management guidance
- An Aboriginal Postdoctoral Research Fellow at the Ngarruwan Ngadju First Peoples Health and Wellbeing Research Centre, University of Wollongong, speaking on alternative models for indigenous research that reconsider data custodianship, governance, and language
- Australia's National Children's Commissioner speaking about her current priorities of child health development and wellbeing, child mental health and the impacts of COVID-19 on children
- The Chair of the National Review Panel in Ireland speaking about the Panel's approach to child death review, and in particular writing effective recommendations, based on learning from a recent research study, and
- An Emeritus Professor from the University of Warwick in the UK speaking about applying a systems analysis approach to child death review and how this can shift the culture of child death review from blame to learning.

Participants gave overwhelmingly positive feedback about the presentations, including comments on the range and relevance of topics covered, and the value of the diversity of international perspectives brought by the presenters.

On 18 May 2022 the ANZCDR&PG held its annual meeting, attended by the group's jurisdictional representatives. The meeting included focused contributions from each jurisdiction, an update from the working group developing a national data collection, a presentation from the National Children's Commissioner and planning for the next year. The group agreed that the Queensland Family and Child Commission (QFCC) will convene the annual conference in 2023 and 2024.

6. Disclosure of information

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

The CDRT is required to include in this annual report whether any information has been disclosed by the Convenor under section 34L(1)(b) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act). The section allows the Convenor to authorise the release of information acquired by the CDRT in connection with research '*that is undertaken for the purpose of helping to prevent or reduce the likelihood of deaths of children in NSW*.' Under that section the following information was provided:

- In November 2021, and January and February 2022, the CDRT provided information to the Australian Competition and Consumer Commission (ACCC) in response to their request for data relating to injuries, fatalities or near-misses caused by Infant Inclined Products. In June 2022, we provided additional information to the ACCC in relation to deaths associated with Infant Sleep Products.
- In February 2022, we provided de-identified and collated data to a CDRT member for a presentation to a pathology conference.
- In March 2022 and April 2022, we provided information about the CDRT's SUDI classification system to an expert adviser to the CDRT and separately, to the Director of Forensic Pathology, Forensic Science SA (South Australia).
- In June 2022, we provided information to a CDRT member about a planned audit by an agency of its response to deaths classified as Sudden and Unexpected Death in Infancy.

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

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

- In the financial year 2021-22, the CDRT provided the Coroners Court of NSW with individual case reviews and other information about four children.
- In February 2022, the CDRT provided NSW Crown Solicitors with a copy of the review of the death of a child, in their capacity assisting the Deputy State Coroner with the inquest into the death of the child.
- In July 2021, and February 2022, the CDRT provided information about the number of deaths of children reportable to the NSW Coroner under section 24 of the *Coroners Act 2009*, for the Chief Magistrates Annual Report 2020 and 2021.

6.3 Disclosures under s 34D(3)

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 and Western Australia and provides information to other States and Territories on a case-by-case basis.

In this context, information was provided to the following agencies:

- In August 2021, we provided the Northern Territory Child Death Review & Prevention Committee with information relating to deaths of children in NSW during the period 1 January 2016 to 31 December 2020 who were residents of the Northern Territory.
- In September 2021, we provided the Victorian Consultative Council on Obstetric & Paediatric Mortality and Morbidity (CCOPMM) with de-identified data in relation to children who died in NSW but were residents of Victoria.
- In November 2021, information relating to the death of a child who was a resident of the ACT, but died in NSW, was provided to the ACT Children and Young Person Death Review Committee (CYPDRC).
- In February 2022, we provided the ACT Children and Young People Death Review Committee with information about the deaths of children in NSW in 2021 who were residents of the ACT.
- In April 2022, the CDRT provided the Queensland Child Death Review Board with information about the identification and reporting of Aboriginal and Torres Strait Islander children by the CDRT.

7. CDRT recommendations

One of the functions of the CDRT is to make recommendations arising from its 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 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act) require that the CDRT annual report include details of the extent to which its previous recommendations have been accepted, and comment on the extent to which those recommendations have been implemented in practice.

In monitoring recommendations, the CDRT recognises that agencies may take time to fully implement those that are accepted and may make changes incrementally. In that context, the CDRT decides each year whether to:

- close a recommendation on the basis that it is satisfied the intent of the 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.

At present, there are 11 open recommendations relating to SUDI prevention, private swimming pool regulation, road safety and suicide prevention. 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 Summary of recommendations

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation	Section reference
SUDI investigation 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: … **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.	November 2016	NSW Health	Supported	To be closed (intent of recommendation substantially implemented)	7.2
SUDI safe sleeping NSW Health should develop and implement strategies to promote safe sleep infant 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.	June 2019	NSW Health	Supported	Continue monitoring	7.2

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation	Section reference
Infant illness 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.	June 2019	NSW Health	Supported	Continue monitoring	7.2
Transport – child restraints and seatbelts In the context of the findings of a 10-year review of the role of seatbelts and child restraints in the deaths of 66 child passengers aged 1-12 years in vehicle crashes, we recommend 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.	June 2019	Transport for NSW	Supported	Continue monitoring	7.2
Suicide – targeted prevention measures The NSW Government should include in any suicide prevention plan specific measures targeted to school-aged children and young people across the spectrum of need. In particular, this should include: **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.	June 2019	NSW Health	Supported	**a.** To be closed (intent of recommendation substantially implemented) **b.** Continue monitoring **c.** Continue monitoring	7.2

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation	Section reference
Suicide – targeted prevention measures 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.	June 2019	NSW Health	Supported	Continue monitoring	7.2
Suicide – prevention initiatives in schools 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 recommend that: The NSW Department of Education should evaluate postvention initiatives in NSW government high schools, particular the effectiveness of such initiatives in preventing suicide clusters.	June 2019	NSW Department of Education	Supported	To be closed (intent of recommendation fully implemented)	7.2
Suicide – school review following suicide 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.	June 2019	NSW Department of Education	Supported	Continue monitoring	7.2

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation	Section reference
SUDI medical history 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. **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.	August 2021	NSW Health	Supported	Continue monitoring	7.3

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation	Section reference
Transport – young drivers 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.	August 2021	Transport for NSW (Centre for Road Safety)	Supported in principle	To be closed (intent of recommendation substantially implemented)	7.3
Drowning – swimming pool regulation The Department of Customer Service, in its planned upgrade of the Swimming Pool Register, ensure that its collection and reporting capability allows for public amalgamated reporting of compliance data relating to key aspects of swimming pool regulation, including the reasons pool barriers fail inspections, and whether non-compliances were rectified by owners within reasonable timeframes.	August 2021	Department of Customer Service	Supported	Continue monitoring	7.3

7.2 Progress on previous recommendations

Recommendation: SUDI investigation

***Recommendation 3, NSW Child Death Review Team Child death review report 2015* (published November 2016)**

In the context of previous CDRT recommendations and the work of Garstang et al,[2] 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:

…

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.

This recommendation originally comprised seven elements ((a)-(g)). Elements (a), (b), (d), (f), and (g) were closed in October 2020. Element (c) was closed in October 2021 after being replaced by recommendation 1 in the *Biennial Report of the deaths of children in NSW: 2018 and 2019* (see section 7.2). Element (e) remains open.

Why the recommendation was made

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 NSW Police, NSW Health (emergency departments and NSW Health 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, the 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, and the group continued to consider opportunities to strengthen responses to SUDI events.

Noting progress made in a number of key areas, in October 2020 the CDRT accepted that the intent of elements (a), (b), (c), (f), and (g) of this recommendation had been met and reported that it would only continue to monitor elements (c) (SUDI medical history) and (e) (post-mortem investigation).

[2] Garstang J., Ellis C., & Sidebotham, (2015), An evidence-based guide to the investigation of sudden unexpected death in infancy, *Forensic Science, Medicine and Pathology* DOI.1007/s 12024-015-9680, Springer, New York.

In August 2021, the CDRT reported it would cease monitoring element (c) in response to developments in NSW Health's approach to obtaining SUDI medical histories since the recommendation was made. A related recommendation was made to replace element (c) – see section 7.3.

(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 advised that there is a shortage of paediatric pathologists in NSW and Australia which limits access to this resource, and that NSW post-mortem examinations on infants are completed by general pathologists, with selective involvement of paediatric pathologists.

In October 2020, the CDRT reported that there did not appear to have been any further progress in relation to advice about consultations with paediatric pathologists, other than in relation to genetic testing. It also noted that NSW Health Pathology was in the process of finalising a new SUDI post-mortem protocol.

In October 2021, the CDRT acknowledged that NSW Health Pathology was still in the process of finalising a new protocol for SUDI post-mortems, and that it would continue to monitor element (e) of the recommendation, pending release of the protocol.

In August 2022, NSW Health advised that all SUDI post-mortems in NSW are conducted by appropriately qualified forensic pathologists under the direction of the NSW State Coroner, and that where required a forensic pathologist may consult with a paediatric pathologist. NSW Health also advised that all SUDI post-mortem reports are discussed at a multi-disciplinary SUDI meeting, attended by the Chief Paediatrician, paediatric pathologists, forensic pathologists, a clinical microbiologist, state or deputy state coroner, and forensic medicine social workers. NSW Health subsequently provided a copy of the Terms of Reference for the multi-disciplinary review meeting.

NSW Health also advised that that the new protocol for SUDI post-mortems, the Forensic Medicine Clinical Standard: SUDI/Paediatric post-mortem Performance Standard, has been finalised, and that Forensic Medicine is in the process of implementing an electronic case management system (FMIS - Forensic Medicine Information System). A standardised electronic SUDI/Paediatric post-mortem template has been included in the FMIS, as well as a link to the CDRT's SUDI Classification calculator, to standardise SUDI post-mortem reporting and enhance the consistent classification of SUDI in NSW.

Assessment of progress

The CDRT acknowledges improvements by NSW Health to SUDI post-mortem processes and procedures, including the establishment of regular multi-disciplinary meetings attended by relevant professionals to discuss SUDI post-mortem reports and cause of death, and finalisation of the new protocol for SUDI post-mortems. A key objective of the SUDI multi-disciplinary meeting is to ensure adequate and appropriate consultation with relevant stakeholders (experts).

In light of this progress, the CDRT considers that the intent of the recommendation – that SUDI post-mortems are carried out by paediatric pathologists where possible, and that where this is not possible forensic pathologists have access to advice from a paediatric pathologist – has been met. The CDRT will therefore close this recommendation.

Recommendation: SUDI – safe sleeping

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

NSW Health should develop and implement strategies to promote safe sleep infant 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 the recommendation was made

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, the CDRT considers SUDI prevention initiatives should target high-risk populations, and that NSW government agencies should take specific actions to address risk issues.

To what extent has the recommendation been implemented?

NSW Health supported the recommendation.

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 the hospital.

In November 2019, NSW Health met separately with the Department of Communities and Justice (DCJ) and Red Nose,[3] and then hosted a meeting between both agencies to discuss opportunities for the two agencies to work together to support vulnerable families. Further planned meetings were delayed due to the impact of the response to COVID-19.

In September 2021, NSW Health advised it had published a revised *Recommended Safe Sleep Practices for Babies* Guideline, containing strategies for supporting families. A Safe Sleeping Recommendations information sheet has also been developed and is available on the NSW Health website. NSW Health also noted existing resources had been updated to reflect the revised Guideline.

In August 2022, NSW Health advised that from 2021, the My Personal Health Record (Blue Book) for babies, given to all parents of children born in NSW, includes information and messaging about safe sleep in-line with the revised Guideline. The Having a Baby book also includes safe sleeping information and messaging. NSW Health further advised that the Health and Education Training Institute facilitates the Training Support Unit Jumbunna Webcast Series, which focuses on the health and wellbeing of Aboriginal children, families and communities. In March 2022, a Jumbunna webinar, Safe Sleep Little One, focused on the NSW Health *Recommended Safe Sleep Practices for Babies* Guideline. Staff from

[3] 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

Aboriginal Maternal and Infant Health Services, Building Strong Foundation Services, and other NSW Health services working with Aboriginal families were invited to the webinar which attracted approximately 130 attendees from around NSW, including services located in regional and rural areas of the state.

Assessment of progress

The CDRT acknowledges inclusion of safe sleeping information and messaging in the Blue Book 2021 and the Having a Baby book, which are resources given to all new parents and/or families planning or expecting a pregnancy, in NSW. The CDRT also notes work to target information on safe sleeping to Aboriginal families via a webinar. We will continue to monitor the recommendation, including the development and implementation of strategies focusing on families known to child protection services, families living in remote areas, and families living in areas of greatest socio-economic disadvantage.

Recommendation: identification of illness in infants

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

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 the recommendation was made

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 relatively minor illness. Infants can also develop an acute illness very quickly and deteriorate very rapidly.

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

To what extent has the recommendation been implemented?

NSW Health supported the recommendation.

In August 2019, NSW Health provided advice that it was in the process of contacting Red Nose to work collaboratively to promote evidence-based and evaluated resources for parents and carers. In its July 2020 update, NSW Health provided a summary of existing resources available, such as the Health Direct website, and information and links to resources available via the Blue Book.

In October 2021, the CDRT noted that its recommendation had not been implemented, and that as preceding infectious illness continued to be a factor present in a substantial proportion of infant deaths in 2018 and 2019 that were classified as SUDI, it would continue to monitor this recommendation.

In February 2022, NSW Health advised that it was fully committed to promoting information that will support reduction in SUDI but has found there is a lack of evidence-based resources it can use for this purpose. As a result, NSW Health recommended updating and strengthening existing resources and key messages that inform parents and carers about key risk factors as well as where and how to find help if they are concerned about the health of their child. NSW Health advised it will continue to strengthen the information available to parents and carers to help them care for babies and infants safely, and is

currently scoping a campaign for parents about infant and child health and wellbeing and will provide further advice as available.

In August 2022, NSW Health noted that messaging about recognition of a sick child has featured in recent communications relating to COVID-19 and respiratory illnesses, including video messages. They also noted that other resources – such as the My Personal Health Record (the Blue Book) and the Baby Bundle – provide valuable information about child health and development, safety, common health problems, and parenting, and also contain links to NSW web-based resources such as Healthdirect, Raising Children, and children's hospital websites. NSW Health is also exploring options for a 'digital front door' for parents to access information to support their child's development during the first 2000 days of life.

Assessment of progress

The CDRT acknowledges recent communications and video messages around COVID-19 and respiratory illness, and that existing NSW Health resources are a good source of information for parents. The CDRT will continue to monitor this recommendation, including NSW Health's promotion of resources that aim to assist parents and carers to identify illness in infants, and will seek to meet with NSW Health in the coming months in relation to the intent of this recommendation.

Recommendation: child restraints and seatbelts

Recommendation 4, Biennial report of the deaths of children in NSW: 2016 and 2017 **(published June 2019)**

In the context of the findings of a 10-year review of the role of seatbelts and child restraints in the deaths of 66 child passengers aged 1-12 years in vehicle crashes, we recommend 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.

Why the recommendation was made

In 2019, we released a report detailing the CDRT's findings from a review of the deaths of 66 children who died as passengers in NSW during the period 2007-2016.[4] 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.

To what extent has the recommendation been implemented?

In August 2019, Transport for NSW (TfNSW) advised it supported the recommendation and had engaged Neuroscience Research Australia (NeuRA) to conduct a study to estimate child restraint practices in NSW across 10 selected Local Government Areas (LGAs).

[4] 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.

In June 2020, TfNSW advised that NeuRA had completed work across all metro and outer metro LGAs, and partially completed work in regional LGAs.

In July 2021, TfNSW advised that NeuRA's report had been finalised, but was not fully completed due to the disruptions caused by bushfires and COVID-19 restrictions. TfNSW advised it was not possible to resume the survey because too much time had passed between data collection points. TfNSW further advised that in June 2021, NeuRA had approached the Minister for Transport and Roads seeking a new study focused on regional areas. This was intended to address some of the gaps in the previous study due to disruptions, and to provide additional insights. TfNSW were awaiting advice from the Minister's office about whether this new proposed work would proceed.

In October 2021, the CDRT reported its acknowledgement of the work undertaken to date, noting the original study was not able to be completed due to circumstances outside of TfNSW's control. It also noted that it would continue to monitor the recommendation, pending further advice about the new study.

In July 2022 TfNSW advised that a new study focussing on child restraint practices in rural and remote areas of NSW will proceed, and that the results would be compared to previous observations made in metropolitan areas. TfNSW noted that NeuRA is ready to conduct the study, but that approvals from schools and day care centres to observe at their sites are required and that it will take 3-6 months for these approvals to be obtained.

Assessment of progress

The CDRT acknowledges a revised study will be undertaken. We will continue to monitor this recommendation.

Recommendations: suicide – targeted prevention measures

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

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

- **a.** 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.

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

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 the recommendations were made

The CDRT's 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-age young people have particular vulnerabilities and needs that should be considered in suicide prevention strategies. It has 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.

The CDRT has 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* (the Framework) supports whole of government suicide prevention activity across all NSW communities, and it should therefore be leveraged to provide targeted youth mental health services.

To what extent have the recommendations been implemented?

The NSW Government supported both recommendations.

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, and that NSW Health would provide future updates on behalf of the NSW Government.

In September 2021, NSW Health advised that implementation of the *Towards Zero Suicides* initiatives was well underway and included a range of activities relevant to children and young people. NSW Health also advised that the *NSW School-Link Action Plan 2020-2025* was released in 2020 to facilitate early identification of and timely access to specialist services and support suicide prevention and postvention in school communities, and that the *Getting on Track in Time – Got it!* program in select primary schools was a relevant initiative.

In October 2021, the CDRT noted that in relation to recommendation 10 it remained concerned about the number of child and adolescent mental health workers available to deliver interventions, particularly in regional areas. The CDRT also noted it was unclear if co-funded initiatives would be expanded across NSW if successful, and how sustainability would be ensured. In relation to recommendation 11, the CDRT noted that current initiatives do not address the gaps in the delivery of appropriate specialist mental health services for children and young people, and that the emphasis of initiatives is largely on the identification of risk, not the management of risk. The CDRT reported that it would continue to monitor the implementation of both recommendations.

In August 2022, NSW Health advised that, in relation to access to early intervention and school-based supports, the NSW Government continues to deliver the *Got It!* program in schools, which now includes a specific, culturally sensitive Aboriginal *Got It!* program in South-West Sydney Local Health District. The government is also in the process of establishing 25 Safeguards Teams across NSW – a new dedicated multidisciplinary resource designed to provide care to children and adolescents aged 0-17 years experiencing acute mental health distress.

Specific non-clinical therapeutic support to young people at high risk is supported via funding, in partnership with the Commonwealth Government, of a new Youth Aftercare pilot program (branded "i.am") to provide community-based support to children and young people who have attempted suicide, are experiencing suicidal thinking, or have self-harmed. The pilots will operate in Blacktown, Coffs Harbour, Tamworth, and Bankstown until June 2023.

NSW Health also noted other initiatives focused on connecting suicide prevention planning to child and youth specific needs, including:

- A *Zero Suicides in Care* initiative to improve suicide prevention skills among staff within acute and community-based mental health services across NSW.
- Suicide Prevention Outreach Teams that provide outreach support to people in suicidal distress, including a specific Youth Response Team in Northern Sydney Local Health District and Sydney Children's Hospitals Network.

- 11 Safe Havens that provide an alternative to emergency departments for those under 16 years with suicidal thoughts or distress.
- The Building on Aboriginal Communities' Resilience initiative which provides funding to 12 Aboriginal Community Controlled Health Organisations to deliver culturally appropriate, Aboriginal designed and led social and emotional wellbeing activities. Two services located in Nowra, NSW, deliver programs within local schools for Aboriginal youth.
- The Community Response Package for Young People includes funding to Wellways Australia to deliver programs to raise awareness for suicide prevention for young people in NSW, promote the know-how for having safe conversations around suicide and suicidal distress, and increase access to appropriate support services. The UrHere campaign offers support for young people, including those who identify as members of the LGBTQ+, Aboriginal, CALD and other communities.
- The LivingWorks Suicide Prevention Training initiative includes training for up to 275,000 people in suicide prevention skills training, targeting NSW Independent, Catholic, and public high school education sector teachers and support staff, parents/carers, the wider school community, and targeted community first responders, to create a network of safety around young people.

Assessment of progress

The CDRT acknowledges NSW Health's continued endeavours to improve child and adolescent mental health services in the midst of the sustained COVID-19 pandemic.

Recommendation 10

(a) Universal strategies to promote wellbeing

The CDRT accepts that the intent of this element – the provision of universal strategies targeted to school-aged children and young people that promote wellbeing – has been met through various programs and school-based initiatives which focus on bullying, physical health, resilience, and other relevant topics. In particular, we welcome NSW Health's advice about the funding of 12 Aboriginal Community Controlled Health Organisations to deliver culturally appropriate, Aboriginal designed and led social and emotional wellbeing activities aimed at diverse groups within their communities, including children and young people. In light of this advice, the CDRT will no longer monitor this element.

(b) Early intervention

The CDRT acknowledges the *Got It!* program is an early intervention strategy that employs screening, an evidence-based intervention, and follow up. The limitation of this program is the age band it addresses (currently Kindergarten to Year 2). At this point, it is unclear if NSW Health are considering extending *Got It!* deeper into the primary school years, or if NSW Health have plans to replicate the model to address problems associated with suicidal behaviour that affect children closer to adolescence – for example, in relation to school non-attendance. Recognising this gap, the CDRT will continue to monitor the development and implementation of early intervention measures targeted to older school-aged children and young people that are designed to arrest emerging problems and difficulties, noting that the social, emotional and behavioural concerns for children vary with age.

(c) Targeted, sustained, intensive therapeutic support

The CDRT acknowledges information about various support measures such as funding over four years to establish Safeguards teams across the state, a new Youth Aftercare pilot program, and other generic initiatives (e.g., Zero Suicides in Care, SPOT, Safe Havens). However, we note that none of the programs provide sustained intensive therapeutic support, as follows:

- The Safeguards teams are designed to provide crisis assessment, clinical care and short-term therapeutic interventions to resolve mental health crisis, rather than sustained intensive therapeutic support. It is also unclear if the teams will be established in areas that do not have access to community child and adolescent mental health services, and if not, whether NSW Health will invest in building up those resources to support the Safeguards teams.
- The new Youth Aftercare pilot program provides non-clinical, psychosocial support using a peer and youth worker workforce. While the proposal has the potential to improve access and inclusivity for young people in distress, it is not targeted to providing intensive therapeutic support to young people at high risk. We also note the program is being piloted in a few regions.
- Other generic services described are not specifically targeted to children and young people, and primarily offer skills development and outreach support, rather than sustained intensive therapeutic support. Some are being delivered in a few areas of NSW, but there is no indication whether they are pilots, will be evaluated, or if there is an intention to extend them to other regions.

The CDRT will therefore continue to monitor the development and implementation of initiatives that focus on providing sustained and intensive therapeutic support to young people at high risk, including those who are hard to reach, and how these services work to provide coordinated care and support.

Recommendation 11

This recommendation was made in response to concerns about gaps in services, and in the context of the government's acknowledgement that the demand for access to developmentally appropriate specialist mental health services for children and adolescents in NSW regularly outstrips capacity to supply timely services. The CDRT recommended that the government direct funds to address gaps in services, particularly in relation to strategies to manage and contain risk (as opposed to risk identification, which we did not identify as a weakness in NSW).

It is not clear to us that the programs and initiatives described adequately address gaps in services, or how funding has been directed to bolster capacity to provide specialist mental health services for children and young people. The CDRT will therefore continue to monitor recommendation 11.

Recommendation: suicide prevention initiatives in schools

Recommendation 12, Biennial report of the deaths of children in NSW: 2016 and 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 recommend that:

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

Why the recommendation was made

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,[5] 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

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

strategies,[6] and the CDRT's ongoing work in reviewing the suicide deaths of school-aged children and young people in NSW.

Together, this work suggested suicide prevention activities in schools 'lacked coordination and consistency',[7] and that the overall effectiveness of postvention activities and strategies in preventing future suicide clusters had not been evaluated.[8]

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

To what extent has the recommendation been implemented?

The Department of Education supported this recommendation.

In June 2020, the Department advised that it had engaged Orgyen to conduct an evaluation of its postvention initiatives.[9]

In September 2021, the Department advised the evaluation was complete, and that 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 further advised that Orgyen had made recommendations to further enhance postvention initiatives in secondary schools, and that it is progressing work on these recommendations. The Department also advised it is working with Orygen and EveryMind to update training for school wellbeing staff in postvention.[10]

In October 2021, the CDRT reported it would seek a copy of the evaluation. The Department subsequently provided a copy of the *Evaluation of the effectiveness of postvention initiatives in New South Wales secondary schools* report.[11]

In July 2022, the Department advised it had updated its 'Guidelines for responding to the death of a student by suicide' and they are being prepared for release to schools in Semester 2, 2022. The updated guidelines address three key issues outlined in the Orygen evaluation:

a) **information on how to manage social media and memorials in the aftermath of a student suicide**. Following consultation with internal and external stakeholders to obtain advice, direct input and review, this has been integrated into the updated guidelines.

b) **recommendations for conducting a critical incident review in the months following the suicide**. The Department has incorporated clear information and a dedicated template for schools to engage in an operational reflection and planning following a postvention response.

c) **recommendations regarding the conduct of an annual review of the emergency response plan**. A School Postvention Response Plan has been included with information and guidance on completing this tool.

[6] NSW Child Death Review Team 2019. Review of suicide clusters and evidence-based prevention strategies for school-age children, prepared by the Australian Institute for Suicide Research and Prevention. NSW Ombudsman, Sydney.

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

[8] AISRAP review, 2019

[9] Orygen is an Australian research and advocacy organisation focused on youth mental health.

[10] EveryMind is an Australian institute dedicated to the prevention of mental ill-health and suicide.

[11] Final report, March 2021, https://education.nsw.gov.au/about-us/educational-data/cese/evaluation-evidence-bank/reports/effectiveness-of-postvention-initiatives-in-nsw-secondary-schools

Release of the updated guidelines will occur in conjunction with training to support schools in understanding the updates and in postvention response preparation and planning, led by Psychology and Wellbeing Coordinators.

The Department further advised that in January 2022, it expanded its team of Psychology and Wellbeing Coordinators to six with a plan to have eight coordinators by 2023. Part of the work of the Psychology and Wellbeing team is to systematically review internal incident data to identify emerging trends and inform future practice, including consideration of known risk factors to strategically target intervention and prevention programs.

On 7 September 2022, the Department provided a copy of its updated postvention Guidelines, published on 31 August 2022. The new guidelines include information about preparation and planning for postvention, and four response periods:

i) immediate response (first 24 hours)
ii) short-term response (24-48 hours)
iii) the next 48-72 hours
iv) longer term.

The guidelines also include templates, resources, and other reference and contact material.

Assessment of progress

The review conducted by Orygen on behalf of the Department of Education to examine the effectiveness of postvention initiatives in NSW public secondary schools found that the Department's postvention guidelines were closely aligned with international best practice and current evidence and were effective in supporting schools to manage postvention responses.[12] The evaluation report also noted that it was 'beyond the scope of the current evaluation to make any findings in relation to the efficacy of the guidelines in preventing suicide or suicide clusters'.

The evaluation identified a number of areas for improvement, including updating the Department's postvention guidelines, considerations following a student death by suicide, and enhancing the effectiveness of postvention responses in schools.

The CDRT welcomes the findings of Orygen's evaluation, as well as the Department's advice about its response to recommendations made in the report regarding areas for improvement. The CDRT acknowledges the limitations of the evaluation in relation to assessing the efficacy of the guidelines in preventing suicide clusters.

The CDRT also welcomes advice about the publication of the Department's updated postvention *Guidelines for responding to the death of a student by suicide* in late August 2022. The CDRT considers that the new guidelines address Orygen's recommendations.

In light of this positive progress, the CDRT accepts that the intent of this recommendation has been met and will no longer monitor this recommendation.

[12] Responding to Student Suicide – Support Guidelines for Schools (2016).

Recommendation: school review following suicide

Recommendation 15, Biennial report of the deaths of children in NSW: 2016 and 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 the recommendation was made

Schools are a critical part of the service systems for identifying and intervening early to prevent suicide of school-age children and young people. The NSW Department of Education does not currently have a process to undertake a critical incident style review of a student death by suicide. Learning from missed opportunities to frame future practices and policy should be a key strategy in improving the capacity of agencies to develop effective prevention strategies.

To what extent has the recommendation been implemented?

The Department of Education supported this recommendation.

In June 2020, the Department 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.

In September 2021, the Department advised it had established a pilot of four new Psychology and Wellbeing Services Coordinator roles to strengthen support to schools in suicide prevention and postvention. The Department also advised that based on Orygen's review, it would not be establishing a death review process. Instead, it would proceed with other initiatives, such as the systematic review of internal incident data.

In October 2021, the CDRT reported it would seek a copy of the review. In February 2022, the Department provided a copy of Orygen's Literature and Policy Review (LPR). Senior Departmental staff then met with NSW Ombudsman officers to discuss statements made in the LPR about recommendation 15, and to clarify the intent and the purpose of the CDRT's recommendation.

In April 2022, the Department advised that following this clarification, it would proceed to establish a multidisciplinary team to develop and lead a critical incident review process to facilitate learning and inform future work at a systems level. While this team is being planned and established, the Department has set up a group to review relevant available internal information and data to identify emerging trends and inform future practice.

In July 2022, the Department advised that it is finalising a framework for reviewing the death by suicide of students in public schools. Senior Departmental staff met with relevant counterparts from NSW Health and the Department of Communities and Justice to inform the development of the framework. The framework will use a trauma-informed systems approach to understand and enhance good practice in supporting the wellbeing and mental health of children and young people. A multidisciplinary team, led by the Psychology and Wellbeing Coordinators, will lead the process to facilitate learning and inform future work at a systems level.

Assessment of progress

We acknowledge the Department's efforts to implement this recommendation following clarification of the CDRT's intent and purpose.

The CDRT will continue to monitor this recommendation, pending further advice about the Department's progress in finalising and implementing its planned framework for reviewing the death by suicide of students in public schools, and how it will use outcomes from reviews to inform future practice and policy.

7.3 New recommendations

Recommendation: SUDI medical history

***Recommendation 1, Biennial report of the deaths of children in New South Wales: 2018 and 2019* (published August 2021)**

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.
- **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.

Why the recommendation was made

As noted in section 7.2, recommendation 3 from the *Child Death Review Report 2015* originally contained an element (c) that related to SUDI medical history.

In July 2019, NSW Health introduced a revised Policy Directive on the Management of Sudden Unexpected Death in Infancy (SUDI), which includes a mandatory requirement to complete an infant medical history and provide a copy of the infant's health care record to NSW Health Pathology Forensic Medicine within 24 hours of the infant's death. The former SUDI medical history form (now titled the *Medical History Guide – Sudden Unexpected Death in Infancy (SUDI)*) was revised into a set of questions to guide a clinician to take a medical history in the context of a SUDI death.

At a Coronial inquest into the deaths of two infants in 2019, NSW Health gave evidence about a proposed audit of the revised SUDI Medical History Guide to assess whether the changes were effective. The State Coroner recommended that the audit be implemented over a period of 12 months, and for the Department of Forensic Medicine to ensure that its policies require the SUDI Medical History Guide to be provided to the case forensic pathologist in a timely manner.

The CDRT's recommendation takes account of the updated policy and seeks information about the proposed audit.

To what extent has the recommendation been implemented?

In December 2021, NSW Health advised that an audit plan has been developed, but not yet finalised. In January 2022, NSW Health advised that its response was delayed due to COVID.

In February 2022, NSW Health advised it accepted the recommendation, and provided a copy of the NSW Health plan to conduct an audit of medical history procedures when there has been a sudden and unexpected death of an infant.

The audit plan includes a number of project phases, including initiation, planning, implementation, governance, and reporting. At the time the plan was provided, work was underway in the planning phase, with plans to conduct the audit by May 2022, and report back to the SUDI cross-agency working group by July 2022.

In August 2022, NSW Health advised that implementation of the audit plan was delayed by the COVID-19 (Omicron) response in early 2022. However, the implementation phase of the plan had commenced, an audit officer to complete the audit had been identified and it anticipated that the SUDI audit would be formally completed by December 2022. NSW Health advised that the scope of the audit has been widened from the medical history protocol to include broader evidence considered during a SUDI response. This includes presence and adequacy of the Police P79A form, medical history, and NSW Ambulance forms, as well as availability and access to scene photography. NSW Health will keep the CDRT informed as the audit progresses and is finalised.

Assessment of progress

The CDRT will continue to monitor this recommendation, pending further advice from NSW Health.

Recommendation: young drivers

Recommendation 2, Biennial report of the deaths of children in NSW: 2018 and 2019 **(published August 2021)**

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.

Why the recommendation was made

The CDRT's 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.

This recommendation replaces recommendation 3 from the *Biennial report of the deaths of children in NSW: 2016 and 2017*, relating to TfNSW's *Safer Vehicle Choices Save Lives* campaign website.

The previous recommendation was replaced following advice from TfNSW in July 2021 that it was working with ANCAP and the Vehicle Safety Research Group to develop a new website allowing consumers to search vehicles within a price range, providing the most appropriate safety rating for that vehicle. TfNSW advised that once launched, the website would be particularly promoted to young drivers. It noted that, in the interim, the Centre for Road Safety had been promoting the 'howsafeisyourcar' website operated by the Victorian-based Transport Accident Commission, which allows drivers to search for safety ratings for new and used vehicles.

To what extent has the recommendation been implemented?

In July 2022, TfNSW advised that it is committed to supporting and implementing the recommendations that have been accepted, noting replacement of the previous recommendation (from the 2016-2017 biennial report) with the current recommendation.

TfNSW advised that it has implemented this recommendation by linking the Centre for Road Safety webpage to the 'howsafeisyourcar' website. The 'howsafeisyourcar' website helps car buyers to find the safest car in their price range, and includes both ANCAP and Used Car Safety Ratings as well as other safety features fitted to vehicles. [13, 14]

In August 2022, we met with representatives from TfNSW and the Centre for Road Safety to discuss the promotion of information to young drivers. TfNSW staff discussed various initiatives and programs that specifically target young drivers. In September 2022, the Centre for Road Safety provided more detailed information about relevant programs. For example:

- Road Safety Education Program – a partnership between TfNSW, government and non-government school bodies, and the Early Childhood Road Safety Education Program to teach road safety in NSW schools as part of the K-10 Syllabus. In Years 11 and 12, students learn about road safety as part of the mandatory 25-hour Life Ready Course in government schools, and through wellbeing and pastoral care courses in non-government schools.
- Used Car Safety Ratings (UCSR) – annual promotion of UCSR information at events such as the Sydney Royal Easter Show and bstreetsmart (road safety education event targeted at year 10-12 students) and through the Road Safety Officer network run through local government areas. UCSR information is also included in learner driver kits given to all new learner licence holders and through the Helping Learner Drivers Become Safer Drivers workshop.
- Empowr Mobility pilot project – currently operating in Orange, Armidale and Queanbeyan, this program supports young people experiencing disadvantage to access a low-cost, safer vehicle with a 5-star ANCAP rating and fitted with telematics which provide tips and feedback to drivers via a mobile app so they can develop safer driving habits.
- Road User Handbook – a resource for all drivers and those seeking to obtain a learner licence which provides information on road rules, safe driving practices, and novice driver high performance vehicle restrictions.
- Get Licensed, Get Legal, Get Work – a resource to help people with low literacy and numeracy to understand the Road User Handbook, and pass the Driver Knowledge Test, delivered as part of the Driver Licensing Access Program.
- Safer Drivers Course – teaches learner drivers under 25 to develop safe driving skills, including a 3-hour group discussion with other learners and a 2-hour coaching session in a vehicle with another learner.
- Bstreetsmart – an annual large-scale road safety education event for secondary school students to raise awareness of the fatality and injury rates of young people and to ensure the community is aware of injury prevention, trauma care services and related resources.
- RYDA – workshops designed to help senior high school students explore and address road safety.

[13] Centre for Road Safety, https://towardszero.nsw.gov.au/safesystem/safe-vehicles

[14] Centre for Road Safety, https://roadsafety.transport.nsw.gov.au/stayingsafe/vehiclesafety/safety-ratings.html

Assessment of progress

The CDRT acknowledges that the Victorian Transport Accident Commission's 'howsafeisyourcar' website[15] is relevant and accessible to all Australian drivers and welcomes advice from TfNSW that the Centre for Road Safety website is now linked to the 'howsafeisyourcar' website.

The CDRT also notes that TfNSW are involved in providing a wide range of programs and initiatives that specifically target young drivers, including information to assist young drivers to purchase the safest car in a range of price brackets, and understand the importance of road safety and safe driving.

The CDRT is satisfied that the intent of its recommendation has been met and will therefore close this recommendation.

Recommendation: swimming pool regulation

Recommendation 3, Biennial report of the deaths of children in NSW: 2018 and 2019 **(published August 2021)**

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

Why the recommendation was made

Pool inspection and compliance with legislation is managed within local government areas. The *Swimming Pools Regulation 2018* requires local councils to report publicly on its regulatory activities and outcomes, including the number of pool inspections carried out, the proportion of pools deemed non-compliant with legislation, details of the defects identified, and whether or not owners have rectified defects within a reasonable period of time. However, each council does not comprehensively or consistently publish the information on swimming pool safety and inspection.

This recommendation amends recommendation 10 from the *Child Death Review Report 2015* on the publication of annual data from the Swimming Pool Register. This followed advice from the Department of Customer Service (DCS) in June 2020 that the Register cannot currently provide an amalgamated report of key aspects of swimming pool regulation, and that planned upgrades to the Register are required to do this. In September 2021, DCS advised that upgrades to the Register are planned for 2022.

To what extent has the recommendation been implemented?

In July 2022 DCS advised that they support the recommendation. They advised that they continue to develop the NSW Swimming Pool Register's enhanced amalgamated reporting capability, and anticipate that the upgrades will be complete by December 2022.

Assessment of progress

We acknowledge that work to implement the recommendation is ongoing and will continue to monitor progress pending further advice from DCS.

[15] Victorian Transport Accident Commission, howsafeisyourcar? https://howsafeisyourcar.com.au/

7.4 NSW Ombudsman recommendations: reviewable child deaths

In addition to recommendations monitored by the CDRT described above, the biennial report tabled in August 2021 (the *Biennial Report of the deaths of children in New South Wales: 2018 and 2019*) included four recommendations that relate to reviewable child deaths (recommendations 4, 5, 6 and 7). 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 its work and prioritise resources. This year the CDRT continued to work on actions agreed in its Strategic Priorities Plan 2019-22. This will be the final reporting of the 2019-22 plan. From 1 July 2022, the CDRT commenced work on its new three-year plan.

Meeting our priorities

The table below details progress against key strategic priorities as of 30 June 2022.

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	Completed	As part of the AIHW data linkage project, detailed in Chapter 4, key external data sets 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	Substantially completed	Work to build dashboards that provide interactive real-time data about information held in the Register is nearing completion.
Work with external stakeholders to promote the Register and patterns and trends identified	Ongoing	Since completing a design review of the Register in 2018, information about the Register and our data dictionary has been shared with various interstate stakeholders, including technical information about analytic processes to identify patterns and trends. Work to optimise our reach and promote our findings, data, and recommendations is ongoing.
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	Ongoing	The CDRT continues to monitor progress of the cross agency working group through its reviews and monitoring of recommendations, as detailed in Chapter 7.

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	Ongoing	The CDRT continues to monitor and report on 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	Ongoing	Actions taken by Catholic and independent schools were documented in the CDRT's 2019-20 Annual Report. The CDRT will continue to monitor measures in public schools. Chapter 7 provides full details of progress made.
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	Completed 2021	Tabled 26 October 2021
CDRT Annual Report 2021-22	Drafted	To be tabled by 31 October 2022
Biennial report of the deaths of children in New South Wales: 2018 and 2019	Completed 2021	Tabled 24 August 2021
Biennial report of the deaths of children in New South Wales: 2020 and 2021	Carried forward	To be tabled in 2023
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	Substantially completed	As detailed in Chapter 4, work on this project is nearing completion. We intend to table a public report in relation to this work in 2022.
Undertake and report on at least three detailed group reviews, which will examine data held in the Register of Child Deaths relating to: • Asphyxia-related deaths of newborn infants • Deaths of Aboriginal and Torres Strait Islander children • The role of young drivers in fatal motor vehicle crashes	Carried forward	As detailed in Chapter 4, the project relating to the deaths of newborns due to severe brain injury is nearing completion, and the project examining the suicide deaths of Aboriginal children and young people is well progressed. 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 priority will be to:		

Develop a communication 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. The Charter and Code of Conduct are described in Chapter 2.
Prepare and promote fact sheets to highlight potentially avoidable child death and share evidence-based prevention strategies	Not progressed	Work on this initiative has been placed on hold, pending capacity.
Work with the State Coroner's Office, NSW Health Pathology's Forensic Medicine, and other key stakeholders to promote a revised SUDI classification	Carried forward	In 2021-22 information about the CDRT's revised SUDI classification was provided to various external stakeholders. Work to provide information sessions with coronial staff was placed on hold in 2021, pending capacity. We plan to conduct these sessions in 2022-23.
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'	Finalised	The CDRT continues to monitor one recommendation arising from this report, discussed in Chapter 7. The CDRT also engaged with the NSW Police Force in relation to its Child Car Seat Program, which was developed and implemented in response to the CDRT's research report. This work is detailed in Chapter 6 of the Biennial report of child deaths in 2018 and 2019.
Lead the Australian and New Zealand Child Death Review & Prevention Group, with a focus on engaging all jurisdictions in determining forward priorities and working with states to implement a future work agenda	Completed	The CDRT and the NSW Ombudsman hosted the group's annual conference and convened its meeting in May 2022. The role of Chair of the Group has passed to Queensland in 2023, as detailed in Chapter 5.
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	Not progressed	Work on this initiative was placed on hold, pending capacity.
Include analysis of injury data (intentional self-harm) in our review of	Finalised	Injury data is being considered as part of the project examining the suicide deaths of Aboriginal

suicide deaths of Aboriginal children and young people		children and young people discussed in Chapter 4.
Review progress of recommendations from the Senate Select Committee Inquiry into Stillbirths in Australia (finalised December 2018). The CDRT will consider the need for further work in linking perinatal deaths and stillbirths.	Not progressed	Work on this initiative was placed on hold, pending capacity.

Appendix 2: Agency advice regarding recommendations

Mr Paul Miller
Convenor, NSW Child Death Review Team
NSW Ombudsman
Email: cdrt@ombo.nsw.gov.au

Your ref
Our ref H21/235054

Dear Mr Miller

I am writing in response to recommendations for NSW Health in the Child Death Review Team (CDRT) biennial and annual reports released respectively in August and October 2021.

CDRT recommendation: Sudden Unexpected Death in Infancy audit
NSW accepts this recommendation. Please find attached a copy of the NSW Health plan to conduct an audit of medical history procedures when there has been a sudden and unexpected death of an infant (SUDI).

CDRT recommendation: Identification of Illness in infants
In 2019, NSW Health accepted this recommendation and agreed to promote evidence-based and evaluated resources to parents and carers on identification of illness in infants. We are fully committed to promoting information that will support reduction in SUDI, however we have found a lack of evidence-based resources that we can use for this purpose that would be in addition to those reported to the CDRT in July 2020.

NSW Health now recommends updating and strengthening existing resources and key messages that inform parents and carers about key risk factors as well as where and how to find help if they are concerned about the health of their child.

NSW Health will continue to strengthen the information and support available to parents and carers to help them care for the babies and infants safely. We are currently scoping a campaign for parents about infant and child health and wellbeing and will provide further advice as available.

I seek your agreement that the CDRT recommendation on identification of illness in infants is being progressed by NSW Health.

NSW Ministry of Health
ABN 92 697 899 630
1 Reserve Road, St Leonards NSW 2065
Locked Mail Bag 2030, St Leonards NSW 1590
Tel (02) 9391 9000 Fax (02) 9391 9101
Website: www.health.nsw.gov.au

Recommendations from the NSW Coroner
As you are aware the NSW Government's SUDI Cross Agency Working Group (CAWG) continues to consider opportunities to strengthen response to SUDI events, including work to address the recommendations made by the NSW Coroner following the inquest into the deaths of Kayla Ewin and Iziah O'Sullivan.

I am pleased to report that work to address the NSW Coroner's recommendation is complete and that an update has been provided to the NSW State Coroner. In 2022 the SUDI CAWG will continue to consider cross agency work that can be progressed to achieve further improvement in the SUDI response by NSW Government agencies. NSW Health will continue to lead the SUDI CAWG.

Thank you for leading this important work. If you would like more information please contact Ms Tish Bruce, Executive Director, Health and Social Policy Branch on [redacted] or at [redacted]

Yours sincerely

[redacted]

Dr Nigel Lyons
Deputy Secretary, Health Systems Strategy and Planning
03 February 2022

Encl. NSW Health SUDI Audit Plan.

Sudden Unexpected Death in Infancy

2022 SUDI Audit Plan	Recommendation from the Child Death Review Team (CDRT) for NSW Health

CDRT Recommendation

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
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

SUDI Audit Project Plan				
Project Phase	**Key activities**	**Outcome(s)**	**Timeframe**	**Status/Comments**
Initiation	• Review CDRT recommendation to clarify scope and timeline for response • Confirm project lead and budget • Identify key stakeholders for planning and design	CDRT receive NSW Health's response to the recommendation from the Biennial report	Dec 2021	**Status: Complete** Lead: Health and Social Policy Branch (HSPB) Stakeholders: NSW Health Pathology, NSW Coroner, NSW Chief Paediatrician, Clinical Excellence Commission.
Planning	• Consult with key stakeholders • Develop project proposal • Collect SUDI case data • Commission auditor	Audit is designed and developed to: ▪ meet the requirements of the CDRT	Dec 2021- January 2022	**Status: Underway** Consultation completed Audit proposal in development- see below

H21/ 235054

	• Establish governance and reporting • Develop audit tools	▪ support NSW Health quality improvement activity in the response and management of SUDI incidents ▪ build interest and engagement in SUDI policy implementation with LHDs ▪ Inform the work of the SUDI Cross agency working group. Audit is completed by skilled and qualified personnel Scope, timeframe and resources are feasible and achievable.		Case data: case data range - Oct 2019 until June 2021. Governance and reporting: The SUDI Cross Agency Working Group (CAWG) will be asked to form a sub-group to steer and provide oversight of the audit. Next meeting of the SUDI CAWG is 29 Jan 2022
Implementation	• Consultation with key stakeholders and relevant clinicians and manager • Conduct audit • Analyse audit data • Develop audit report findings and recommendations	Local Health Districts have background and context to audit and are fully engaged.	February-May 2022	**Status: Not yet started**
Governance	• Fortnightly project support by HSPB • Monthly monitoring by steering group • Interim report to April SUDI CAWG	Project progresses on time, within scope and on budget Interim findings inform planning and reporting Audit is conducted professionally and respectfully.	Jan-July 2022	**Status: Not yet started**
Reporting	• Final Report to SUDI CAWG • Formal Response to CDRT	Results of the audit inform discussions about quality improvement and policy development.	July 2022 August 2022	**Status: Not yet started**

Draft Audit Outline

Project Scope: Audit SUDI case data from1 Oct 2019 – 30 June 2020 **Project Time:** January – July 2022

RESOURCES				
Human resources	**Purpose**	**Timeframe**	**Anticipated cost**	**Comments**
0.2 Paediatric Staff Specialist	Design and conduct audit	28 weeks[1]	$29,977.87	HR allocation based on approx. 50-60 cases over the reporting period.
0.2 Paediatric Clinical Nurse Consultant	Design and conduct audit	28 weeks	$13,901	Resourcing dependent on actual case data and geographic location of SUDI cases. May need operational flexibility: practically may be better to do 2 days per fortnight or 1 week in four to accommodate travel/site visits and evidence collection.
Data Analyst 0.1	Support Design, analysis and reporting	9 weeks	$2,812.5	3 weeks design 6 weeks analysis
Governance/steering group	Project steering and monitoring	6 meetings of up to 1.5 hours	In kind	In kind from HSPB and SUDI CAWG members with additional members co-opted from Emergency Care Institute and CEC
Audit Costs				
Travel and accommodation	Site visits and stakeholder engagement	28 weeks	$10,000	Up to 2 site visits per weeks spread over 18 weeks assumes some SUDI cases will be clustered and some will be remote. Travel may include flight/hire car
Catering allowance	Supports local engagement	28 weeks	$4200	Build engagement in subject with time poor people.
Tools and resources				
Computers and accessories	Collect and store data securely; communication with stakeholders	28 weeks	In kind	In kind contribution from HSPB

[1] Timeframe dependent on volume of cases identified for the reporting period.

H21/ 235054

3

Audit Tools – QARS	Data collection and analysis		In kind	In kind by NSW Health
SUDI Data	Case evidence		In kind	Supplied by NSW Health Pathology

Ms Monica Wolf
Acting NSW Ombudsman
Acting Convenor, NSW Child Death review Team
Level 24
580 George Street
SYDNEY NSW 2000

Our ref O22/1

Dear Ms Wolf

NSW Health Update on NSW Ombudsman Child Death Review Team recommendations

I am writing in response to your request to provide an update on the previous recommendations made by the Child Death Review Team to NSW Health towards the preparation of the 2021-22 CDRT Report which you intend to table in October this year.

Please find attached NSW Health's response which provides a status update on the recommendations that are being currently monitored by your office.

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

Yours sincerely

[redacted]

Susan Pearce
Secretary, NSW Health

NSW Ministry of Health
ABN 92 697 899 630
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NSW HEALTH UPDATE – August 2022

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
SUDI investigation ***Recommendation 3e, Child Death Review Report 2015*** In the context of previous CDRT recommendations and the work of Garstang et al, noting that responsibility for management of the implementation of this recommendation subsequently transferred from the NSW Government to NSW Health: *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 [including]:* *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.* The original recommendation listed seven elements – the CDRT is continuing to monitor only one of these elements, as noted above.	All SUDI post-mortems in NSW are conducted by appropriately qualified Forensic Pathologists under the direction of the NSW State Coroner. Where required, the Forensic Pathologist may consult with a Paediatric Pathologist. All SUDI post-mortem reports are discussed at a multi-disciplinary SUDI meeting. The multi-disciplinary team includes the Chief Paediatrician, paediatric pathologists, forensic pathologists, a clinical microbiologist, state or deputy state coroner and forensic medicine social workers. The Forensic Medicine Clinical Standard: SUDI/Paediatric post-mortem Performance Standard has been finalised. Forensic Medicine is in the process of implementation of an electronic case management system (FMIS- Forensic Medicine Information System). A standardised electronic SUDI/Paediatric post-mortem template has been included in the FMIS which will further serve to standardise SUDI post-mortem reporting. The SUDI/Paediatric post-mortem template is based on the guidelines provided by the Clinical Standard. Consent has been obtained from the CDRT to include the SUDI Classification calculator they developed as a link in FMIS. This will further enhance the consistent classification of SUDI deaths in NSW.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
Safe sleeping in vulnerable families ***Recommendation 1, Biennial report of the deaths of children in NSW 2016 and 2017*** 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.	The My Personal Health Record (Blue Book) is a universal resource given to all parents of children born in NSW, and sets out the recommended schedule of child health checks and underpins child health screening and surveillance in NSW. The Blue Book 2021 includes information and messaging about safe sleep for parents in line with the revised Recommended Safe Sleep Practices for Babies Guideline (GL2021_013). The Having A Baby book is a universal resource provided free of charge to all families planning or expecting a pregnancy, in NSW. The book is currently under review and provides information about having a healthy pregnancy, birth and the postnatal period. The book includes safe sleeping information and messaging in line with the revised Recommended Safe Sleep Practices for Babies Guideline (GL2021_013). The Health and Education Training Institute (HETI) NSW Health facilitates the Training Support Unit (TSU) Jumbunna Webcast Series. Jumbunna sessions focus on the physical, cognitive, social, emotional health and wellbeing of Aboriginal children, families and communities. On16 March 2022 a Jumbunna webinar called Safe Sleep Little One was facilitated and focused on the NSW Health Recommended Safe Sleep Practices for Babies Guideline. The webinar will be uploaded to the TSU Jumbunna Webcast Series webpage so it can be accessed by staff who were unable to attend the webinar. Staff from Aboriginal Maternal and Infant Health Services (AMIHS), Building Strong Foundation Services (BSF) and other NSW Health services working with Aboriginal families were invited to the webinar. AMIHS and BSF services are predominantly located in regional, rural areas of NSW. There were about 130 registrations from around NSW.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
Identification of illness in infants ***Recommendation 2, Biennial report of the deaths of children in NSW 2016 and 2017*** 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.	Messaging about recognition of a sick child has featured in recent communications around COVID-19 and respiratory illnesses, including video messages https://www.schn.health.nsw.gov.au/our-hospitals/parents-carers/seasonal-health-alerts/winter-and-your-sick-child. As previously noted, other resources provided in the Blue Book remain a good source of information for parents, including Raising Children, Healthdirect, and children's hospital websites. This recommendation may require further consideration, given that there is no established link between delayed recognition of illness or response to illness and SUDI.
Suicide – focused prevention plan, managing and containing risk ***Recommendations 10 and 11, Biennial report of the deaths of children in NSW 2016 and 2017*** Noting that in June 2020, the NSW Government transferred responsibility to NSW Health to lead the implementation of these recommendations: 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 –	The NSW Government continues to improve the availability of child and youth mental health services to address the rising impacts of mental ill-health in this population. *Access to early intervention and school-based supports* The NSW Government continues to deliver the Got It! Program in NSW schools, in collaboration with parents and teachers. Got It! is a specialist school-based early intervention mental health program for children who display early social, emotional, and behavioural concerns and reduce the emergence of conduct disorders. The program is directed toward children from Kindergarten to Year two and their parents/carers and is delivered in partnership with NSW Department of Education school staff. It comprises of a universal screening and teacher/ parent training component, a focused assessment and support component, and a targeted therapeutic intervention. Independent evaluation in 2014 and 2016 demonstrated that the Got It! program has a positive impact and resulted in state-wide funding to all 15 LHDs. Got It! has also evolved to include a specific, culturally sensitive Aboriginal Got It! program in South West Sydney LHD. Aboriginal Got It! promotes a holistic, family-centred approach for Aboriginal children and families.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
including strategies for reaching those who are hard to engage. The NSW Government should direct funds associated with the Strategic Framework for Suicide Prevention in NSW 2018-2023 to address gaps in the delivery of appropriate specialist mental health services for children and young people in NSW.	*Improving acute community based mental health care for children and young people* The 2021-22 Budget included $109.5 million over four years to establish 25 Safeguards teams across NSW. The Safeguards Teams are a new dedicated child and adolescent mental health resource designed to provide innovative and best practice care to children and adolescents aged 0-17 years experiencing acute mental health distress. • The Teams are community based and provide rapid, mobile, intensive, and flexible short-term delivery of skilled evidence-based interventions to resolve mental health crisis. They will provide extended hours mental health services and partner with relevant health services to ensure 24/7 support to young people and families while in crisis. • The Teams will respond to young people in their schools, homes, and communities and in hospital-based settings (EDs/Wards), through face to face, phone and telehealth appointments. This flexible model will be adapted to work across rural, regional, and metropolitan locations and be tailored to meet local cultural and diversity needs. • Within a stepped care approach, the Safeguards Teams provide a more intensive acute service component on the spectrum of care supporting the work of community-based child and adolescent mental health services and the tertiary acute child and adolescent inpatient units. • The multidisciplinary teams are comprised of psychiatry, nursing, and allied health professionals with the clinical expertise to deliver crisis assessment, specialist clinical care and short-term therapeutic interventions for young people with high and complex mental health needs and their families/carers. • Teams will incorporate psychiatry registrar training positions which will grow a much-needed sustainable child and adolescent psychiatry workforce and support the expansion and professional development of a skilled multidisciplinary child and adolescent workforce.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
	Enhancing non-clinical therapeutic support to young people at high risk In partnership with the Commonwealth Government, the NSW Government is conducting a new Youth Aftercare pilot program (branded "i.am") to provide community-based support to children and young people who have attempted suicide, are experiencing suicidal thinking, or have self-harmed. • Entry to the service is broad (including by the young person or their family) and is independent of any clinical diagnosis. • The Pilots provide children and young people living in four trial sites (Blacktown in Western Sydney, Coffs Harbour on the Mid North Coast, Tamworth in Hunter New England, and Bankstown in South-West Sydney) with non-clinical, psychosocial support for up to 6 months, or longer if needed. • The service model has been developed by a consortium of Community Managed Organisations and has had extensive consultation with various community services. The program's establishment criteria requires evidence of significant ongoing co-production from young people with a lived experience and their carers. Following consultation with young people the program has adopted the brand name "i.am." • The service largely uses a peer and youth worker workforce with support from clinical advisors, and with ongoing training and supervision provided by a leading suicide prevention advocacy organisation. • The mix of regional, rural and metropolitan locations is providing rich information on the needs of high-risk children and young people across various locations. • An independent evaluation of the implementation and outcomes is due at the end of 2022. This will provide an evidence-base for future delivery of non-clinical developmentally informed suicide prevention for high-risk children and young people. • The Pilots will run until June 2023.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
	Connecting suicide prevention planning to child and youth specific needs The **Zero Suicides in Care** initiative includes improvements to suicide prevention skills among staff within acute and community-based mental health services across NSW. Suicide prevention training currently shifts the focus from suicide risk stratification to suicide prevention formulation and safety planning that enhances protective factors and support systems. **Suicide Prevention Outreach Teams** (SPOT) provide outreach support to people in suicidal distress where they live and connect them with appropriate supports and services. SPOT is also staffed by peer workers with lived experience and mental health clinicians. *Youth example*: Northern Sydney Local Health District established the Youth Response Team (YRT), a hybrid Safe Haven/SPOT model. The YRT supports emergency department alternatives and avoidance for young people in acute mental health crisis, psychological distress or suicidal crisis. Sydney Children's Hospitals Network have a Safe Haven and SPOT specifically for young people under 16 years of age. **Safe Havens** provide an alternative to emergency departments for people with suicidal thoughts or distress. Safe Havens are co-designed and staffed by people with a lived experience of suicidality and mental health clinicians. Of the 17 Safe Havens currently operational across rural, regional and metropolitan NSW, 11 Safe Havens are accessible for those under 16 years of age. These are located at Parkes, Randwick, Campbelltown, Tweed, Lismore, Wagga Wagga and Griffith, Port Macquarie, Wollongong, Newcastle and The Sydney Children's Hospital Safe Haven at Randwick for 16 years and under only. **The Enhancement to Rural Counselling initiative** invested in fifteen full time equivalent counsellors across nine local health districts to enhance access to suicide prevention support. This is in the context of rural and regional communities experiencing suicide at higher rates comparative to metropolitan areas. While this initiative is not targeted to children and young people, they are likely to benefit, as their parents, carers, families, and community experience enhanced supports.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
	Building on Aboriginal Communities' Resilience initiative 12 Aboriginal Community Controlled Health Organisations (ACCHOs) are currently funded under Towards Zero Suicides to deliver culturally appropriate, Aboriginal designed and led social and emotional wellbeing activities. Each ACCHO has developed activities aimed at diverse groups within their communities, including children and young people. These activities include support groups, camps on Country, physical activity programs, wellbeing resources, cultural programs, and case management. Youth example: South Coast Medical Service Aboriginal Corporation and Waminda South Coast Women's Health & Welfare Aboriginal Corporation, both located in Nowra, NSW, deliver cultural and support programs within local schools for Aboriginal youth. The ACCHOs funded under the initiative are: • Armajun Aboriginal Health Service – Armidale/ Inverell (HNELHD) • Bullinah Aboriginal Health Service – Lismore/ Ballina (NNSWLHD) • Coomealla Health Aboriginal Corporation – Dareton (FWLHD) • Coonamble Aboriginal Health Service – Dubbo/ Coonamble (WNSWLHD) • Durri Aboriginal Corporation Medical Service – Taree/ Kempsey (MNCLHD) • Maari Ma Health Aboriginal Corporation – Broken Hill/ Wilcannia (FWLHD) • South Coast Medical Service Aboriginal Corporation – Nowra (ISLHD) • Tharawal Aboriginal Corporation – Airds/ Campbelltown (SWSLHD) • Ungooroo Aboriginal Corporation – Singleton (HNELHD) • Waminda South Coast Womens Health & Welfare Aboriginal Corporation – Nowra (ISLHD) • Yerin Aboriginal Health Services - Eleanor Duncan Aboriginal Health – Wyong/ Gosford (CCLHD) • Yoorana-Gunya Family Healing Centre Aboriginal Corporation – Forbes (WNSWLHD)

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
	Community Response Package for Young People Wellways Australia is funded to deliver programs to raise awareness for suicide prevention for young people in NSW, promote the know-how for having safe conversations around suicide and suicidal distress, and increase access to appropriate support services. Wellways has developed the UrHere campaign offering support for young people, including those who identify as members of the LGBTQ+, Aboriginal, CALD and other communities. UrHere is a statewide social media campaign providing youth-informed and specific content on suicide prevention, including a dedicated website with relevant links to youth-specific services. **LivingWorks Suicide Prevention Training initiative** This Initiative is part of the NSW Government's Mental Health Recovery Package to support people whose mental health is affected by the COVID-19 pandemic. LivingWorks Australia are training up to 275,000 people in suicide prevention skills training, targeting NSW Independent, Catholic and Public High School education sector teachers and support staff, parents/carers and wider school community including sport coaches and music teachers. As well as targeted community suicide first responders (sports clubs, community clubs, small businesses, Aboriginal leaders, youth leaders, local leaders and Police). This is the largest suicide prevention training blitz in the world and aims to create a network of safety around young people in NSW by training their most trusted peer, adult and community touchpoints in how to recognise the signs that someone may be thinking about suicide, intervene, and refer to further help.
SUDI medical history ***Recommendation 1, Biennial report of the deaths of children in New South Wales: 2018 and 2019*** NSW Health complete a detailed audit of compliance with the revised SUDI medical history protocol. The audit should include information and analysis about:	Implementation of the audit plan was delayed by the Omicron response in early 2022. The team has recently moved into the implementation phase and has identified an audit officer to complete the audit. It is anticipated that the SUDI audit will be formally completed by December 2022.

Recommendation	Summary of advice to date and additional requested information for reporting to NSW Parliament
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. 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	The scope of the audit has been widened from the medical history protocol to include broader evidence considered during a SUDI response. This includes presence and adequacy of the police P79 form, medical history and NSW Ambulance forms, as well as availability and access to scene photography. The CDRT will be kept informed as the audit progresses and is finalised.

Ms Monica Wolf
Acting Ombudsman
Acting Convenor, NSW Child Death Review Team
By email: [redacted]

Re: NSW Child Death Review Team (CDERT) Annual Report (our ref: SER22/03673, your ref: ADM/2021/472)

Dear Ms Wolf,

Thank you for your correspondence seeking an update on the implementation of the recommendations made by your Office in the Biennial reports of the deaths of children in NSW, and the extent to which those recommendations have been implemented.

Transport for NSW (TfNSW) is committed to supporting and implementing the recommendations that have been accepted.

I refer to recommendation 4 in relation to the study of child restraint practices in NSW. TfNSW has discussed with Neuroscience Research Australia (NeuRA) about resuming the study of child restraint practices in NSW following the previously reported disruptions caused by bushfires and COVID-19 restrictions. NeuRA previously indicated that it was not possible to resume the population-representative survey of child restraint practices across NSW because the disruptions meant too much time had passed since the observations made in Greater Sydney.
As a result, TfNSW intends to commission a new study focussing only on child restraint practices in rural and remote areas of NSW. NeuRA indicates that the results from this new study could be compared to previous observations made in metropolitan areas.

NeuRA has further indicated that they are ready to conduct the survey, however, approvals from schools and day care centres to do the observations at their sites are likely to take 3 to 6 months before data collection can commence.

TfNSW notes the replacement of recommendation 3 from the 2016 and 2017 report, with recommendation 2 of the 2108 and 2019 report. TfNSW has implemented this recommendation by linking the Centre for Road Safety webpage to howsafeisyourcar.com.au. This website helps car buyers to find the safest car in their price range. It includes both ANCAP and Used Car Safety Ratings as well as other safety features fitted to the vehicles.

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(02) 8202 2200
transport.nsw.gov.au

If you have any further questions, please contact Greg Dikranian A/Senior Manager Safer Vehicles, Safety Environment and Regulation on [redacted]

Sincerely,

[redacted]

Rob Sharp
Secretary
11/07/2022

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Recommendation 2, Biennial report of the deaths of children in NSW: 2018 and 2019 (published August 2021)

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.

Local Government Road Safety Program

- Local Government Road Safety Program delivers road safety initiatives at a local level to improve road user behaviour. Under LGRSP, Transport for NSW (TfNSW) provides 50/50 funding for Road Safety Officers (RSO) and funding for projects. There are 80 Road Safety Officers in 86 Local Government Areas across the state.

Road Safety Education Program

- The Road Safety Education Program is a partnership between TfNSW, the Department of Education, Catholic Schools NSW, The Association of Independent Schools of NSW and *Kids and Traffic*, the Early Childhood Road Safety Education Program at Macquarie University. This has been an ongoing partnership since 1986.
- Road safety is taught in NSW schools as part of the *Personal Development, Health and Physical Education K-10 Syllabus*. This subject is mandatory for all students in NSW.
- In Years 11 and 12, student learn about road safety as part of the mandatory 25-hour Life Ready Course in government schools, and through wellbeing and pastoral care courses in non-government schools.

Used Car Safety Ratings

- TfNSW annually promotes the Used Car Safety Ratings brochure on the NSW Road Safety Facebook page, Centre for Road Safety website, Towards Zero website and Towards Zero newsletter
- The Used Car Safety Ratings brochure is promoted at events including the Sydney Royal Easter Show and bstreetsmart (road safety education event targeted at students in years 10-12) and through the Road Safety Officer network under the Local Government Road Safety Program (LGRSP).
- Promote the Used Car Safety Ratings brochure through the learner driver kits (folder of information given to all new learner licence holders) and through the Helping Learner Drivers Become Safer Drivers workshop.

Road User Handbook

- The Road User Handbook provides information on novice driver high performance vehicle restrictions, as well as provides a link to the NSW Government website for the full list of banned high performance cars.
- The Handbook is the foundational resource for those wanting to obtain a learner driver licence and drivers wanting to refresh their road rule knowledge and safe driving practices. All people seeking to obtain a learner licence are encouraged to read the Handbook.

Get Licensed, Get Legal, Get Work

- Get Licensed, Get Legal, Get Work is a resource delivered as part of the Driver Licensing Access Program and other driver licensing access service providers to help people with low

literacy and numeracy to understand the Road User Handbook and commence the Graduated Licensing System journey by passing the Driver Knowledge Test.

- A section on vehicle safety and compliance is included in this resource and the teacher guide suggests that teachers discuss with students the importance of selecting a safe car when buying second hand and directs them to the used car safety ratings webpage.

Helping Learner Drivers Become Safer Drivers

- Transport for NSW currently offers free 'Helping Learner Drivers Become Safer Drivers' workshops across NSW. Workshops are designed to support parents and supervisors of learner drivers become confident and effective supervisors.
- The workshops includes practical advice about current driving rules and requirements for L and P platers, how learners benefit from supervised on-road driving, the role of the supervising driver, the importance of on-road driving experience, how supervisors can help make learning to drive a safe and positive experience, tips for using the learner driver logbook and the importance of providing constructive feedback.
- Workshops are run by TfNSW, local council Road Safety Officers and contractors across NSW, including in border communities. In response to the COVID pandemic, workshops have increasingly been provided online, with greater uptake.
- To further increase accessibility for all supervising drivers, TfNSW is developing a digital supervising driver resource to evolve and enhance the content of current 'Helping Learner Drivers Become Safer Drivers' workshops. Enhancements will also include greater information on safer vehicle choices.

Safer Drivers Course

- The NSW Safer Drivers Course teaches learner drivers under 25 to develop safe driving skills and prepare for driving solo.
- During the 2021/22 financial year, 28,075 participants completed the course, including 659 through the disadvantaged program.
- This course can help you understand speed management, gap selection, hazard awareness, safe following distances, and how to keep driving safely when you get distracted.
- The course includes a 3-hour group discussion with other learners and a 2-hour coaching session in a vehicle with another learner.

Empowr Mobility pilot project

- TfNSW funds the Empowr Mobility pilot project to support young people experiencing disadvantage to access a low-cost, safer vehicle.
- The pilot allowed individuals to apply for vehicles with a 5-star ANCAP rating, fitted with telematics collecting driving data and providing tips and feedback to drivers via a CAR[A] mobile app so they could develop safer driving habits.
- Individuals could join the program via Empowr Mobility in various NSW locations (Orange, Armidale, Queanbeyan).

Bstreetsmart

- bstreetsmart is an annual large-scale road safety education event for secondary school students. WSLHD's Trauma Unit at Westmead Hospital coordinates the development and delivery of the event. TfNSW provides sponsorship, road safety advice and an interactive presentation for the event.
- The primary objective is to raise awareness of the fatality and injury rates of young people, and to ensure that the community is aware of injury prevention, trauma care services and related

resources available. Students and teachers who attend watch a live crash scene simulation; learn about the impacts of dangerous/distracted driving and the consequences for those directly and indirectly involved in a crash.

RYDA

- The RYDA program, delivered by Road Safety Education Ltd, is designed to help senior high school students explore and address the issue of road safety through a series of small group workshops delivered over one day.
- The RYDA workshop sessions are designed to be held in small classroom-sized groups (approximately 25 students) and are led by a team of trained facilitators including Police, driving instructors, and other community sector specialists.
- The workshops explore speed and stopping distances, self-coaching strategies, distraction, and fatigue and hear crash survivor stories.

Safer Vehicle Choices

- TfNSW has linked the Towards Zero webpage to howsafeisyourcar.com.au. This website helps car buyers to find the safest car in their price range. It includes both ANCAP and Used Car Safety Ratings as well as other safety features fitted to the vehicles. The Towards Zero Safer vehicles page, where this information is linked, was viewed 45,454 times from 1 July 2021 to 30 June 2022.

Study of child restraint practices

- Update on recommendation 4, of the *Biennial report of deaths of children in NSW: 2016 and 2017* - the study of child restraint practices in NSW
- TfNSW has tendered a new study focussing only on child restraint practices in rural and remote areas of NSW. The tender closes on the 29 of September 2022.

Ms Monica Wolf
Acting Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

DGL 22/341

Dear Ms Wolf

I write in response to your letter of 22 June 2022 to Ms Georgina Harrisson, Secretary, Department of Education, regarding Recommendations 12 and 15, made in the *Biennial report of the deaths of children in New South Wales: 2016 and 2017*, that the NSW Child Death Review Team (CDRT) is currently monitoring. The Secretary has asked me to respond on her behalf.

In relation to recommendation 12 the Department has updated its "Guidelines for responding to the death of a student by suicide" and these are being prepared for release to schools in Semester 2, 2022. The Department will provide the updated guidelines to the NSW Ombudsman upon completion and release.

Within these updated guidelines, the Department has addressed the following outlined in the Orygen evaluation (pages 65- 66):

a) ***information on how to manage social media and memorials in the aftermath of a student suicide***. The Department consulted with internal and external stakeholders, including Orygen, Everymind and headspace Be You, to obtain advice, direct input and review on how to manage social media and memorials in updating the 'Responding to Student Suicide Support Guidelines for Schools'. This has now been integrated into the updated guidelines.
b) ***recommendations for conducting a critical incident review in the months following the suicide***. The Department has incorporated this and provides clear information and a dedicate template for schools to engage in an operational reflection and planning following a postvention response.
c) ***recommendations regarding the conduct of an annual review of the emergency response plan.*** The updated guidelines include a postvention specific emergency response plan "School Postvention Response Plan" with information and guidance on completing this tool. This response plan is integral in the preparation and planning for a postvention response in the updated guidelines. The guidelines stipulate the conduct of an annual review of this plan.

The release of the updated guidelines will occur in conjunction with access to dedicated training to support schools in understanding the updates and in postvention response preparation and planning. The Department Psychology and Wellbeing Coordinator's will be leading the delivery of this training.

In January 2022, the Department enhanced its team of Psychology and Wellbeing Coordinators whose main role is to support schools in suicide prevention and postvention.

The team has been increased to six with a plan to have eight Psychology and Wellbeing Coordinators by 2023. Part of the work of the Psychology and Wellbeing team is to systematically review internal incident data to identify emerging trends and inform future practice. This includes the consideration of known risk factors to strategically target intervention and prevention programs.

After clarifying the intent of Recommendation 15, the Department is finalising a framework for reviewing the death by suicide of students in public schools. Senior Department staff met with relevant counterparts from NSW Health and the Department of Communities and Justice to inform the development of the framework.

The framework for reviewing student deaths by suicide will use a trauma-informed systems approach to understand and enhance good practice in supporting the wellbeing and mental health of children and young people. A multidisciplinary team, led by the Psychology and Wellbeing Coordinators, will lead the process to facilitate learning and inform future work at a systems level.

If you require any further information, please contact Maria Casbolt, R/Director, Student Health and Mental Wellbeing on [redacted] or at [redacted] or Traci Prendergast, Leader, Psychology and Wellbeing Services on [redacted] or at [redacted]

Yours sincerely

[redacted]

Laura Milkins
Executive Director, Inclusion and Wellbeing
28 July 2022

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Office of the Secretary

Our reference: BN-03595-2022

Ms Monica Wolf
Acting NSW Ombudsman
Acting Convenor, NSW Child Death Review Team
By email: c/- [redacted]

Dear Ms Wolf

Thank you for your letter seeking advice about a recommendation made in the *Biennial report of the deaths of children in New South Wales: 2018 and 2019*, tabled in August 2021.

I confirm that the Department of Customer Service (the Department) supports the new recommendation.

The Department is the administrator of the NSW Swimming Pool Register (the Register) from which recommended data is published.

On 20 July 2021, the NSW Ombudsman was advised that the Register would be upgraded in 2022.

A project is currently progressing which will provide the enhanced amalgamated reporting capability covering the matters sought by the NSW Ombudsman from the existing Register by December 2022.

If you would like more information, please contact Mr Dominic Wong, Manager, Programs and Business Governance, Building Construction Compliance on [redacted] or via email [redacted].

Yours sincerely

[redacted]

Emma Hogan
Secretary

Date: 12/07/22