nsw cdrt child death review team

Ombudsman New South Wales

# NSW Child Death Review Team Annual Report 2022–23

30 October 2023

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.

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30 October 2023

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

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

Dear Mr President and Mr Speaker

**NSW Child Death Review Team Annual Report 2022-23**

As Convenor of the NSW Child Death Review Team (CDRT), I present the NSW Child Death Review Team Annual Report 2022-23 for tabling in Parliament.

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

I recommend that this report be made public immediately.

Yours sincerely

Paul Miller
**Convenor, NSW Child Death Review Team**
**NSW Ombudsman**

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# About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during the period 1 July 2022 to 30 June 2023.

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

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

The report is arranged in the following chapters:

- Chapters 1 and 2: The NSW Child Death Review Team – outlines the constitution of the CDRT, its members, and the functions of the CDRT.
- Chapter 3: Reporting of child deaths – information about the biennial report of child deaths in 2020 and 2021.
- Chapter 4: Research to help reduce child deaths – details research projects to meet the CDRT's purpose and functions.
- Chapter 5: Other activities – notes other work of the CDRT.
- Chapter 6: Disclosure of information – details information disclosures as prescribed in the Act.
- Chapter 7: CDRT recommendations – summarises responses by agencies to CDRT recommendations, and their progress towards implementation.
- Appendices: progress in relation to current strategic priorities, meeting attendance 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 likelihood of deaths of children in NSW through the exercise of its functions under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (the Act).

CDRT membership is prescribed by the Act. Members are:

- The NSW Ombudsman, who is the Convenor of the CDRT
- The 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 2023

### Ex officio members

**Mr Paul Miller PSM** (Convenor)
NSW Ombudsman

**Ms Monica Wolf**
Community Services Commissioner/Chief Deputy Ombudsman

**Ms Zoë Robinson**
NSW Advocate for Children and Young People

### Agency representatives

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

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

**Mr 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

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

**Ms Eloise Sheldrick** (on leave)
Coordinator and Assistant Coroner, Coronial Information and Support Program
Office of the NSW State Coroner

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

## Independent members

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

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

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

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

**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**
Consultant Child and Adolescent Psychiatrist
Child and Adolescent Mental Health Services
Top End Mental Health Services, Department of Health
Northern Territory Government
Clinical Professor, Charles Darwin University
Honorary Professor, University of Sydney

**Professor Heather Jeffery AO**
Neonatologist
Honorary Professor of International Maternal and Child Health
University of Sydney

**Professor Ilan Katz**
Professor Social Policy Research Centre
University of New South Wales

**Ms Catherine Lourey**
Commissioner
Mental Health Commission of New South Wales

## 1.3 Expert advisers

The Act provides for the Convenor to appoint persons with relevant qualifications and experience to advise the CDRT in the exercise of its functions. Expert advisers who assisted the CDRT in its work and/or who undertook research on behalf of the CDRT during 2022-23 include:

- Dr Fadwa Al-Yaman PSM, Group Head, Indigenous and Children's Group, Australian Institute of Health and Welfare
- Ms Tania Andrews, Clinical Midwifery Consultant, NSW Pregnancy and Newborn Services Network
- Ms Tracy Dixon, Unit Head, Indigenous Burden of Disease, Australian Institute of Health and Welfare Children's Group
- Dr Devon Indig, Senior Research Consultant
- Dr Marlene Longbottom, Associate Professor, Indigenous Education and Research Centre, James Cook University
- Ms Fionola Sulman, Acting Coordinator, Coronial Information and Support Program, Office of the NSW State Coroner
- Dr Prem Thapa, Acting Unit Head, Research Modelling, Australian Institute of Health and Welfare Children's Group
- Dr Lorraine du Toit-Prinsloo, Chief Forensic Pathologist and Clinical Director, Forensic Medicine Newcastle, Forensic and Analytical Science Services, NSW Health Pathology
- Professor Ted Weaver OAM, Senior Medical Officer and Professor, Department Obstetrics & Gynaecology/Women's and Children's, Clinical Sub-Dean Griffith University School of Medicine and Dentistry Sunshine Coast, Sunshine Coast Hospital and Health Service
- Emeritus Professor Les White AM, former NSW Chief Paediatrician
- Ms Maryann Wood, Lecturer, School of Public Health and Social Work, Queensland University of Technology

# 2. CDRT functions

Under Part 5A of the Act, the CDRT's 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.

Under Part 6 of the Act, 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 ("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** (section 34F), which details the activities of the CDRT and progress of its recommendations. This is the annual report for 2022-23.
- The **biennial child death review report** (section 34G), which consists of data collected and analysed in relation to child deaths. Since 2019, the CDRT biennial report and the Ombudsman biennial report of reviewable child deaths are combined as one report. The focus of both functions is to help prevent the deaths of children.

  The next biennial report, covering deaths of children that occurred in NSW in 2020 and 2021, will be tabled in Parliament in late 2023.
- **Other reports** (section 34H), which provide information on the results of research undertaken in the exercise of the CDRT's research functions. The CDRT may report to Parliament at any time and is expected to report on its research at least once every three years. Details of recent and current research are provided in Chapter 4.

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

## 2.2 CDRT Charter and Code of Conduct

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

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 pursuing its *Strategic Priorities Plan 2022-2025*.

## 2.3 CDRT Strategic Priorities Plan

Every three years, the CDRT develops a plan which identifies its main priorities for the next three-year period and initiatives to achieve them. On 10 May 2022, the CDRT endorsed its *Strategic Priorities Plan 2022-2025* and on 14 February 2023, the CDRT endorsed an action plan to implement these priorities. The plan, and progress against actions, is included at Appendix 1.

## 2.4 Meetings of the CDRT

The CDRT met formally on four occasions in 2022-23: August 2022, November 2022, February 2023, and May 2023. The August, November and May meetings were held via an online platform, and the February 2023 meeting was a hybrid format with some members attending in person and others online. An attendance table is at Appendix 2.

## 2.5 CDRT Member survey

In January 2023, the NSW Ombudsman initiated a confidential governance survey of CDRT members and expert advisers to seek feedback about their views and experiences of CDRT meetings, NSW Ombudsman secretariat support and the CDRT composition. Consolidated results of the survey were provided to and discussed at the subsequent CDRT meeting.

It is proposed to conduct the survey annually to help identify potential improvements in the organisation and outcomes of the CDRT's work.

## 2.6 CDRT Secretariat

The CDRT's day-to-day work is supported by staff of the Child Death Reviews Unit in the NSW Ombudsman's office. The unit is also responsible for the Ombudsman's reviewable child death function. At the end of the 2022-23 period, this unit comprised 17 staff.

Work undertaken by staff to assist the CDRT includes:

- Registration of individual deaths. On average, approximately 450-500 children die in NSW each year.
- Gathering relevant information and records from stakeholders and service providers.
- Recording information in the Register of Child Deaths and analysing and reviewing that information.
- Identifying systemic issues and providing strategic advice to the CDRT.

- Coordinating, overseeing, and completing research and other projects to support the work of the CDRT.
- Preparing statutory reports (annual, biennial, research).
- Monitoring recommendations from previous reporting periods.
- Performing secretariat functions for the CDRT.

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 Committees Guidelines[1] and the Act.

[1] NSW Government, NSW Government Boards and Committees Guidelines, September 2015

# 3. Reporting of child deaths

## 3.1 Biennial report

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

The CDRT's *Biennial report of child deaths of children in New South Wales: 2020 and 2021* will be tabled in late 2023.

## 3.2 Recommendations

Chapter 7 of this report 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), suicide prevention (3) and private swimming pool regulation (1).

# 4. Research to help reduce child deaths

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

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

## 4.1 Research finalised in 2022-23

### Linking data on social determinants and early childhood mortality

In December 2022 the CDRT tabled a report, '*Effects of perinatal conditions and local area socioeconomic status on early childhood mortality in New South Wales – linked data analysis*'. This report outlines the results of the CDRT's joint research project with the Australian Institute of Health and Welfare (AIHW) into the relationship between socio-economic factors and early childhood mortality, as detailed below.

In 2019, the CDRT commissioned the AIHW to conduct a data linkage research project which analysed the effects of birth conditions and socio-economic status on early childhood mortality in NSW. While the general association between socioeconomic status and risk of child death has been well established, questions remained about the factors underpinning this relationship.

The project aimed to identify and quantify the key risk factors behind child mortality in NSW at specific ages (infants under one year, and children aged 1-4 years) for all children born in NSW between 2005 and 2018. The project also involved a separate analysis for Aboriginal and Torres Strait Islander children.

Linked data analysed in the project included 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 included selected area-level data derived from the 2011 and 2016 Census based on the usual place of residence.

The summary and full report were tabled in NSW Parliament on 9 December 2022, and are available on the NSW Ombudsman website.

A key finding of the study was that preterm birth was the strongest and most consistently significant risk factor for infant mortality (death under age 1), especially for babies born under 32 weeks gestational age. Other consistent significant risk factors for infant deaths included being born with a birthweight that is small for gestational age or being born to a teenage mother (aged 19 or under).

Significant risk factors for deaths of children between ages 1 to 4 included having a low birthweight for gestational age, being an Indigenous baby, being a male baby, being born to a mother aged 20–25, and maternal smoking during pregnancy. The report confirms previous findings that there has been a "pronounced narrowing of the gap in infant mortality between Indigenous and non-Indigenous babies across the 15-year period (2005–2019)".

An unexpected result of the research was that area-level socioeconomic status indicators (based on the usual place of residence of the mother at the time of the birth) were not found to be consistently significant risk factors, when other maternal and baby characteristics in the perinatal records were accounted for. This may require further investigation, given that previous work has shown that socioeconomic status, even when measured as an area-level average, is expected to affect health and mortality outcomes, including overall life expectancy.

The report demonstrates for the first time in NSW that perinatal (birth) and death records can be reliably linked. Doing so provides a richer understanding of risk of early childhood death than can be achieved through consideration of death records alone.

### Infant deaths from severe brain injury in NSW, 2016-2019

In 2017, the CDRT commenced a project reviewing neonatal deaths associated with asphyxia-related causes such as hypoxic ischemic encephalopathy over a four-year period (2016-2019). In 2021, the CDRT engaged a clinical midwife consultant to undertake a case review of 101 infant deaths who were born alive but who had died from severe perinatal brain injury in NSW over the four-year period.

The research project aimed to better understand possible key contributory factors and identify opportunities for improved prevention. The project considered issues such as the fetal intrauterine growth restriction, decreased fetal movements, fetal heart rate monitoring, post-birth/newborn onset of deterioration, use of oxytocin to induce labour, instrumental vaginal birth and critical incident investigation.

The preliminary study identified that there was rarely one single risk or modifiable factor that contributed or may have contributed to an infant's death from severe perinatal brain injury. Rather, there were often several critical factors in these cases, highlighting that the reasons for perinatal deaths and adverse outcome are complex and multifactorial.

A summary report outlining key observations and high-level thematic areas will be annexed to the *Biennial report of child deaths of children in New South Wales: 2020 and 2021*, to be tabled in late 2023.

## 4.2 Research in progress in 2022-23

### 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 43 were identified as being of First Nations background.

The primary aim of this project is to identify opportunities for preventing and reducing the likelihood of 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 engaged the Ngarruwan Ngadju First People Health and Wellbeing Research Centre to conduct the research.

The scope of the project was expanded in May 2023 and now includes:

- detailed case reviews of Aboriginal and Torres Strait Islander children and young people who died by suicide in the ten-year period (completed by Ombudsman review staff and expert advisers connected to the project),
- oversight by a newly established Aboriginal Suicide Prevention First Nations Advisory Group,
- consultation with stakeholders in regional forums (including representatives from Aboriginal community-controlled organisations) and a metropolitan policy workshop, and
- an updated literature and policy review and service mapping (building on work completed by the Sax Institute).

The project has an estimated completion date of 30 June 2024 and the CDRT will be tabling a public report on this research.

# 5. Other activities and information

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

## 5.1 National child death review group

In 2022-23, the role of convening the Australia and New Zealand Child Death Review and Prevention Group shifted from NSW to the Queensland Family and Child Commission as part of an agreed rotation of roles. The group involves member representatives from every state and territory in Australia, as well as New Zealand. The group meets every year to share information, knowledge, and ideas about child death-related work to assist members to meet their common goal of preventing deaths of children.

The group's third 'virtual' annual conference was held on 23 May 2023. The conference was split into three sessions with multiple presentations within each. Topics included:

- Data linkage and knowledge sharing to deepen our understanding of child deaths
  - Paediatric sepsis and data linkage
  - Linking First Nations suicide mortality rates with community cultural connectedness data to understand protective factors preventing First Nations suicide
- Sudden unexpected death in infancy (SUDI) – the classification and identification of accidental suffocation in the context of the USA SUID case registry
- Child death classification – issues for the future of analysis and reporting
  - the introduction of ICD-11 and anticipated changes to recording mortality data and child death review work
  - the impact of new 2021 Census-based Aboriginal and Torres Strait Islander population estimates on child death monitoring in Queensland.

The group's annual Secretariat meeting was held on 25 May 2023, attended by the group's jurisdictional representatives. The meeting included an update from the National Children's Commissioner, discussion on unascertained deaths with a focus on SUDI, an update from the working group developing a national data collection, and jurisdictional updates from members.

# 6. Disclosure of information

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

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

- In July 2022, we provided information to Red Nose Australia about its most recent reporting on SUDI, and the SUDI classification system used by the CDRT.

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

Section 34L(1)(c) of 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 2022-23, we provided the Coroners Court of NSW with individual case reviews and other information about the deaths of certain children.
- In 2023, we provided information to the Health Care Complaints Commission about the deaths of certain children and relevant medical practitioners.

## 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. The CDRT currently has formal agreements in place with similar bodies in the Australian Capital Territory and Western Australia and provides information to bodies in other States and Territories on a case-by-case basis.

In this context, information was provided to the following agencies in response to requests received between 1 July 2022 and 30 June 2023:

- In July 2022, we provided the Queensland Child and Family Commission (QFCC) with 2020 Australia and New Zealand child death data for inclusion in the *Australian child death statistics 2020* report, prepared by the QFCC on behalf of the ANZCDR&PG.
- In September 2022, we provided the Northern Territory Child Deaths Review and Prevention Committee with data on the deaths of children in New South Wales during the period 1 January 2017 and 31 December 2021 who were normally resident in the Northern Territory.
- In December 2022, we provided the South Australia Child Death and Serious Injury Committee with data on deaths of children in New South Wales between 2005 and 2021 who were normally resident in South Australia.
- In December 2022 and February 2023, we provided the ACT Child & Young People Death Review Committee with data on deaths of children in New South Wales during the period 1 January and 31 December 2022 who were normally resident in the ACT.
- In July 2023, we provided Safer Care Victoria (the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, CCOPMM) with data on deaths of children in New South Wales during the 2021 and 2022 calendar years who were normally resident in Victoria.

# 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. These recommendations are made in the CDRT's biennial report, or other individual research reports.

Sections 34F(2)(b) and (3) of 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, or
- amend the recommendation to take account of progress to date or to reflect developments since the original recommendation.

At present, there are eight 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 relevant to each recommendation is provided at Appendix 3.

## 7.1 Summary of recommendations

| Recommendation | Date of recommendation | Agency responsible | Agency response to recommendation | CDRT monitoring of implementation (2023) |
|---|---|---|---|---|
| **SUDI safe sleeping**<br>NSW Health should develop and implement strategies to promote safe infant sleep practices to vulnerable families. In particular, NSW Health should target:<br>• In consultation with the Department of Family and Community Services, families known to child protection services<br>• Families living in remote areas of the state, and<br>• Families living in areas of greatest socio-economic disadvantage. | June 2019 | NSW Health | Supported | Continue monitoring |
| **Infant illness**<br>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 |
| **Transport – child restraints and seatbelts**<br>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:<br>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 |

| Recommendation | Date of recommendation | Agency responsible | Agency response to recommendation | CDRT monitoring of implementation (2023) |
|---|---|---|---|---|
| **Suicide – targeted prevention measures**<br>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:<br>***a.*** *(element met and closed in 2021-22)*<br>**b.** Early intervention designed to arrest emerging problems and difficulties<br>**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 | b. To be closed – substantially implemented<br>c. Continue monitoring |
| **Suicide – targeted prevention measures**<br>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 | To be closed – substantially implemented |
| **Suicide – school review following suicide**<br>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.<br>Outcomes of the reviews should inform future practice and policy. | June 2019 | NSW Department of Education | Supported | To be closed – substantially implemented |

| Recommendation | Date of recommendation | Agency responsible | Agency response to recommendation | CDRT monitoring of implementation (2023) |
|---|---|---|---|---|
| **SUDI medical history**<br>That NSW Health complete a detailed audit of compliance with the revised SUDI medical history protocol. The audit should include information and analysis about:<br>**a.** The number of infants presented to emergency departments following their sudden and unexpected death.<br>**b.** The number of medical history interviews conducted in response to these deaths.<br>**c.** An assessment of whether the intent of the Policy Directive has been met and is reflected in the information gathered.<br>**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.<br>**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).<br>**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.<br>**g.** Details about any strategies or outcomes arising from the audit.<br>NSW Health should provide an audit plan and timeframes to the CDRT by 17 December 2021. | August 2021 | NSW Health | Supported | Continue monitoring |

| Recommendation | Date of recommendation | Agency responsible | Agency response to recommendation | CDRT monitoring of implementation (2023) |
|---|---|---|---|---|
| **Drowning – swimming pool regulation**<br>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 | To be closed – complete implementation not feasible in the context of the current regulatory framework |

## 7.2 Progress on previous recommendations

### 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 infant sleep practices to vulnerable families. In particular, NSW Health should target:

- In consultation with the Department of Family and Community Services,[2] 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 and Torres Strait Islander 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.

#### Agency progress updates in relation to implementation

NSW Health supported the recommendation.

From 1 January 2019, NSW Health's *Baby Bundle* – a bag containing items (including a baby-safe sleeping bag and safe sleep information) to support the health, development and wellbeing of babies born in NSW, including to reduce the risk of sudden unexpected death in infancy (SUDI) – has been given to parents and caregivers of newborn babies when discharged from the hospital, or delivered on request when the birth is registered with NSW Births, Deaths and Marriages.

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[4], containing strategies for supporting families. A Safe Sleeping Recommendations information sheet[5] was also developed, and existing resources updated to reflect the revised Guideline.

In August 2022, NSW Health advised that from 2021, the My Personal Health Record (Blue Book)[6] for babies, given to all parents of children born in NSW, includes information and messaging about safe

[2] Now the Department of Communities and Justice

[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

[4] NSW Health, Recommended Safe Sleep Practices for Babies Guideline, 27 July 2021

[5] NSW Health, Safe sleeping recommendations, 27 February 2023

[6] NSW Health, My personal health record, August 2023

sleeping in line with the revised Guideline. NSW Health further advised that the Health and Education Training Institute facilitates the Training Support Unit Jumbunna Webcast Series, which focus on the health and wellbeing of Aboriginal children, families, and communities.

On 17 August 2023, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation. NSW Health provided advice about SAFE START, a model of universal psychosocial assessment, depression screening and follow-up care and support during the perinatal period to respond to families identified as being at risk of adverse outcomes. Under the model families are assessed and supports provided in response to a family's needs and level of vulnerability. Advice about safe sleeping is an important part of the child and family health services offered to all families.

Level 1 and 2 families receive universal level supports, which may include support through Sustaining NSW Families (SNF), a nurse-led home health visiting service that aims to strengthen relationships between children and carers, build parenting capacity, and enhance child development, wellbeing, and health, including providing safe sleeping advice. Each SNF team includes child and family health nurses, a nurse coordinator, a social worker, and up to five part-time allied health staff members who support the nurse home visitor.

Pregnancy Family Conferencing (PFC) – a new program that operates in partnership with DCJ – is available for level 3 families, in addition to other supports. The aim of PFC is to support vulnerable families who are the subject of a prenatal Risk of Significant Harm report and ensure a safe home environment. PFC has been trialled in six metropolitan Local Health Districts; an evaluation of the program in Sydney Local Health District reported a high success rate, prompting expansion of the program to large rural Local Health Districts. NSW Health is seeking to tailor the program to the needs of Aboriginal and Torres Strait Islander communities, including through conducting community consultation through yarning circles. The 2022-23 NSW budget has allocated more than $38 million in combined NSW Health-DCJ funding over four years for this program.

In addition to these supports, Aboriginal child and family health services provide opportunities to disseminate safe sleeping messaging throughout the state. The NSW Government is expanding Aboriginal Child and Family Centres to better engage Aboriginal communities.

The *Brighter Beginnings: First 2000 days of life* program allows Local Health Districts to implement services best suited to the needs of each District's population, with extra resources deployed across NSW to support families requiring more support than those offered by the universal platforms already in place.

On 1 September 2023, NSW Health further advised that its Child and Family Health team has engaged the Alcohol and Other Drugs branch to discuss how safe sleeping information can be incorporated into messaging for pregnant women.

### Has the intent of the recommendation been met?

NSW Health communicates safe sleeping messages to all families through various resources (digital and paper-based), its website, and a range of programs and services such as those outlined above. The CDRT notes that the Blue Book recommends babies have their own cot/sleeping space, rather than explicitly recommending against co-sleeping. Its safe sleeping messaging is supported by revised policies and practices and a renewed focus on engaging early and more effectively with families.

Strategies that specifically target vulnerable communities include staff training and support, more effective screening and assessment of families via NSW Health's universal programs, and an enhanced capacity to respond to the needs of families through the SNF and PFC programs. The expansion of these

programs to large rural Local Health Districts is a positive step towards achieving change. Given the program is still being rolled out, the CDRT will be seeking further information from NSW Health (and DCJ) about the operation of the PFC program, including the process and criteria for referral for targeted support, the number of infants and families involved, and any evaluations conducted. The CDRT will also seek information about strategies for accessing vulnerable families not reached by the SNF and PFC programs.

The CDRT will therefore continue to monitor this recommendation and the progress and effectiveness of work within vulnerable families, including those known to child protection authorities, those living outside major cities, and those 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 primarily web-based resources available to assist parents by providing guidance on illness in infancy, the CDRT considered more could be done to actively support carers to identify and respond to illness in infants.

### Agency progress updates in relation to implementation

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 Healthdirect website and Sydney Children's Hospital Network fact sheets available in several community languages, 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 updating and strengthening existing resources and key messages that inform parents and carers about risk factors and how to access help about the health of their child. NSW Health also advised it was scoping a campaign for parents about infant and child health and wellbeing and would provide further advice as available.

In August 2022, NSW Health noted that messaging about recognition of a sick child had featured in recent communications relating to COVID-19 and respiratory illnesses. They noted that other resources –

such as the Blue Book and the Baby Bundle – provide information about child health and development, safety, and common health problems, and contain links to NSW web-based resources such as Healthdirect, Raising Children, and children's hospital websites.

In December 2022, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation. NSW Health provided advice about the development of a digital version of the Blue Book, which will include QR codes connecting consumers to online information, online health checks, a digital reminder service, digital signs of illness checklist and automatic upload of a summary of a child's visits to health services. NSW Health also advised that its website was being revised to improve visibility of resources for parents with an unwell child.

On 1 September 2023, NSW Health advised that Healthdirect had reported that over a 2-year period (July 2021-June 2023), Healthdirect received 80,210 calls relating to infants under 1 year. The vast majority of these calls were from non-Indigenous families, and most were residing in metropolitan locations. NSW Health also provided advice about its review and digitisation of the Blue Book.

An online survey seeking information from parents, carers, and clinicians about the Blue Book was planned for August-September 2023 as part of the Blue Book digitisation process. The survey was to ask families about where they would seek information, who they would contact, and where they would take their sick child. NSW Health was also to consult with focus groups including Aboriginal families, fathers, culturally and linguistically diverse cohorts, 'rainbow' families, those identified as having a drug and alcohol background or a history of family and domestic violence, and where a parent/carer and/or child has a disability. The findings from the surveys and focus groups are anticipated to be available in October 2023.

### Has the intent of the recommendation been met?

The CDRT notes the results of NSW Health's initial analysis of data relating to *who* is accessing Healthdirect (a key resource) for information about infant health. The CDRT acknowledges NSW Health's inclusion of questions related to infant illness in a stakeholder survey as part of its review and digitisation of the Blue Book, and efforts to seek input from a range of demographic and diverse family groups in this process. The CDRT also acknowledges the digitisation of the Blue Book will provide increased opportunities for parents to access information about their child's health.

NSW Health's actions to better understand whether all families are benefiting from its existing resources and information about infant health, and specifically the identification of illness in infants, is evidence of positive progress towards implementing the intent of the CDRT's recommendation. However, the CDRT notes that the accessibility of the information for families who may not have internet access, or speak English as a first language, could be improved.

The CDRT will continue to monitor this recommendation to oversee NSW Health's response to the findings of its survey and data analysis, and the development of strategies to ensure that critical information about infant illness is accessed by all families, and particularly those families who are over-represented in deaths classified as SUDI.

## 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.[7] 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 found that most of the children died in crashes that occurred on high-speed roads with speed limits of 80km/hour or more, and that some groups of children were over-represented in the fatal crashes, including:

- Children who lived in the lowest socio-economic areas of NSW, and
- Aboriginal and Torres Strait Islander children.

### Agency progress updates in relation to implementation

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

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. It advised that it was not possible to resume the survey because too much time had passed between data collection points. TfNSW further advised that NeuRA had approached the Minister for Transport and Roads seeking a new study focused on regional areas to address gaps in the previous study due to disruptions, and to provide additional insights. At that time, TfNSW was awaiting advice from the Minister's office about whether this new proposed work would proceed. In July 2022, TfNSW advised that a new study focussing on child restraint practices in rural and remote areas of NSW would proceed, and the results would be compared to previous observations made in metropolitan areas.

On 18 July 2023, TfNSW advised that the George Institute for Global Health had been engaged to conduct the new study. The study of child restraint practices in rural and remote areas has required new methods for data collection, including tailored and community specific approaches in remote and very remote LGAs. An Aboriginal Reference Group is being formed to coordinate this approach, with the first draft Terms of Reference under review by the Guuna-maana team at the George Institute. As at 30 June 2023, data collection was ongoing and had been completed in one of ten randomly selected rural and remote LGAs. TfNSW estimates a revised completion date for the study of March 2024.

### Has the intent of the recommendation been met?

The CDRT acknowledges progress made and challenges experienced with both the earlier and the new study. We will continue to monitor this recommendation.

[7] 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.

## 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.** (*element met and closed*)
- **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)[8] supports whole of government suicide prevention activity across all NSW communities, and it should therefore be leveraged to provide targeted youth mental health services.

### Agency progress updates in relation to implementation

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, including the *Getting on Track in Time – Got it!* program.

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

[8] Since replaced by the Strategic Framework for Suicide Prevention in NSW 2022-2027

a specific, culturally sensitive Aboriginal *Got It!* program in South-West Sydney Local Health District. The government is also establishing 25 Safeguards Teams across NSW – a dedicated multidisciplinary resource designed to provide care to children and adolescents aged 0-17 years experiencing acute mental health distress. 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 (YAP) program (branded "i.am") which will 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 strategies and initiatives focused on connecting suicide prevention planning to child and youth specific needs, such as:

- 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 (SPOTs) 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.

On 18 July 2023, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendations. Information about new initiatives co-funded under the National Mental Health and Suicide Prevention Agreement and Bilateral Agreement between NSW the Commonwealth (both agreed in 2022) was provided, including:

- the planned rollout of four *Head to Health Kids Hubs* for children aged 0-12 (a primary and secondary care initiative providing assessment without referral and connection to specialist services where needed).
- establishment of 3 new *headspace* sites and enhancement of current and planned *headspace* services to facilitate support for more complex and acute presentations where appropriate.

An out-of-home-care (OOHC) mental health framework has been developed in partnership with the Department of Communities and Justice, to provide access for children in out-of-home care to appropriate mental health services as part of the OOHC Health Pathway Program.

Updates on existing programs and infrastructure were also provided, including:

- the Safeguards program, comprising teams of healthcare professionals across NSW to manage intensive, acute short-term care for children aged 0-17 who have presented to an Emergency Department in mental health crisis and are not already linked in with services. Safeguards services provide care for up to 8 weeks, allowing Child and Youth Mental Health Services (CAMHS) staff to focus on longer-term therapeutic interventions.
- the expansion of the Youth Aftercare Pilot (YAP) program so that all regions have access to aftercare services (funded until June 2026).
- numbers of acute inpatient units and beds for children and young people across NSW.

On 1 September 2023, NSW Health's advice about implementation was as follows:

*Recommendation 10 (early intervention, and targeted, sustained, and therapeutic support)*

- The new teen *Got It!* program is an adaptation of the existing Got It program. It provides screening, assessment and therapeutic intervention services for children aged 11-17 years, as

well as capacity building, and training and development to school staff for responding to young people displaying early violence.

- Extension of the Project Air Schools initiative to provide targeted training needed to build the capability of child and youth mental health service clinicians to deliver specialised therapeutic interventions to young people with complex mental health issues.
- Further details about the Head to Health Kids Hubs, mental health and wellbeing centres that are being established in NSW in Wollongong, the Central Coast, Orange, and Penrith. All 4 hubs will be operational by 2027.
- Implementation of the Enhancement and Integration of Youth Mental Health Services initiative, which will provide early access to specialist care for young people presenting to *headspace* services with severe and complex mental health needs – to be progressively implemented at selected locations over 3 years, commencing 2023-24.
- Updates about existing programs such as:
  - School-Link – a long-standing program that aims to improve early identification of students experiencing mental health problems and link students with the care they need
  - treatment and support services available through CAMHS
  - funding of an additional 7 Safeguard teams in 2024
  - early intervention in psychosis programs in some LHDs, and
  - Youth Community Living Support Services – a non-government program currently available in 5 LHDs that supports core CAMHS services.
- Advice about Towards Zero Suicides Community Response Packages for priority groups.

*Recommendation 11 (funding to address gaps in specialist mental health service delivery)*

- The Suicide Prevention Fund delivers community aftercare services and engagement campaigns, building awareness of suicide prevention, wellbeing and support pathways available to communities at elevated risk of suicide, including young people throughout NSW.
- New and expanded initiatives and programs funded under *Towards Zero Suicides* (from 2022-23 to 2025-26), including Safe Havens, Suicide Prevention Outreach Teams (SPOTs), and the Building on Aboriginal Communities' Resilience initiative.
- Youth Aftercare Pilot (YAP) – currently delivered in 4 sites across NSW. An evaluation of YAP is due to be delivered in November 2023. Interim findings support the need for a youth specific model of aftercare.
- Funding of 12 Community Collaboratives in partnership with Lifeline until 2023-24.
- Completion of the NSW Health and DCJ joint framework to improve mental health responses for children and young people in out-of-home care in the third quarter of 2023.
- Additional funding of Kids Helpline (details of enhancement currently in negotiation).

### Has the intent of the recommendation been met?

The CDRT acknowledges NSW Health's continued endeavours to enhance child and adolescent mental health services.

*Recommendation 10*

*(b) Early intervention*

The CDRT acknowledges NSW Health's advice about various early intervention services and strategies that aim to arrest emerging problems and difficulties.

Based on this advice, the CDRT has assessed that the intent of this element has been met.

*(c) Targeted, sustained, intensive therapeutic support*

NSW Health's most recent advice includes information about several programs that appear to provide intensive therapeutic support to children and young people, including Safeguards Teams that provide 'multidisciplinary specialist mental health care', Youth Community Living Support Services that support those recovering from severe and complex mental illness, and the Enhancement and Integration of Youth Mental Health Services initiative that provides early access to specialist care for young people presenting to *headspace* services with severe and complex mental health needs. The extent to which these services are providing sustained support is unclear, particularly as funding for some initiatives appears time limited.

Despite NSW Health's progress towards implementation, the CDRT notes that access to comprehensive mental health care is still an issue given the increasing demands on the system. The CDRT is unclear about NSW Health strategies for reaching those who are hard to engage. The CDRT would also appreciate further advice on NSW Health's approach to providing services that address gaps for young people who are experiencing mental health issues, using drugs and alcohol, or exhibiting offending behaviour.

The CDRT will therefore continue to monitor this element of the recommendation.

*Recommendation 11*

The advice provided by NSW Health indicates that there is a sustained commitment to facilitate and fund mental health and suicide prevention services for children and young people in NSW. Noting that the *Towards Zero Suicides* initiatives and the Strategic Framework for Suicide Prevention in NSW 2018-2023 both conclude in 2023, information about arrangements with the Commonwealth through the National Suicide Prevention Agreement and Bilateral Agreement is positive. The CDRT also notes that the Strategic Framework has been refreshed as the Strategic Framework for Suicide Prevention in NSW 2022-2027, and that Strategic Framework funding has been directed towards enhancing existing programs to build capacity.

Based on NSW Health's advice, the CDRT accepts that the intent of this element has been met.

## 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 did not have a process to undertake a critical incident style review following a student death by suicide. It is critical that agencies

learn from missed opportunities to enable them to improve the effectiveness of their response to risk of suicide and self-harm.

### Agency progress updates in relation to implementation

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 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 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 was being planned and established, the department 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 was finalising a framework for reviewing suicide deaths of students in public schools. Department of Education staff met with relevant counterparts from NSW Health and the Department of Communities and Justice to inform the development process. The framework was to use a trauma-informed systems approach to understand and enhance good practice in supporting the wellbeing and mental health of children and young people. The multidisciplinary team, led by the Psychology and Wellbeing Coordinators, would lead the process to facilitate learning and inform future work at a systems level.

On 7 July 2023, representatives from the NSW Ombudsman and the Department of Education met to discuss the recommendations. Following this meeting, on 17 July 2023, the department provided additional advice that it has established and implemented a 'Postvention Follow-Up' process, overseen by a multidisciplinary team of representatives from across the department, after the suicide death of a student in a government school. The process involves a desktop review of documentation and opportunities for guided conversations with key staff. A report of the key learnings is compiled for the Postvention Advisory Group to consider. Information is also presented to the department's Child Protection Executive Directors Group quarterly meetings for consideration of any policy and/or practice enhancements.

### Has the intent of the recommendation been met?

The department has implemented a process of review after the suicide death of a student in a public school that considers key learnings, emerging trends, and possible policy and/or practice enhancements. Based on this advice, the CDRT has assessed that the intent of this recommendation has been met.

## 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

In July 2019, NSW Health introduced a revised Policy Directive, *Management of Sudden Unexpected Death in Infancy (SUDI)*,[9] 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 new *Medical History Guide – Sudden Unexpected Death in Infancy (SUDI)* comprises a set of questions to guide clinicians to take a medical history in the context of a SUDI death.

At a Coronial inquest into the deaths of two infants in 2019,[10] NSW Health gave evidence about a proposed audit of its 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.

### Agency progress updates in relation to implementation

In December 2021, NSW Health advised that an audit plan had been developed, but not yet finalised.

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

[9] NSW Health Policy Directive PD2019_035, published 30 July 2019. See PD2019_035.pdf (nsw.gov.au)

[10] Inquest into the deaths of Kayla Ewin and Iziah O'Sullivan. See Inquest into the deaths of Kayla EWIN and Iziah O'SULLIVAN (nsw.gov.au)

The audit plan involved various project phases, including initiation, planning, implementation, governance, and reporting. At the time the plan was provided, the audit was planned for May 2022, to be reported 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, resources to conduct the audit identified, and the audit was anticipated to be completed by December 2022. NSW Health advised that the scope of the audit had been widened from the medical history protocol to include broader evidence considered during a SUDI response. This includes the presence and adequacy of the Police P79A form, medical history, and NSW Ambulance forms, as well as availability and access to scene photography.

On 1 September 2023, NSW Health advised it had completed the file review component of the audit in June 2023. The SUDI audit report was being drafted and was expected to be finalised in September 2023. Findings from the SUDI audit report were to be discussed at the SUDI cross agency working group meeting in September 2023.

### Has the intent of the recommendation been met?

The CDRT will continue to monitor this recommendation, pending further advice from NSW Health on the progress and outcomes of the audit.

## 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 their regulatory activities and outcomes, including the number of compliance and non-compliance certificates issued for pool barriers. However, this information does not provide a comprehensive picture of compliance with swimming pool barrier requirements across NSW.

This recommendation amended 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 could not provide an amalgamated report of key aspects of swimming pool regulation, which would be addressed by planned upgrades to the Register. In September 2021, DCS advised that upgrades to the Register were planned for 2022.

### Agency progress updates in relation to implementation

In July 2022, DCS advised it supported the recommendation. DCS advised it was continuing to develop the NSW Swimming Pool Register's enhanced amalgamated reporting capability, and anticipated that the upgrades would be complete by December 2022.

On 31 May 2023, DCS provided an advance copy of compliance data for 2021 on the key aspects of swimming pool regulation requested to be publicly reported, extracted from the Swimming Pool Register. On 14 June 2023, DCS advised that funding of the upgrade/rebuild of the Swimming Pool Register would be considered by its Finance Committee in June 2023. As an interim measure, DCS requested confirmation that the data it had already provided (in respect of the 2021 period) meant that it had met the intent of the CDRT's recommendation and that the Ombudsman's office was 'comfortable' continuing to receive annual Swimming Pool Register data, on request, until the new register is built. DCS also sought advice about how the compliance data should be published within the new register.

On 4 July 2023, NSW Ombudsman staff met with DCS staff to discuss the recommendation, and received further information from DCS following the meeting. DCS provided advice about the legislative requirements associated with the Swimming Pool Register, and current data captured. DCS confirmed that while it was responsible for maintenance and operation of the Register, local councils collect and enter information into the Swimming Pool Register. DCS also provided advice about certificates of compliance and non-compliance, information recorded on these certificates, and how the process of pool inspection currently operates. DCS advised that it had manually filtered information in the Swimming Pool Register to provide the advance copy of compliance data for 2021, and that it could provide the CDRT with this information in this format annually without a system upgrade. However, DCS also raised concerns about the recommendation that it be responsible for publication of this data.

On 19 September 2023, DCS reiterated its understanding that by enabling reporting of compliance data relating to the key aspects of swimming pool regulation without the need to update the current Swimming Pool Register, it had met its commitment, noting that it can provide this data on an ongoing basis. However, DCS remained concerned about being responsible for publication of the data as it is not responsible for the regulation of swimming pool barriers, does not 'own' the data that is to be published, and cannot compel the production of the data under the *Swimming Pools Act 1992*. DCS advised that responsibility for publishing the data would better sit with the NSW Office of Local Government, which oversights local councils that regulate pool barriers in NSW.

### Has the intent of the recommendation been met?

The CDRT appreciates the assistance of DCS staff in providing data from and advice about the Swimming Pool Register. Based on its advice about the operation of the Register and the requirements of the NSW pool fencing inspection regime, the CDRT has assessed that the intent of the recommendation cannot be met. NSW legislation only requires the inspection of residential swimming pools in limited circumstances, such as when properties are for sale[11] or lease,[12] or they may be inspected at an owner's request.[13] There is no provision for mandatory compliance directions,[14] nor for follow-up of compliance directions made. The CDRT also acknowledges the difficulty of separate entities having responsibility for regulating pool barriers and compiling the regulatory data.

The CDRT is of the view that the current regulatory framework cannot support meaningful public amalgamated reporting of compliance data relating to key aspects of swimming pool regulation. The CDRT also notes that there has been a significant reduction in the number of drowning deaths of children in private swimming pools over the last 15 years, with the lowest number of fatal immersions observed in the five years 2017-2021.

[11] *Conveyancing (Sale of Land) Regulation 2022* Schedule 1 cl 15.

[12] *Residential Tenancies Regulation 2019* Schedule 1 cl 46.

[13] *Swimming Pools Act 1992* s 22C.

[14] See *Swimming Pools Act 1992* s 23(1) – compliance orders are discretionary.

The CDRT will close this recommendation, but continue to monitor drowning deaths and any issues relating to the regulation of private pool barrier fencing.

# Appendix 1: CDRT Strategic Priorities Plan 2022-2025

The CDRT finalised its Strategic Priorities Plan 2022-2025 in February 2022 and developed an Action Plan setting out actions and associated tasks for 2022-23 against the strategic priorities identified.

Progress against those actions as of 30 June 2023 is set out in the table below.

## Meeting our strategic outcomes

| PRIORITY | STATUS | COMMENTS |
|---|---|---|
| **1. Nurture strategic relationships and collaboration with key partners and stakeholders to optimise our influence and reach** | | |
| Revise and refine our list of stakeholders<br>*Focus initiative: stakeholder network mapping* | In progress | We are reviewing a 2019-20 mapping of key stakeholders to identify gaps or changes. |
| Leverage the expertise of CDRT members, and collaborate with research and community partners (such as universities and institutes) to bring further authority and academic expertise to our work | Ongoing | We have engaged CDRT member, Professor Kathleen Clapham through Ngarruwan Ngadju, First Peoples Health and Wellbeing Research Centre, University of Wollongong to lead the Aboriginal and Torres Strait Islander Suicide Project. CDRT member Professor Ngiare Brown is the CDRT project lead for this project and a member of the project's Aboriginal Suicide Prevention First Nations Advisory Group.<br><br>We consulted with members of the CDRT's SUDI sub-committee in relation to the perinatal brain injury preliminary study. |
| Embed a collaborative approach in our work and ways we do business | In progress | We have implemented additional engagement processes with stakeholders during the monitoring of recommendations. |
| Proactively engage with stakeholders to ensure our recommendations are well-targeted, understood, and attainable | Ongoing | We held 7 stakeholder meetings with agencies including Transport for NSW's Centre for Road Safety, NSW Health, the Department of Customer Services, and the Department of Education, to clarify the intent and purpose of the CDRT's recommendations.<br>We now explicitly outline the CDRT's intent and purpose when making and monitoring recommendations. |
| Develop strategies to improve the visibility of our work with stakeholders and community partners<br>*Focus initiative: promoting our work* | In progress | A communications strategy was developed for the public release of the AIHW research report (see Chapter 4.1). |
| Share information and data from the Register of Child Deaths to support | In progress | The NSW Ombudsman website will be updated to provide information and contact details for those seeking access to |

| PRIORITY | STATUS | COMMENTS |
|---|---|---|
| stakeholders in research and other work related to the prevention of child deaths | | information from the Register of Child Deaths. |
| **2. Identify and generate current data that provides insight into the effect of society-wide stressors such as COVID-19** | | |
| Identify relevant data to be captured and address any gaps<br>*Focus initiative: identifying data to be captured* | In progress | We are preparing a definition of 'societal stressors', and guidance regarding recording societal stressors in the Register of Child Deaths. |
| Extract information from case records for inclusion in the Register of Child Deaths | In progress | We will report on matters associated with COVID-19 in the *Biennial report of the deaths of children in New South Wales: 2020 and 2021.* |
| Analyse captured information to provide insight into the impact of societal stressors, including partnering with relevant agencies where required<br>*Focus initiative: analysis and insight* | Ongoing | Discussion of how COVID-19 related societal stressors may have impacted children who died by suicide will be included in the *Biennial report of the deaths of children in New South Wales: 2020 and 2021.* |
| **3. Undertake meaningful and well-targeted projects, and make the most of existing data** | | |
| Complete and publish reports for each of our current projects:<br>Analysing the effects of antenatal care, birth conditions, and socioeconomic status on early childhood mortality in NSW using linked data (AIHW data linkage project)<br>Infant deaths from severe brain injury in NSW, 2016-2019<br>Preventing the suicide deaths of Aboriginal children and young people | Complete/<br>In progress | Status of three research projects is as follows:<br>Complete: AIHW data linkage research report tabled in Parliament on 9 December 2022.<br>In progress: key thematic observations report tabled as an annexure to the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*.<br>In progress: research to be completed in 2024. |
| Report on agency responses to any recommendations made in these reports, together with their progress in implementing recommendations | Ongoing | Agency updates on the implementation of recommendations are included in this report (see Chapter 7). |
| Track, to the extent this is practicable, the direct and indirect impacts of our project work and recommendations<br>*Focus initiative: measuring our impact* | In progress | Work considering approaches for delivering this action has commenced. |
| Select, plan, and resource at least one new project or piece of research that can be achieved and delivered during the 3-year period. Shortlisted topics should support CDRT strategic priorities, build on/consolidate previous recommendations, | In progress | A list of potential future CDRT research projects is being developed, for when the current projects (listed above) are completed. |

| PRIORITY | STATUS | COMMENTS |
|---|---|---|
| and actively leverage current work and projects. | | |
| Explore further opportunities for additional person-centred datasets that link numerical and qualitative data to deepen our understanding of the context of child deaths<br>*Focus initiative: exploring opportunities* | Pending | Not yet commenced. |
| Develop recommendations that are both systems level and specific | In progress | We are preparing internal guidance on best practice in making recommendations. |
| **4. Apply an equity lens to our work as core business** | | |
| Define an 'equity lens', and how to apply it in our work, considering the specific role of the CDRT and how/where we might lead work in this area | In progress | A draft paper is being developed for the CDRT. |
| Focus on equity aspects of preventable mortality – including access to resources and services. We will consider any unresolved and/or worsening trends in the post-COVID environment, as well as inequitable distribution of serious injury and morbidity | In progress | The *Biennial report of child deaths in New South Wales: 2020 and 2021* will include additional data and analysis in relation to equity (for example, in demographic reporting). |
| Identify any groups which should be the focus of targeted work, and consider opportunities to collaborate with associated stakeholders | In progress | Ombudsman staff presented to a meeting of NSW Coroners and will prepare a fact sheet on the Ombudsman's child death functions for Coroners. |
| Identify and consider how to obtain/generate relevant equity-related data<br>*Focus initiative: data generation* | Pending | Not yet commenced. |
| Consider commitments in the NSW Implementation Plan for achieving the National Agreement on Closing the Gap to improve the lives of Aboriginal and Torres Strait Islander people in relevant child death cases<br>*Focus initiative: Closing the Gap* | Pending | Not yet commenced. |
| **5. Deliver powerful and influential evidence-based recommendations that bring about change** | | |
| Develop evidence-based recommendations that incorporate lessons from previous strategies, such as the use of smaller inter/intra-agency working groups to workshop actions needed to bring about change<br>*Focus initiative: review of unsuccessful recommendations* | In progress | CDRT recommendations from 2017-2022 have been reviewed and initial learnings presented to the CDRT. |

| PRIORITY | STATUS | COMMENTS |
|---|---|---|
| Explore ways of communicating and targeting our messaging to incentivise agencies to act on our recommendations – whether they are directly or indirectly impacted – and align with our broader purpose to prevent deaths<br>*Focus initiative: broadening our reach* | Pending | Not yet commenced. |
| Develop strategies to track the impact of our recommendations in future data, including beyond 2025 | Pending | Not yet commenced. |
| Review our public reporting<br>*Focus initiative: review of public reporting* | In progress | A discussion paper is being prepared for discussion with the CDRT. |

# Appendix 2: Member meeting attendance

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

| Member | 9 August 2022 | 8 November 2022 | 14 February 2023 | 9 May 2023 |
|---|---|---|---|---|
| Mr Paul Miller (Convenor) | Y | Y | Y | Y |
| Ms Monica Wolf | N | N | Y | Y |
| Ms Zoë Robinson | N | N | Y | N |
| Ms Sarah Bramwell | Y | Y | Y | Y |
| Det Super Danny Doherty | Y | Y | Y | N |
| Mr Matthew Karpin | N | Y | Y | Y |
| Dr Matthew O'Meara | Y | Y | Y | Y |
| Ms Anne Reddie | Y | Y | N | Y |
| Ms Eloise Sheldrick | N | Y | Y | On leave[15] |
| Ms Alison Sweep[16] | N/A | N/A | N | Y |
| Mr Ben Spence[17] | N | N | N/A | N/A |
| Dr Susan Adams | Y | Y | Y | Y |
| Dr Susan Arbuckle | Y | Y | Y | N |
| Prof Ngiare Brown | Y | Y | Y | Y |
| Prof Kathleen Clapham | N | Y | Y | Y |
| Dr Luciano Dalla-Pozza | Y | Y | Y | N |

[15] Eloise Sheldrick granted leave from CDRT under clause 5(1)(d) of Schedule 2 to the *Community Services (Complaints, Reviews and Monitoring) Act 1993.*

[16] Alison Sweep's CDRT membership commenced on 31 October 2022.

[17] Ben Spence's CDRT membership ceased on 29 September 2022.

| | | | | |
|---|---|---|---|---|
| Dr Bronwyn Gould | Y | Y | Y | Y |
| Prof Philip Hazell | N | Y | Y | Y |
| Prof Heather Jeffery | Y | Y | Y | N |
| Prof Ilan Katz | N | Y | Y | Y |
| Ms Catherine Lourey | N | N | Y | Y |
| Dr Isabel Brouwer[18] | N | N | Y | N/A |

[18] Isabel Brouwer's CDRT membership ceased on 11 April 2023.

# Appendix 3: Agency advice regarding recommendations

Ref023/1

Ms Helen Wodak
Deputy Ombudsman
NSW Ombudsman's Office
Email: [redacted]

**NSW Health Update on Child Death related Recommendations**

Dear Ms Wodak

I refer to your letter of 23 June 2023 seeking an update on the implementation of recommendations made in earlier reports relating to child deaths and also providing an extension for us to report back to your office.

Please find attached (TAB A) that provides a status update on earlier recommendations made by the NSW Ombudsman in relation to Child Deaths.

I also refer to your Section 34 Notice with regard to making available the full report titled Final Evaluation Report: OOHC Health Pathway Program Enhancement Funding, NSW Ministry of Health 2 December 2022. I am pleased to provide the complete report at Tab B however, I request that the report is not shared with other services, and the stakeholder quotes in the report not be publicly cited by the NSW Ombudsman

I look forward to my officers working collaboratively with officers from your office in the implementation of those recommendations relating to child deaths. For more information, please contact Paul Giunta, Director, Corporate Governance and Risk Management at email [redacted] or on [redacted].

[redacted]

Susan Pearce AM
Secretary, NSW Health

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| **SUDI – safe sleeping**<br>**Recommendation 1, Biennial report of the deaths of children in NSW: 2016 and 2017**<br>NSW Health should develop and implement strategies to promote safe infant sleep practices to vulnerable families. In particular, NSW Health should target:<br>• in consultation with the Department of Family and Community Services, families known to child protection services,<br>• families living in remote areas of the state, and<br>• families living in areas of greatest socio-economic disadvantage. | NSW Health supported the recommendation.<br>In 2019, NSW Health held initial meetings with the Department of Communities and Justice (DCJ) and Red Nose to discuss opportunities for supporting vulnerable families.<br>In 2021, NSW Health advised that it had published a revised *Recommended Safe Sleep Practices for Babies Guidelines* and had developed a *Safe Sleeping Recommendations* information sheet.<br>In August 2022 NSW Health advised it had updated the My Personal Health Record (Blue Book) and the Having a Baby book with information and messaging about safe sleeping, and was facilitating the Jumbunna Webcast Series, which focused on the health and wellbeing of Aboriginal children and families.<br>In October 2022, the CDRT reported it would continue to monitor implementation of this recommendation.[1]<br>Except for the information provided about the 2019 meeting and the webcast series, the information provided to date relates to general resources. We are seeking information about the development and implementation of strategies focused on the families referenced in the recommendation, that are known to child protection services, living in remote areas, | NSW Health held a meeting with officers from NSW Ombudsman's Office regarding initiatives being taken in relation to Better Sleeping Practices. A number of specific projects were discussed and explained in relation to this recommendation.<br><br>NSW Health's Maternity Child and Family team has engaged the Alcohol and Other Drugs branch to discuss how the safe sleeping information can be incorporated into their messaging for pregnant women and new parents.<br><br>The Ministry of Health is working with Local Health Districts on developing Pregnancy Family Conferencing (PFC) and considering how PFC may be positioned to incorporate safe sleep messaging into their support for families. |

[1] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2016-17* (October 2017) pp. 32-33

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | and /or living in areas of greatest socio-economic disadvantage. | |
| **SUDI – medical history protocol**<br><br>**Recommendation 1, Biennial report of the deaths of children in NSW: 2018 and 2019**<br><br>NSW Health complete a detailed audit of compliance with the revised SUDI medical history protocol. The audit should include information and analysis about:<br>• The number of infants presented to emergency departments following their sudden and unexpected death.<br>• The number of medical history interviews conducted in response to these deaths.<br>• An assessment of whether the intent of the policy directive has been met and is reflected in the information gathered.<br>• 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. | NSW Health supported the recommendation.<br>In February 2022, NSW Health provided a copy of its plan to conduct an audit of medical history procedures when there has been a sudden and unexpected death of an infant. At that time, the planning phase of the audit was underway, with plans to conduct the audit by May 2022 and report back to the SUDI cross-agency working group by July 2022.<br>In August 2022, NSW Health advised that the audit had been delayed by the COVID-19 response, and that it anticipated an expanded audit would be completed by December 2022.<br>In October 2022, the CDRT reported it would continue to monitor the recommendation, pending further advice from NSW Health.[2]<br>The NSW Health representative on the CDRT has been updating the CDRT on the audit's progress, and at the February 2023 meeting advised that the audit was near completion and the results were expected by mid-year.<br>Against this background we are seeking an update on the progress of the audit and analysis of its findings, including the information covered in elements a to g of the recommendation. | NSW Health completed the file review component of the SUDI audit in June 2023. The SUDI audit report is currently being drafted and is expected to be finalised by September 2023.<br><br>The findings from the SUDI audit report will be discussed at the SUDI cross agency working group (CAWG) meeting in September 2023. |

[2] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (25 October 2022) pp. 42-43

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| • 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).<br>• 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.<br>• Details about any strategies or outcomes arising from the audit. | | |
| **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. | NSW Health supported the recommendation. NSW Health initially provided advice (2019) that it would be contacting Red Nose to work collaboratively to promote evidence-based and evaluated resources for parents and carers. Subsequent updates (2021 and February 2022) by NSW Health provided information about existing resources and advice about updating and strengthening its existing resources and key messages to inform parents and carers about key risk factors, and where and how to find help if they are concerned about their child.<br>In August 2022, NSW Health noted recent messaging related to COVID-19 and respiratory illnesses and reiterated information available to parents and carers via existing resources. Health also advised it was exploring options for a 'digital front door' for parents. | In an effort to assist parents and carers to identify illness in infants, NSW Health held several meetings with Healthdirect to understand who is accessing their service and how parents and carers are connecting to care.<br><br>Healthdirect were able to provide the following insight relating to the service's helpline calls: |

<table>
<tr><th>Recommendation</th><th>Summary of advice to date and requested information</th><th>NSW Health Status Update</th></tr>
<tr><td></td><td>In October 2022, the CDRT reported it would continue to monitor the recommendation and would seek to meet with NSW Health.[3]<br>In December 2022, representatives from the NSW Ombudsman and NSW Health, including the Executive Director Health and Social Policy Tish Bruce, met to discuss the recommendation. At this meeting, NSW Health representatives provided advice about the development of a digital version of the Blue Book and other web-based initiatives and resources. Agreed actions arising from the meeting included seeking information about Healthdirect.<br>Against this background we are seeking an update on Health's progress to promote resources that aim to assist parents and carers to identify illness in infants, including:<br>• review and digitisation of the Blue Book, including consumer testing and focus groups,<br>• work to improve parent engagement with health services,<br>• review of the NSW Health website,<br>• advice from the government relations unit within the Ministry of Health about the monitoring of users of Healthdirect, and<br>• any other relevant initiatives, either planned or underway, that address the recommendation.</td><td>
<table>
<tr><th>Metro-Rural</th><th>Cultural Background</th><th>Triage Services (No. of)</th></tr>
<tr><td>Metro</td><td>Non Indigenous</td><td>57,227</td></tr>
<tr><td>Metro</td><td>ATSI</td><td>3,137</td></tr>
<tr><td>Rural</td><td>Non Indigenous</td><td>16,287</td></tr>
<tr><td>Rural</td><td>ATSI</td><td>3,272</td></tr>
<tr><td>Unknown</td><td>Non Indigenous</td><td>269</td></tr>
<tr><td>Unknown</td><td>ATSI</td><td>18</td></tr>
<tr><td></td><td>Total calls</td><td>80,210</td></tr>
</table>
Between July 2021 to June 2023, the Healthdirect Service Helpline received 80,210 calls relating to patients under 1 year old in NSW.<br>Of these calls, 92 per cent were from non-indigenous backgrounds and 75 per cent were from metro locations. There was a higher proportion of calls from Aboriginal and/or Torres Strait Islander (ATSI) backgrounds who lived in rural locations; 17 per cent of rural calls were from ATSI backgrounds compared to only 5 per cent of metro calls being from ATSI backgrounds.<br><br>While NSW Health was aiming to better understand the access rates to this resource by minority groups and vulnerable populations, there were limitations to the data. Healthdirect do not capture information relating to culturally and</td></tr>
</table>

[3] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (25 October 2022) p. 33-34

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | linguistically diverse cohorts and were unable to provide data broken down by postcode level.<br><br>**The Blue Book**<br>The Health and Social Policy Branch (HSPB) is currently undertaking a Major Review of the My Personal Health Record (Blue Book). As agreed with representatives from the NSW Ombudsman on 14 December 2022, additional questions have been included in an online survey instrument which will be undertaken with parents and care givers, and clinicians, to inform the review. These questions have been developed in close consultation with the Ombudsman's office. The survey instrument is currently being finalised and is anticipated to 'go live' in early August 2023 for a period of 4-6 weeks. The survey will be promoted on all NSW Health social media channels and distributed through key NSW Health networks and governance forums to facilitate a robust response rate.<br>HSPB will provide survey analytics for the below two questions to the NSW Ombudsman once the survey has closed. It is anticipated that this information will be ready in October 2023.<br>The 2 questions are: |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | A17 **Which sources would you go to seek <u>information</u> if your child is sick?** — Mandatory & multiple response<br>The Blue Book<br>Social media<br>Internet<br>Friends<br>Family<br>HealthDirect<br>Parents group<br>Chemist/pharmacist<br>Other: *please specify*<br><br>A18 **Where would you go/who would you contact if your child is sick?** — Mandatory & multiple response<br>HealthDirect<br>GP/family doctor<br>Local hospital – Emergency Department<br>Chemist/pharmacist<br>Child and Family Health Nurse<br>Other: *please specify*<br><br>Also agreed with representatives from the NSW Ombudsman on 14 December 2022 were additional focus groups, as part of the Major Blue Book Review methodology, with specified groups of vulnerable parents/caregivers to comprehensively understand where information is sought if a child is sick. It was agreed that additional focus groups would be undertaken with families with:<br>• a drug and alcohol background<br>• a history of family and domestic violence |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | • a parent/caregiver and/or child with disability.<br>These focus groups have now been completed and draft findings are being analysed and will be presented to the Ombudsman in conjunction with the online survey analytics in October 2023. |
| **Suicide – targeted prevention measures Recommendation 10, Biennial report of the deaths of children in NSW: 2016 and 2017**<br>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:<br>• [element closed]<br>• Early intervention designed to arrest emerging problems and difficulties<br>• The provision of targeted, sustained and intensive therapeutic support to young people at high risk – including strategies for reaching those who are hard to engage. | The NSW Government supported the recommendation.<br>In June 2020, the Department of Premier and Cabinet advised that NSW Health would provide future updates on behalf of the NSW Government.<br>In September 2021, NSW Health advised that implementation of the *Towards Zero Suicides* initiatives was well underway, and included information about a range of activities relevant to children and young people. NSW Health also advised that the NSW School-Link Action Plan 2020-2025 (released in 2020), and the Getting on Track in Time – Got It! program, were relevant state-wide initiatives.<br>In October 2021, the CDRT reported that it remained concerned about the number of child and adolescent mental health workers available to deliver interventions, particularly in regional areas, that it was unclear if co-funded initiatives would be expanded across NSW if successful, and how sustainability would be ensured.<br>In August 2022, NSW Health provided an update about the Got It! program and work to establish Safeguards Teams across NSW. Advice about other existing funding/initiatives was also provided. | A meeting was held between NSW Health and officers from NSW Ombudsman's Office on 18 July regarding Recommendations 10 and 11.<br><br>The development and implementation of early intervention measures targeted to older school-aged children and young people, including whether the Got It! program will be extended to primary school years 3 to 6, and whether the same or a similar program will be introduced to address problems associated with suicidal behaviour that affect older children.<br><br>The NSW Got It! program continues to deliver across all Local Health Districts. The universal component of the Got It! program targets the whole school community (teachers, support staff, parents and children) to improve the level of support to all families and to enhance safe and nurturing environments for children. It includes professional development for teachers to deliver classroom social-emotional learning programs for children and a parent information campaign addressing child behaviour, socio-emotional development and parenting practices. These whole of-school interventions are run alongside the K-2 screening for |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | In October 2022, the CDRT reported that it would continue to monitor elements b and c of the recommendation.[4]<br>Against this background, we are seeking information about:<br>• The development and implementation of early intervention measures targeted to older school-aged children and young people, including whether the Got It! program will be extended to primary school years 3 to 6, and whether the same or a similar program will be introduced to address problems associated with suicidal behaviour that affect older children.<br>• 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. | the targeted intervention, with Got It! clinicians also being available as consultants to teachers and other school staff.<br><br>Teen Got It! is an adaptation of the Got It program for older children 11- 17 years. It is delivered by the Justice Health and Forensic Mental Health Network and provides screening, assessment and therapeutic intervention services, as well as capacity building, training and development to school staff for young people who are displaying early violence. This program aims to improve pro-social behaviours, family relationships and reduce domestic violence.<br><br>School-Link is a long-standing program available in every local health district and speciality network with 30 School-Link Coordinators employed across the state. School-Link Coordinators collaborate with education professionals to improve the early identification of students experiencing mental health problems and link students with the care they need. They also play a key role in suicide postvention activities in schools and assist schools to manage challenging behaviours related to complex mental health issues such as self-harm and suicidal ideation through initiatives such as Project Air for Schools.<br><br>Project Air Schools is jointly funded by NSW Health and the Department of Education. Project Air for Schools equip school staff with the skills and knowledge they need to identify, support and refer students with complex mental health issues |

[4] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (25 October 2022) p. 35-38

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | into supportive services. Project Air is also being extended to provide targeted training needed to build the capability of child and youth mental health service clinicians to deliver specialist therapeutic interventions to young people with complex mental health issues.<br><br>The Commonwealth is working in partnership with states and territories to establish a national network of Head to Health Kids Hubs (mental health and wellbeing centres) for children aged 0 - 12 years and their families. Four Head to Health Kids Hubs are being established in NSW. Through an integrated, multidisciplinary team approach the Kids Hubs will deliver a range of specialist medical and allied health services (including culturally appropriate services), enabling families to access a range of supports and services including for behavioural and developmental concerns. The Kids Hubs will complement and integrate with existing state funded maternal and child health services, including child and adolescent mental health services, to ensure seamless support and transition for families and to make a complex system more accessible. The Kids Hubs will be located in Wollongong, the Central Coast, Orange and Penrith. The services will be rolled out progressively until 2027 when all four hubs will be operational.<br>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 | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | Child and Youth Mental Health Services provide a range of different treatment and support options. Young people will be provided with a comprehensive assessment and evidence based therapeutic interventions including: family therapy, group based therapy, individual therapy. to address. Outreach is provided to children, young people and their carers who are difficult to engage or who are in crisis ensuring that the needs and safety of children and young people are met.<br><br>A statewide long-term investment in community-based Safeguard teams provide in-reach to hospitals and outreach to homes, schools and communities seeks to address growing demand on our NSW specialist mental health service system. Safeguards Teams provide multidisciplinary specialist mental health care, helping young people experiencing acute mental distress, and their families navigate the system and access the care they need in the community. Safeguards is being rolled out in Tranches, with 11 LHDs receiving funding for teams in late 2021 and 7 LHDs receiving funding for teams in late 2022. An additional 7 teams will be funded in 2024.<br><br>Early intervention in psychosis programs are available in some Local Health Districts to deliver specialist care to young people with an emerging psychotic illness.<br><br>Core CAMHS services are supported by specialist programs such as the Youth Community Living Support Services (YCLSS) delivered by an NGO providing psychosocial support services for young people recovering from severe and complex mental illness in the community. YCLSS is available in five LHDs |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | (Hunter New England, Nepean Blue Mountains, Northern NSW, South Western Sydney, Western Sydney).<br><br>The Enhancement and Integration of Youth Mental Health Services initiative under the bilateral agreement will provide early access to specialist care for young people presenting to headspace services with severe and complex mental health needs. This will be progressively implemented at selected headspace services over 3 years (commencing 2023-24). This initiative will support more effective coordination and care between CAMHS and headspace services including planning between agencies about how to holistically monitor the changing risks and needs of the young person.<br><br>**Suicide Prevention Training**<br>• LivingWorks Australia are providing suicide intervention skills training, targeting NSW Independent, Catholic and Public High School education sector, parents/carers, youth sporting groups and targeted community suicide first responders.<br>▪ The training 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.<br>▪ The initiative is funded under the Mental Health Recovery Package until 30 June 2024. |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
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| | | ▪ A key priority is further engagement with the Department of Education to support promotion of the LivingWorks training across the public school sector.<br><br>**Towards Zero Suicides Community Response Packages for Priority Groups**<br>• Towards Zero Suicides Community Response Packages (CRPs) for priority groups are designed to encourage safe conversations around suicide, increase community knowledge and participation about suicide prevention and mental health, and create awareness of appropriate suicide prevention services available in the local community.<br><br>• Wellways Australia are funded to deliver UrHere, a youth specific media campaign to support safe conversations around suicide. As part of UrHere, Wellways have developed:<br>▪ A youth reference group including representatives from key groups such as CALD, Aboriginal and Torres Strait Islander, and LGBTIQI+ communities, aged 12-25<br>▪ A calendar of key youth events or high impact times (exams, national youth week)<br>▪ Targeted suicide prevention messaging<br>▪ Collaborations with a number of influencers and community champions to develop youth focused, relevant and safe social media content and messaging<br>▪ An annual social media campaign including messaging around COVID 19 lockdown wellbeing, Mental Health Month (Oct), and exam preparation. |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
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| | | • Cox Inall Ridgeway are funded to deliver the Heal Our Way campaign as part of the Community Response Package for Aboriginal people, a targeted promotional campaign supported by a suite of culturally appropriate resources and community events with a strong focus on Aboriginal young people.<br>• As part of Heal Our Way, Cox Inall Ridgeway have delivered:<br>▪ An Aboriginal designed and led social and promotional campaign to support safe conversations around suicide prevention in community<br>▪ A suite of culturally appropriate resources to support communities and know how to access appropriate support<br>▪ Community events and development, including strength-based Yarning circles |
| **Suicide – gaps in specialist services Recommendation 11, Biennial report of the deaths of children in NSW: 2016 and 2017**<br>The NSW Government should direct funds associated with the Strategic Framework for Suicide Prevention in NSW 2018-2023 to address gaps in the delivery of appropriate specialist mental health services for children and young people in NSW. | The NSW government supported the recommendation.<br>As with recommendation 10, in June 2020, the Department of Premier and Cabinet advised that NSW Health would provide future updates on behalf of the NSW Government.<br>In September 2021, NSW Health provided general advice about implementation of the *Towards Zero Suicides* initiatives and other activities relevant to children and young people. NSW Health also confirmed the *NSW School-Link Action Plan 2020-* | **The Suicide Prevention Fund** delivers community aftercare services and engagement campaigns, building awareness of suicide prevention, wellbeing and support pathways available to communities at elevated risk of suicide, including young people throughout NSW.<br><br>Many of the new and expanded initiatives and programs funded under **Towards Zero Suicides** are increasingly responding to the needs of young people. |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
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| | *2025* was released in 2020 to facilitate early identification of and timely access to specialist services and support.<br>In October 2021, the CDRT reported that current initiatives did 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.<br>In August 2022, NSW Health provided information about the establishment of Safeguards Teams to provide care to children and young people aged 0-17 experiencing acute mental health distress, along with some other targeted initiatives such as Suicide Prevention Outreach Teams, and Safe Havens.<br>In October 2022, the CDRT reported that it was not clear that the programs and initiatives described by NSW Health adequately addressed gaps in services to manage and contain risk (rather than identify risk), or how funding has been directed to bolster capacity to provide specialist mental health services for children and young people.[5]<br>Against this background, we are seeking information about:<br>• Services and initiatives that specifically focus on the management and containment of suicide risk among children and young people who have been identified as at risk. | • **Safe Havens**<br>Safe Havens have been established across all local health districts (LHDs) as a calm and supportive alternative to Emergency Departments for people experiencing suicidal crisis or distress.<br>These facilities are supported by peer workers with a lived experience of suicide and mental health professionals who collaborate to provide accessible, compassionate support and pathways to other services in a welcoming, non-clinical space.<br>19 Safe Havens are operational across NSW LHDs and are accessible to people 12 years and above.<br>Safe Havens are currently funded through Towards Zero Suicides over 4 years from 2022-23 to 2025-26.<br>• **Suicide Prevention Outreach Teams (SPOTs)**<br>Suicide Prevention Outreach Teams (SPOT) are a mobile clinical and peer support service responding to people experiencing suicidal crisis or at risk of self-harm within the community where they live.<br>19 SPOTs are currently operational across NSW local health districts (LHDs) and are accessible to people 12 years and above.<br>Northern Sydney LHD have established a dedicated pilot Youth Response Team available for young people aged 12-17 (or 18 if still at school).<br>SPOTs are currently funded through Towards Zero Suicides over 4 years from 2022-23 to 2025-26.<br>• **Youth Aftercare Pilot** |

[5] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (25 October 2022) p. 35-38

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
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| | • Funding directed from the *Strategic Framework for Suicide Prevention in NSW 2018-2023* to support specialist youth mental health interventions to be more effective (less episodic and fragmented). | Delivered in 4 sites across NSW (Mt Druitt, Coffs Harbour, Tamworth, and Bankstown) to provide psychosocial and practical supports for children and young people at increased risk of suicide or significant self-harm.<br><br>The service is delivered by peer support workers and the model of care is informed by a continuing co-production process with staff and young people.<br>YAP also provides targeted support to relevant at-risk groups, including Aboriginal young people, LGBTIQ+ young people, young people who have contact with the child protection system or are in out of home care, young people experiencing homelessness, and young people in contact with juvenile justice.<br>An evaluation of YAP is currently in progress with interim findings supporting the need for a youth specific model of aftercare and identify some of the core elements of this:<br>▪ Youth Aftercare responds to the needs of young people who have previous negative experience with clinical services or lack of experience with services, by providing a soft entry to supports, and by working with the young person from where they are at, at their pace.<br>▪ Youth Aftercare peer workers are responsive to young people's preferences about communication modes and frequency of communication and the language used, which differ from the preferences of adults.<br>▪ The program also enables young people to re-engage with supports without going through another formal |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
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| | | referral process, to respond to the changes in their readiness to engage over time.<br>▪ A final evaluation report for YAP is due to be delivered in November 2023.<br><br>• **Community Collaboratives**<br>NSW Health has funded headspace in partnership with Lifeline to deliver 12 Community Collaboratives annually as well as mental health information sessions for parents, carers and community members in localities with increased suicide risk. Funding is continuing at $2 million per annum across 2022-23 to 2023-24.<br><br>• NSW Health and Department of Communities and Justice are developing a joint **Framework to improve mental health responses for children and young people in Out-of-Home-Care** – due for completion in the third quarter 2023.<br><br>• **Kids Helpline**<br>Significant additional funding has been identified to support increased capacity to respond to children and young people in distress. Details of this enhancement are currently in negotiation.<br><br>• **Building on Aboriginal Communities' Resilience**<br>The Building on Aboriginal Communities' Resilience initiative provides funding to 25 Aboriginal Community Controlled Health Organisations (ACCHOs) to deliver culturally |

| Recommendation | Summary of advice to date and requested information | NSW Health Status Update |
|---|---|---|
| | | appropriate community-led suicide prevention and social and emotional wellbeing (SEWB) activities in NSW Aboriginal communities to address high rates of suicide and self-harm.<br>The initiative is a partnership between the NSW Ministry of Health, the Aboriginal Health and Medical Research Council of NSW (AH&MRC), and the participating ACCHOs.<br>A large number of these ACCHO programs are youth-focused and deliver a range of targeted programs including:<br>▪ Cultural activities<br>▪ Camps on Country<br>▪ School-based counselling programs<br>▪ Physical health and sporting group interventions<br>▪ Clinical and peer-based support services.<br>• The initiative is funded through Towards Zero Suicides and NSW Closing the Gap. |
| [redacted] | | |

Ms Helen Wodak
Deputy Ombudsman, Monitoring and Review
NSW Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

Email: [redacted]

**Re: Child death-related recommendation (TfNSW Ref: SER23/02941, OTS23/02756)**

18 July 2023

Dear Ms Wodak,

Thank you for your correspondence of 20 June 2023 (ref: ADM/2022/694) to the Acting Secretary, seeking a response to the NSW Child Death Review Team recommendation made in the Biennial report of the deaths of children in NSW: 2016 and 2017. It was recommended that Transport for NSW 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.

Since our last update, Transport for NSW engaged the George Institute for Global Health to conduct the study of child restraint practices in rural and remote areas of NSW, with the contract for service provision executed in December 2022. The George Institute team includes the same academic researchers who conducted the study in metro areas, led by Professor Julie Brown who has moved to the George Institute from Neuroscience Research Australia (NeuRA).

The new study of child restraint practices in rural and remote areas has required new methods for data collection and experienced unexpected delays. Approval to collect data from schools was not received due to restrictions imposed during COVID-19. A new approach to data collection was trialled and found to be successful, involving recruitment at alternative community locations and linked to provision of child restraint fitting services. Furthermore, data collection in remote and very remote Local Government Areas (LGAs) has been found to require a tailored, community-specific approach. An Aboriginal Reference Group is being formed to coordinate this and the first draft Terms of Reference for this group is under review by the Guuna-maana team at the George Institute.

As at June 2023, data collection is ongoing and has been completed in one of 10 randomly selected rural and remote LGAs. The new timeline for the study, incorporating the delays, estimates data collection will be completed in March 2024.

Yours sincerely

**Sally Webb**
Deputy Secretary
Safety, Environment and Regulation
[redacted]

NSW GOVERNMENT | Education

Ms Helen Wodak
Deputy Ombudsman, Monitoring and Review
Ombudsman New South Wales
Level 24, 580 George Street
SYDNEY NSW 2000

Email: c/-[redacted]

DGL23/317

Dear Ms Wodak

I write in response to your letter of 20 June 2023, regarding your monitoring of the recommendation made in the Biennial report of the deaths of children in NSW: 2016 and 2017, published in June 2019 that the Department of Education establish a process of review after the suicide death of a child or young person in a government school.

In 2023, the department established a process that will occur after the suicide death of a student in a government school. This process is referred to as a Postvention Follow-Up. The process is overseen by a multidisciplinary team of representatives from across the department, the Postvention Advisory Group. The process provides an opportunity to learn about what is working well and considers potential systems improvements in policy and/or practice.

The Postvention Follow-Up process has been implemented. It seeks to understand the young person's interaction with education at a systems level, as one facet of their social and emotional life. It involves a desktop review of documentation and opportunities for guided conversations with key staff.

The postvention follow-up process is led by one of the eight Psychology and Wellbeing Coordinators who compile a report of the key learnings for the Postvention Advisory Group. The Postvention Advisory Group considers these key learnings and emerging trends. This information is presented to the department's Child Protection Executive Directors Group at their quarterly meetings for their consideration of any policy and/or practice enhancements.

The department is committed to supporting government schools in our collective child protection and suicide prevention and postvention work.

If further information is required, you may contact Ms Anne Reddie, Director, Child Wellbeing and Mental Health Services, by email at [redacted] or by telephone on [redacted]

Yours sincerely

[redacted]

Murat Dizdar
**SECRETARY**
**DEPARTMENT OF EDUCATION**
17 July 2023

**Department of Customer Service**
Office of the Secretary

Our reference: COR-03433-2023
Your reference: ADM/2022/694 ADM/2022/694
Date: 19/09/23

**Ms Helen Wodak**
**Deputy Ombudsman, Monitoring & Review**
**Ombudsman NSW**
via email: [redacted]
Cc: [redacted]

Re: Recommendation regarding swimming pool regulation

Dear Ms Wodak

Thank you for your correspondence seeking advice in relation to the recommendation made in the Biennial report of the deaths of children in NSW: 2018 and 2019, published in August 2021 concerning swimming pool regulation.

I would like to start by thanking the NSW Ombudsman for your continued engagement on this matter and your support in assisting to progress these items. I would also like to pass on my staff's appreciation of the collaborative approach your office has taken.

It is my understanding that the Department of Customer Service has met its commitment to the NSW Ombudsman by enabling reporting of compliance data relating to the key aspects of swimming pool regulation, including the reasons pool barriers fail inspections, and whether non-compliance's were rectified by owners within reasonable timeframes, without the need to update the current Swimming Pool Register and can provide this data on an ongoing basis.

The Department of Customer Service has concerns in relation to being responsible for publication of the data as it does not have accountability for the regulation of swimming pool barriers, own the data that is to be published or have powers to compel the production of the data under the *Swimming Pools Act 1992*. The Department of Customer Service consider the responsibility for publishing the data would better sit with Local Government NSW as the regulator for pool barriers in NSW.

Representatives from the Better Regulation Division have reviewed the summary of the advice provided and provided some minor comments for your consideration (see enclosed document).



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Prior to publishing, I would like to understand if the Child Death Review Team will assess whether the intent of the recommendation has been met by the Department, and decide whether the recommendation should be closed, amended, or continue to be monitored.

Thank you for the opportunity to provide further advice prior to tabling in the report.

Should your staff have any further queries, please contact Gavin Blatchford, Manager Risk, Better Regulation Division on [redacted] or by email at [redacted].

Sincerely,

[redacted]

Emma Hogan
Secretary

Enc. Comments on the Summary of Advice.



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**CDRT recommendation on reporting data from the Swimming Pool Register NSW Ombudsman summary of advice.**

| Recommendation | Summary of advice to date | Next steps |
|---|---|---|
| **Recommendation 3, Biennial report of the deaths of children in NSW: 2018 and 2019**<br>The Department of Customer Service, in its planned upgrade of the Swimming Pool Register (the **Register**), ensure its collection and reporting capability allows for public amalgamated reporting of compliance data relating to the key aspects of swimming pool regulation, including the reasons pool barriers fail inspections, and whether non-compliances were rectified by owners within reasonable timeframes. | DCS supported the recommendation.<br><br>In July 2022, DCS advised that the enhanced amalgamated reporting capability of the Register is expected to be operational by December 2022.<br><br>In October 2022, the CDRT reported that it would continue to monitor the recommendation.<br><br>In June 2023, DCS provided an advance copy of compliance data extracted from the Register for 2021 that it intends to publish. DCS further advised that the funding of the program to upgrade/rebuild the Register will be considered by its Finance Committee in June 2023. As an interim measure, DCS requested confirmation that:<br>• the data provided met the CDRT's recommendation for amalgamated reporting of compliance data, and<br>• the data can be provided annually via request for publication until the new Register is built.<br><br>DCS also sought advice about how the compliance data should be published within the new Register.<br><br>NSW Ombudsman staff met with DCS staff on 4 July 2023 about the recommendation and received further advice from DCS following the meeting.<br><br>DCS outlined the separate legislative requirements to include information in the Register and in local council annual reports. DCS provided the fields in the Register and advised that it is responsible for the maintenance and operation of the Register, and local councils for the collection and entry of information onto the Register.<br><br>DCS advised that a pool's compliance with barrier requirements is evidenced through certificates of compliance, which are generated through the Register, and occupation certificates, which are not recorded on the Register.<br><br>All compliance and non-compliance certificates are generated through the Register and available on the Register. Non-compliance certificates contain the date of the certificate, the address of the property on which the pool is located, the date of the inspection, the Australian Standard the pool was inspected against, the reasons for non-compliance, the steps to be taken to ensure it is compliant, and whether the pool poses a significant risk to public safety. | The CDRT requests written confirmation of the advice provided to date and any further comment on the recommendation by 1 September 2023. |

**CDRT recommendation on reporting data from the Swimming Pool Register NSW Ombudsman summary of advice.**

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| | DCS advised it manually filtered the information in the Register to provide the advance copy of compliance data for 2021, being the data requested in the CDRT's recommendation made in 2016 (the number of pools registered, the number of pools inspected, the proportion of inspected pools that were deemed non-compliant with the *Swimming Pools Act 1992* at the time of inspection, the main defects identified at the time of inspection, and whether or not owners rectified defects within a reasonable period of time).<br><br>DCS advised that it could provide the CDRT with this information in this format annually without a system upgrade. However, it raised concerns about being responsible for publication of this data. | |