Ombudsman
New South Wales

NSW Child Death Review Team Annual Report 2023-24

31 October 2024

Pursuing fairness for
the people of NSW.

Ombudsman
New South Wales

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We acknowledge the traditional custodians of the land on which we work and pay our respects to all Elders past and present, and to the children of today who are the Elders of the future.

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31 October 2024

The Hon Ben Franklin MLC	The Hon Greg Piper MP
President	Speaker
Legislative Council	Legislative Assembly
Parliament House	Parliament House
Sydney NSW 2000	Sydney NSW 2000

Dear Mr President and Mr Speaker

NSW Child Death Review Team Annual Report 2023-24

As Convenor of the NSW Child Death Review Team (CDRT), I present the NSW Child Death Review Team Annual Report 2023-24 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 2023 to 30 June 2024.

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 CDRT research projects.
- 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, member 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 2024

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

Ms Vanessa Chan
Director, Criminal Law Specialist, Policy and Reform Branch
Department of Communities and Justice

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

Dr Matthew O'Meara
Senior Staff Specialist Paediatric Emergency Medicine
Sydney Children's Hospital Randwick

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

Representative of the Office of the NSW State Coroner (vacant)

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 AM (Deputy Convenor)[1]
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 Ilan Katz
Professor Social Policy Research Centre
University of New South Wales

Dr Lorraine du Toit-Prinsloo
Chief Forensic Pathologist and Clinical Director
Forensic Medicine Newcastle
Forensic and Analytical Science Services
NSW Health Pathology

[1] Professor Clapham has stepped aside from the position of Deputy Convenor until the conclusion of the Review of the suicide deaths of Aboriginal children and young people.

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 2023-24 include:

- 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
- 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
- Ms Amy Vincent-Pennisi, Coordinator, Coronial Information and Support Program, Office of the NSW State Coroner
- 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 (known as 'reviewable' child deaths).

2.1 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 2023-24 period, this unit comprised 20 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[2] and the Act.

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

2.2 CDRT Charter and Code of Conduct

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

These documents 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's vision and purpose are further expressed through its strategic priorities.

2.3 CDRT Research Framework

In 2024, a framework for managing the CDRT's research functions was developed.[3] The framework guides the prioritisation, delivery and communication of research projects; ensures the CDRT's approach to research is consistent, equitable and inclusive; supports collaboration with stakeholders; and aligns research projects with the CDRT's Strategic Priorities and the NSW Ombudsman's Strategic Plan.

2.4 Meetings of the CDRT

The CDRT met formally on five occasions in 2023-24: August 2023, September 2023, November 2023, February 2024, and May 2024. All the meetings were held via an online platform. An attendance table is at Appendix 2.

2.5 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 2022-2025* and on 9 May 2023, the CDRT endorsed an action plan to implement these priorities. The plan, and progress against actions, is included at Appendix 1.

[3] The endorsed Research Framework is now available on the NSW Ombudsman website.

2.6 CDRT Member survey

In December 2023, the NSW Ombudsman conducted an annual governance survey of CDRT members and expert advisers. The confidential survey sought feedback about their views and experiences of CDRT meetings, NSW Ombudsman secretariat support and the CDRT composition over the calendar year. Consolidated results of the survey were provided to and discussed at the February CDRT meeting. Results indicated that secretariat support is a continuing strength. Members expressed a desire for increased contribution to projects and additional clarity in project updates. Members supported maintaining a breadth of experience, qualifications and expertise among independent representatives.

2.7 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 2023-24.
- The **biennial child death review report** (section 34G), which consists of data collected and analysed in relation to child deaths. The CDRT biennial report and the Ombudsman biennial report of reviewable child deaths were combined as one report for deaths that occurred during the period 2016-2019. However, in 2023 the two biennial reports (of deaths that occurred in 2020-2021) were presented as separate reports. The focus of both functions is to help prevent the deaths of children.

  The CDRT's next biennial report, covering deaths of children in NSW that occurred in 2022 and 2023, will be tabled in Parliament in 2025.
- **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

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 the deaths of children in New South Wales: 2020 and 2021* was tabled in Parliament on 27 November 2023. A summary of the report is presented below.

The CDRT's next biennial report, concerning the deaths of children in 2022 and 2023, will be tabled in 2025.

3.1.1 Biennial report of child deaths in 2020 and 2021: summary

The report (available on the NSW Ombudsman's website) concerns the deaths of the 950 children who died in NSW in 2020 and 2021. It examines underlying factors that may have contributed to preventable deaths, and where possible seeks to identify actions that can and should be done to prevent or reduce the deaths of children in NSW in future. It also provides information about trends in child mortality over time.

The report contains detailed information on each of the primary reporting categories (by cause or classification), definitions of terms used, and additional explanatory information.

A summary of the report is as follows:

Overview of child deaths

Infant and child death rates in NSW continue to decline overall.

During the 15-year period 2007-2021, infant and child death rates declined – infant mortality decreased by 28% from 3.9 to 2.8 deaths per 1,000 live births, and child (ages 1-17) mortality declined by 24% from 15.1 to 11.5 deaths per 100,000 children. These declines are broadly consistent with trends across Australia and are evident in both natural and most, but not all, external causes of death.

However, there are inequalities in mortality between some infants and children. Despite the overall decline and positive evidence of improvements in some areas, certain groups of infants and children continue to be over-represented in deaths in NSW, including:

- males
- Aboriginal and Torres Strait Islander children
- those living in regional and remote areas of the state
- those from the most disadvantaged areas.

Young people aged 15-17 years, and children from families with a child protection history are also overrepresented in deaths.

Cause of death trends differ for infants and children. The overwhelming majority (85%) of infants died from natural causes, whereas for children aged 1-17 years, 51% of deaths were due to natural causes. Conversely, external (injury-related) deaths were more common for children aged 1-17 years (42%) than infants (4%).

Infants (children aged less than 1)

In 2020 and 2021, 570 infants died (60% of all child deaths), corresponding to a death rate of 2.9 deaths per 1,000 live births.

Most infant deaths were due to natural causes (486 of 570, 85%) and occurred in the first month of life (417, 73%). Other infant deaths were due to external causes (4%), were undetermined (5%), or are still under investigation (5%).

Over the 15-year period 2007-2021, Aboriginal and Torres Strait Islander infants have had a higher death rate than non-Indigenous infants. However, the gap in death rates between Indigenous and non-Indigenous infants has narrowed. While infant deaths rates have declined for both groups, the rate for Indigenous infants has declined at a faster rate that the decline for non-Indigenous infants. There has also been a narrowing of the gap in the death rates between infants living in the least and most disadvantaged areas due to the decline in rates for infants living in the most disadvantaged areas.

Children aged 1-17 years

In 2020 and 2021, 380 children aged 1-17 years died (40% of all child deaths), corresponding to a death rate of 11.3 deaths per 100,000 children.

Just over half (193, 51%) of these children died from natural causes, with most of the other deaths occurring due to external (injury-related) causes.

Over the 15-years 2007-2021, the death rate for young people aged 15-17 years was higher than the rate for any other children aged 1-17. The death rate for children living in the most disadvantaged areas of the state was also disproportionately higher than for those living in other areas. While there was a decline in the rate for children living in the most disadvantaged areas of the state, this decline did not result in a narrowing of the gap between most and least disadvantaged over the period.

While there has been an overall decline in mortality for children aged 1-17, this decline is due to an improvement in the death rate for children aged 1-4 and 5-9. Rates for older children aged 10-14 and 15-17 years have remained similar (no significant change) over the period.

Leading causes of death

In 2020-2021, the leading cause of death differed by age:

- For infants, the leading cause of death was perinatal conditions (including prematurity).
- For children aged 1-9 years, the leading cause of death was cancer.
- For children and young people aged 10-17 years, the leading cause was suicide.

Over the 15 years 2007-2021, the five leading causes of death have remained similar, but with different rankings over the period.

Suicide and transport remain prominent among leading causes of death for children and young people aged 10-17 years. Unlike other causes of death, the rate of suicide has increased in NSW over the past 15 years, and in 2020-2021 overtook transport as the leading cause of death due to external (injury) causes for children and young people aged 10-17 years.

Causes of death

All natural causes

In 2020 and 2021, 679 children died from natural causes in NSW. Nearly three-quarters (72%, 486) of these deaths were infants under 1, with most (417) of the infants aged 0-4 weeks. The main causes of death are perinatal conditions (including prematurity) and congenital abnormalities or disorders.

For children aged 1-17, cancers, diseases of the nervous system and congenital anomalies account for most natural cause deaths.

Natural cause death rates continue to decline. Over the 15-year period 2007-2021, the death rate for natural causes declined by 28% from 26.8 to 19.3 deaths per 100,000 children aged 0-17 years.

During this 15-year period, Aboriginal and Torres Strait Islander children had a higher natural cause death rate than non-Indigenous children, with no improvement in the gap between Indigenous and non-Indigenous children.

Infants and children living in the most disadvantaged areas also had a higher death rate. However, over the 15-year period there has been some narrowing (improvement) in the gap between infants living in the most and least disadvantaged areas, but not for children aged 1-17 years.

All external causes (injury-related deaths)

In 2020 and 2021, 180 children died from external causes in NSW, accounting for almost 1-in-5 of all child deaths. Most of these deaths (109, 61%) were unintentional (accidental) injuries, while others (71, 39%) were due to suicide or homicide. In the 2-year period, suicide surpassed transport as the leading cause of death of children from injury for the first time.

External cause child deaths are the 'tip of the iceberg' for childhood injury. However, while rates of hospitalisation due to injury increased over the 15-year period 2007-2021,[4] external cause deaths declined overall by 29%. However, declines in external cause deaths are not uniform across all groups of children or causes.

Young people aged 15-17 years have the highest rate of external cause death of any age group. Other groups with higher injury-related death rates include Aboriginal and Torres Strait Islander children, those living in regional and remote areas of the state, and those living in the most disadvantaged areas. Children with a child protection history are also over-represented in injury-related causes of death.

Suicide is the only external cause of death that has increased over the 15-year period.

Transport

In 2020 and 2021, 57 children died in transport-related incidents. Of these children, 39% were pedestrians, 33% were passengers, and 26% were drivers. Transport fatalities were the second leading external cause of death in the 2 years.

Over the 15-year period 2007-2021, the transport death rate has declined by 43%, however most of this decline occurred before 2014, after which the rate has largely plateaued.

Some groups of children continue to be over-represented in transport-related fatalities, including males, young people aged 15-17 years, Aboriginal and Torres Strait Islander children, those living in regional and remote areas, and those from the most disadvantaged areas of the state.

In 2020 and 2021, 51 of the 57 children died in incidents where drivers were considered at-fault. Most (4 in 5) of these at-fault drivers were male, half were aged under 25 years, and half were never licenced, learners, or drivers on a provisional permit. Unsafe driver behaviours – such as speeding, driver alcohol and drug use, non-use of child restraints and protective equipment, and reckless driving – remain the key contributing factor in transport fatalities.

[4] Health Stats NSW, 'NSW Injury and poisoning hospitalisations by leading cause'. *Hospitalisations* (Web Page, 2021)

Drowning

In 2020 and 2021, 17 children drowned, including 6 children aged 0-4 years and 11 children aged 5-17 years.

The death rate for drowning has declined by 57% over the 15-year period 2007-2021, with this reduction mostly due to a decline in the rate of drowning among children aged 0-4 years.

Location of drowning varies by age. Over the 15-years 2007-2021, children under 5 most frequently drowned in private swimming pools, bathtubs and other bodies of water such as ponds. Older children and young people aged 5-17 years most frequently drowned in coastal locations and other natural bodies of water such as beaches, rivers, and lakes.

Factors identified as contributing to the deaths included (inadequate) supervision, access and barrier issues, environmental hazards, swimming ability, pre-existing medical conditions, and age and developmental stage.

Suicide

In 2020 and 2021, 58 children and young people aged 10-17 years died by suicide in NSW. Unlike other causes of death, the rate of suicide in NSW has not declined. Over the 15-year period 2007-2021, the rate of suicide among young people increased by 68%, from 2.2 in deaths per 100,000 children in 2007 to 3.7 in 2021. Most of this increase occurred before 2015, and the rate has remained high (with little variation) since that time.

No single factor or combination of factors can predict suicide. However, there are a range of recognised factors associated with suicide risk, including proximal events, individual factors, family and relationship breakdown, school-related challenges, and self-harm behaviours. The more risk factors a young person has in their life, the greater their risk of suicide. Some young people appear to be particularly vulnerable to suicide – Aboriginal and Torres Strait Islander children, those with poor access to mental health services, those with an eating disorder, and LGBTIQ+ young people.

Most of the young people who died by suicide had contact or engagement with mental health services prior to their death. Many also had contact with agencies or services other than those related to mental health support. Just over half (55%) of the young people who died from suicide were from families with a child protection history; 2-in-3 had reported risks that were related to the young person's mental health, self-harm, or risk of suicide. The increasing number of deaths of children and young people due to suicide in NSW sits within a wider context of increasing hospitalisations due to intentional self-harm.[5]

Homicide

In 2020 and 2021, 13 children died from assault-related injuries. Most (9) of these deaths occurred in the context of familial homicide; 4 deaths were the result of peer-related violence.

Factors vary for each individual circumstance but can include a background of family violence and relationships, parent mental health issues, alcohol and drug use, and peer violence. More than half (8) the 13 children who died from inflicted injuries were from families with a child protection history, with most (6) of these families the subject of a report screened as meeting the 'risk of significant

[5] Health Stats NSW, 'Intentional self-harm hospitalisations', *Hospitalisations* (Web Page, 2022)

harm' threshold. Cases of familial homicide highlight the need for coordination, communication, and collaboration between service providers, particularly for families experiencing vulnerability. Young people who died in the context of peer violence or affray were also often identified as having been vulnerable or 'at risk' adolescents.

Over the 15-year period 2007-2021, there was no change in the overall homicide rate. Rates have been generally higher for infants and children living in the most disadvantaged areas of the state.

Sudden Unexpected Death in Infancy (SUDI)

In 2020 and 2021, 75 infant deaths were classified as sudden and unexpected. Most of these deaths involved infants who were less than 4 months of age. Following investigation, cause of death was determined for 12 infants, remained unexplained (the investigation was not able to determine cause of death) for 47 deaths, or were not yet finalised (16 deaths).

Other than those infants whose deaths were determined to be due to natural causes (6) or due to abuse (2), the majority of infants who died had been exposed to at least one environmental (modifiable) risk, and most often more than one risk, including exposure to tobacco smoke, loose/soft bedding, and co-sleeping (intentionally or not) with a parent or carer.

Some groups are over-represented in SUDI, including Aboriginal and Torres Strait Islander families, those living in rural and remote areas, and those living in the most socioeconomically disadvantaged areas of the state. Families with a child protection history are also over-represented in SUDI. Interventions by frontline agencies need to focus on disadvantaged and vulnerable communities.

Monitoring previous recommendations

We continue to monitor agency progress in implementing some of our earlier recommendations.

NSW Child Death Review Team Annual Reports for 2020-21, 2021-22, and 2022-23 provide detailed information about the progress agencies have reported to us since our last biennial report was published in August 2021 in relation to CDRT recommendations.

These reports can be accessed here: CDRT Annual Reports - NSW Ombudsman.

3.2 Recommendations

Chapter 7 of this report includes detailed information from agencies about their actions to implement five recommendations currently being monitored by the CDRT. These five recommendations relate to SUDI prevention (3), road safety (1), and suicide prevention (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 2023-24

Infant deaths from severe perinatal brain injury in NSW, 2016-2019: key thematic observations

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 period.

The project aimed to better understand possible key contributory factors and identify opportunities for improved prevention through a preliminary case review. The project considered a range of factors such as infant characteristics; maternal characteristics; risk factors for fetal/newborn compromise; pregnancy, labour, and birth characteristics; maternal and newborn care; and pregnancy, pre- and post-death investigations.

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 was annexed to the Biennial report of the deaths of children in New South Wales: 2020 and 2021, tabled in November 2023. The key thematic areas with strong validity and consistency with the evidence-base were 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.

4.2 Research planned or underway in 2023-24

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 Register of Child Deaths 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 the 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 Peoples Health and Wellbeing Research Centre to conduct the research.

The project 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 preliminary unpublished work commissioned by the CDRT from the Sax Institute completed in 2021).

The substantive work of this project was completed in 2023-24. In 2024-25, the CDRT will consider the report from the project and prepare a public report.

Follow-up review of perinatal deaths from severe brain injury in NSW, 2020-2023

Preparatory work has commenced on a follow-up review of perinatal deaths from severe brain injury in 2020-2023, to build on the preliminary review of deaths in 2016-2019. Work undertaken includes a reflective practice session on the preliminary study, development of a learnings and mitigations table, and presentation of the proposed research to members. Further consultation on the draft research proposal with members and stakeholders will follow.

Preliminary review of suicide-related deaths among LGBTIQ+ young people

The proposal for a preliminary review of suicide-related deaths from 2018-2023 among young people aged 10-17 years who identified as LGBTIQ+ has been approved. The objectives of the project are to understand the specific risk factors that may have contributed to the deaths, (for example mental health issues, prior risk-taking behaviours or related behaviours) as well as the social contexts of the young people who died, identify protective factors and effective approaches to address suicide risks among the cohort, service contact prior to death, identify current support measures available for LGBTIQ+ young people as well as any gaps in the support provided, and to make any appropriate recommendations on prevention of future deaths.

The proposed methodology is to conduct a review of the relevant quantitative and qualitative data in the NSW Register of Child Deaths to identify key insights and potential opportunities, followed by a literature review of effective preventative measures, and a desktop review of countermeasures currently in place in NSW to support LGBTIQ+ young people.

A project plan will now be developed, followed by analysis of relevant data in the NSW Register of Child Deaths.

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

The Australia and New Zealand Child Death Review and Prevention 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 role of convening the group rotates among jurisdictions, and is currently held by the Queensland Family and Child Commission (QFCC).

The group's fourth 'virtual' annual conference was held on 14 May 2024. The conference offers a professional development opportunity for people working in child death prevention, registration, review, policy and research. Presentations included:

- **Suicide risks and prevention**:
  - Preschool predictors of early adolescent suicidality (Dr Joan Luby, Washington University School of Medicine (US))
  - Australian Youth Self-Harm Atlas: spatial modelling and mapping of self-harm prevalence to inform youth suicide prevention strategies (Dr Emily Hielscher, The University of Queensland)
- **Paediatric infection / clinical**:
  - Paediatric Sepsis Mortality Study (2004-2021) – findings and recommendations for practice improvement (Dr Rebecca Shipstone, QFCC, and Dr Paula Lister, Queensland Paediatric Sepsis Program, Children's Health Queensland)
  - Multi incident review of serious paediatric clinical incident reports in Queensland (Dr Sharon McAuley and Jodie Osborne, Queensland Paediatric Quality Council)
  - Genome testing in child death review and prevention (Dr Joanna Garstang, NHS Foundation Trust (UK))
- **Vicarious trauma in the workplace**: Understanding what it is, risk and protective factors, coping strategies, and benefits of having an individual Vicarious Trauma Wellness Plan (Aoife Sheils, Principal Corporate Psychologist)
- **A New Zealand Perspective**:
  - Family Violence Review Committee (NZ) – an ongoing duty to care, responding to survivors of family violence homicide (Kiri Matiatos, Family Violence Mortality Review)
  - The machinery of child death prevention, best practice for recommendations to be implemented (Dr Gabrielle McDonald, Otago University (NZ))

The group's annual Secretariat meeting was held on 21 May 2024, attended by the group's jurisdictional representatives. The meeting included updates on genetic testing and other research projects, presentations about emerging trends and focus topics by each jurisdiction, discussion about establishing a National Child Death Data Collection, and group priorities over the next 12 months.

6. Disclosure of information

6.1 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 2023-24, we provided the Coroners Court of NSW with individual case reviews and other information about the deaths of certain children, including deaths falling under section 24 of the *Coroners Act 2009* in 2023. We also provided information about recent CDRT recommendations about safe sleeping practices.
- In October 2023 we disclosed information relating to the death of a child to the Ombudsman to facilitate preliminary inquiries to the Department of Education under section 13AA of the *Ombudsman Act 1974*.
- In March 2024 we disclosed information to the NSW Police Force in relation to the death of a child.
- In March 2024 we disclosed information relating to the death of a child to the Ombudsman to facilitate preliminary inquiries to Central Coast Local Health District under section 13AA of the *Ombudsman Act 1974*.
- In June 2024 we disclosed information relating to the death of a child to the Ombudsman to facilitate preliminary inquiries to Hunter New England Local Health District under section 13AA of the *Ombudsman Act 1974*.

One type of disclosure under section 34L(1)(c) is 'giving effect to any agreement or other arrangement entered into under section 34D(3)' (section 34L(1)(c)(vi) of the Act). Section 34D(3) allows the Convenor to enter into an agreement or other arrangement for the exchange of information between the CDRT and a person or body having functions under the law of another State or Territory that are substantially 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 2023 and 30 June 2024:

- In July 2023, we provided Safer Care Victoria with data on the deaths of children in New South Wales during the 2021 and 2022 calendar years who were normally resident in Victoria, as well as data on deaths of infants (0-364 days old) in New South Wales, born in New South Wales to mothers normally resident in Victoria, during the 2021 and 2022 calendar years.
- In August 2023, 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 2018 and 31 December 2022 who were normally resident in the Northern Territory.
- In September 2023, we provided the ACT Child & Young People Death Review Committee with data on child deaths related to respiratory illnesses in New South Wales during the period 1 January 2021 to 31 December 2022.
- In October 2023, we provided the Queensland Family and Child Commission with 2021 New South Wales child death data for inclusion in the *Australian child death statistics 2021* report, prepared by the QFCC on behalf of the ANZCDR&PG.

- In January 2024, we provided the Queensland Family and Child Commission with data on child deaths related to caustic substances in New South Wales during the period 1 January 2004 to 31 December 2023.
- In January 2024, 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 2023 who were normally resident in the ACT.
- In February 2024, we provided the South Australia Child Death and Serious Injury Review Committee with data on deaths of children in New South Wales between 2018 and 2022 who were normally resident in South Australia.

7. CDRT recommendations

The CDRT can make recommendations aimed at preventing or reducing the likelihood of child deaths.

Recommendations can be for new or amended legislation, policies, practices, and services. They can be directed to government and non-government agencies, or to the community.

Under sections 34F(2)(b) and (3) of the Act, the CDRT annual report:

(a) must include details of the extent to which its previous recommendations have been accepted, and

(b) may comment on the extent to which those recommendations have been implemented in practice.

The CDRT recognises that in some cases it can take time for agencies to implement recommendations fully, and some recommended changes may be made incrementally.

Accordingly, as well as reporting on any new recommendations made during the reporting year, the CDRT also looks at any open recommendation from previous years, and decides and reports on whether:

- to ***close*** the recommendation on the basis that it is satisfied the recommendation has been substantially implemented or that the intent of the recommendation has otherwise been met
- to ***continue monitoring*** the recommendation, or
- to ***vary*** the recommendation or make a ***new*** recommendation to take account of progress to date or to reflect other developments since the original recommendation was made.

At the beginning of this reporting period there were five open CDRT recommendations. These relate to SUDI prevention, 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 (2024)
SUDI safe sleeping NSW Health should develop and implement strategies to promote safe infant sleep practices to vulnerable families. In particular, NSW Health should target: • In consultation with the Department of Family and Community Services, families known to child protection services • Families living in remote areas of the state, and • Families living in areas of greatest socio-economic disadvantage.	June 2019	NSW Health	Supported	To be closed – implemented
SUDI medical history That NSW Health complete a detailed audit of compliance with the revised SUDI medical history protocol. The audit should include information and analysis about: a. The number of infants presented to emergency departments following their sudden and unexpected death. b. The number of medical history interviews conducted in response to these deaths. c. An assessment of whether the intent of the Policy Directive has been met and is reflected in the information gathered.	August 2021	NSW Health	Supported	To be closed – implemented New recommendation made

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation (2024)
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.				
Infant illness NSW Health should undertake a campaign to promote resources (including fact sheets, websites, apps and phone lines) that aim to assist parents and carers to identify illness in infants. The campaign should focus on resources that are evidence-based and have been subject to evaluation.	June 2019	NSW Health	Supported	To be closed – implemented
Transport – child restraints and seatbelts	June 2019	Transport for NSW	Supported	To be closed – implemented

Recommendation	Date of recommendation	Agency responsible	Agency response to recommendation	CDRT monitoring of implementation (2024)
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: 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.				
Suicide – targeted prevention measures The NSW Government should include in any suicide prevention plan specific measures targeted to school-aged children and young people across the spectrum of need. In particular, this should include: **a.** *(element met and closed in 2020-22)* **b.** *(element met and closed in 2022-23)* **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	Continue monitoring

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,[6] 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,[7] and then hosted a meeting between both agencies to discuss opportunities 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[8], containing strategies for supporting families. NSW Health also published *Safe Sleeping Recommendations* guidance[9] and updated existing resources to reflect the revised Guideline.

[6] Now the Department of Communities and Justice

[7] 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

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

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

In August 2022, NSW Health advised that from 2021, the My Personal Health Record (Blue Book)[10] for babies, given to all parents of children born in NSW, included information and messaging about safe 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 focuses on the health and wellbeing of Aboriginal children, families, and communities.

In August and September 2023, NSW Health provided advice about key programs and supports, including SAFE START, Sustaining NSW Families (SNF), and Pregnancy Family Conferencing (PFC), the expansion of Aboriginal Child and Family Centres, and the Brighter Beginnings program. NSW Health further advised that its Child and Family Health team had engaged the Alcohol and Other Drugs branch to discuss how safe sleeping information can be incorporated into messaging for pregnant women.

On 28 May 2024, representatives from the NSW Ombudsman and NSW Health met to discuss progress.

NSW Health provided an update on the expansion of the PFC program, and detailed information about the delivery of safe sleep messaging as part of the clinical care offered to families assessed at each level of care, including universal care, early intervention/prevention services and targeted programs (SNF and PFC). Health also shared information on its work building trust in Aboriginal communities.

On 30 August 2024, NSW Health advised that:

- PFC has been operating in six metro Health/DCJ districts for some time. In 2022-23, the NSW Government committed to the expansion of PFC to nine rural and regional local health districts to make the program available statewide.
- Consistent safe sleep messaging will be incorporated into digital versions of the Blue Book, with appropriate messaging to be determined as the digitisation project progresses.
- The consumer *Safe Sleeping recommendations* flyer located on the NSW Health website is available to download in 21 community languages.[11]
- NSW Health is working with the Department of Customer Services (DCS) to review the DCS Parent and Carer Hub website to ensure consistent messaging about safe sleeping recommendations.[12] This messaging will be consistent in the Blue Book, and in the digital Blue Book (currently under development).

Has the intent of the recommendation been met?

NSW Health has advised that safe sleeping messages are communicated to all families through its universal care programs, in newborn care setting such as neonatal intensive care, special care nurseries and paediatric units, other health care settings such as Aboriginal Maternal and Infant Health Services, day stay and residential parenting services, and child and family health nurse clinic-based care and home visits. SNF delivers safe sleep messaging to families through its nurse-led home health visiting service; and PFC in partnership with DCJ facilitates the delivery of safe sleep

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

[11] NSW Health's Safe sleeping recommendations flyer can be accessed via its website: Safe sleeping recommendations flyer - Maternal and newborn (nsw.gov.au)

[12] Safe sleeping recommendations - First five years (nsw.gov.au)

messaging to vulnerable families to ensure a safe home environment through antenatal and postnatal services and child and family health care.

The CDRT acknowledges that NSW Health programs support families based on need, with tiered levels of support rather than targeting specific populations or groups (such as those referred to in the recommendation). The CDRT also notes families known to child protection services, those living in remote areas of the state, and families living in areas of greatest socioeconomic disadvantage can access support through the various programs and systems available. It is our understanding that safe sleeping messaging is and will continue to be an integral part of NSW Health early childhood programs.

Information available in the Blue Book, and on NSW Health's safe sleeping recommendations flyer and website advises families that the risk for their baby can be reduced by following safe sleeping recommendations every time a baby is placed for sleep.[13]

The CDRT has assessed that the intent of this recommendation has been substantially met, and that the recommendation can be closed. The impact and reach of Health's safe sleeping messaging, and the effectiveness of this messaging – particularly in vulnerable families – will continue to be assessed through our reviews of individual deaths.

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)*,[14] 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

[13] safe-sleep-flyer.pdf (nsw.gov.au)

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

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,[15] 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. 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 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, including 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. A SUDI audit report was being drafted, to be finalised in September 2023. NSW Health planned to discuss findings from the SUDI audit at the SUDI cross-agency working group meeting in September 2023.

In October 2023, NSW Health provided formal advice of the audit findings and outcomes. The audit found that compliance with the protocol in the PD2019_035 *Management of Sudden Unexpected Death in Infancy* was below expectations. The SUDI cross-agency working group considered the audit findings and agreed to review the Policy Directive. The review will consider options for increasing compliance with the current model, and will investigate the potential benefits and feasibility of other response models. The review was due to commence in July 2024, with a revised Policy Directive expected to be published by the end of 2024.

The CDRT considered the audit results at its February 2024 meeting and discussed the unique challenges of collecting an infant's medical history following a SUDI. The CDRT subsequently offered its support to the review of the Policy Directive. Health responded in May with a commitment to contact NSW Ombudsman staff to seek the CDRT's involvement in the coming months, once the plans for the review were finalised.

[15] 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)]

In August 2024 NSW Health advised that planning the review of the policy directive continues, and that the review will be undertaken in the second half of 2024.

Has the intent of the recommendation been met?

The audit results provided by NSW Health included information and analysis on elements a-g of the recommendation and is assessed as having been fulfilled. The recommendation will therefore be closed as met.

New recommendation

NSW Health has advised that the outcomes of its review of PD2019_035 *Management of Sudden Unexpected Death in Infancy* will inform any changes to its approach to collecting infant medical history following a death in the context of SUDI. Given the review of the policy has not yet commenced, the CDRT makes the following recommendation:

> NSW Health should review PD2019_035 *Management of Sudden Unexpected Death in Infancy,* having regard to the results of its audit of compliance with the revised SUDI medical history protocol completed in October 2023. As part of this review, NSW Health should consult with relevant stakeholders referred to in the Policy and the CDRT.

Recommendation: identification of illness in infants

> ***Recommendation 2, Biennial report of the deaths of children in New South Wales: 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 advised that it was 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 (including a fact sheet on signs of serious illness in children) 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 2022, NSW Health advised it had begun updating and strengthening existing resources and had scoped a campaign for parents about infant and child health and wellbeing. Health advised that messaging about recognition of a sick child featured in recent communications relating to COVID-19 and respiratory illnesses, and that messaging and resources were available through various sources such as the Blue Book and Healthdirect, Raising Children and children's hospital network websites. At a meeting of representatives from the NSW Ombudsman and NSW Health in December 2022, NSW Health provided advice about the development of a digital version of the Blue Book and revisions to its website to improve visibility of resources.

In 2023, NSW Health shared initial data about use of the Healthdirect phone line and provided further advice about its review and digitisation of the Blue Book, including an online survey for parents, carers and clinicians and consultation with a range of focus groups.

On 5 June 2024, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation, and on 30 August 2024, NSW Health provided formal advice of its progress. NSW Health noted the Blue Book digitisation project had been amalgamated with a new single digital patient record (SDPR) project. The SDPR project is developing a single patient record accessible electronically by all local health districts in NSW that will allow users to contribute digital medical records for a patient starting from before birth, including information that would have been provided through the digital Blue Book such as early childhood nurse checks. Development of content for the digitised Blue Book continues and will include a prominent '*Urgent actions in emergencies'* section for parents/carers. The timeline for commencement of the amalgamated project is now late 2026-27. Health confirmed that the paper (hard copy) Blue Book will continue to be available so that families relying on it would not experience any disadvantage.

The practice of translating key resources into languages other than English continues, including new *Building Brains and Bodies* videos promoted through social media and in waiting rooms.

Health also continues to expand and connect its online and hard copy resources. The hard copy *Signs of serious illness in Children* fact sheet now uses QR codes to link to the Sydney Children's Hospital Network Kids health hub page, containing guidance on looking after a sick child at home and when to come to the emergency department, as well as links to the virtualKIDS and Healthdirect websites. Healthdirect is promoted on the NSW Government's Newborn: birth to 3 months page,[16] and the NSW Government/NSW Health Pregnancy and the first five years page.[17]

VirtualKIDS has been available since December 2023, offering a 24/7 virtual triage by a senior paediatric nurse, who provides a direct handover for families to the most appropriate health service via phone, video conferencing or remote monitoring. For all families that contact the virtualKIDS urgent care service, Sydney Children's Hospital Network also send a link to their fact sheet that relates to the issue that the call was about (e.g. fever or vomiting), as well as a link to the fact sheet about recognising a deteriorating child. In May 2024, virtualKIDS received 1156 referrals from

[16] NSW Government, *Newborn: birth to 3 months*

[17] NSW Government/NSW Health, *Pregnancy and the first five years*

Healthdirect, up from 1097 in April 2024, with referrals being widespread across the state and including 30% from rural LHDs.

In addition, Sydney Children's Hospital Network hospitals now send a text to families who have attended an emergency department and left without being seen which links to all the Sydney Children's Hospital Network's illness fact sheets. A one-page information sheet with QR codes linking to the same fact sheets, available in translated versions, is also available in emergency departments.

A NSW Government information campaign about sepsis has disseminated information to clinicians on how to identify a deteriorating child,[18] and to parents and carers about the signs of sepsis in different aged children and encouraging them to seek urgent medical attention.[19]

Has the intent of the recommendation been met?

The CDRT notes work underway in relation to the single digital patient record and digitised Blue Book projects, which it expects will be valuable resources for parents and clinicians in the identification and treatment of illness in infants and children when complete. We also acknowledge the variety of resources in various formats (internet, hard-copy, and telephone) available to parents and carers to assist them to identify and appropriately respond to signs of illness in their children.

While these resources do not comprise a specific campaign, their content appears to be reasonably comprehensive and they utilise a variety of mediums intended to maximise their reach, including to groups who do not speak English as a first language. The CDRT would welcome on-going efforts to evaluate the impact, effectiveness and reach of these resources. However, based on the advice provided, the CDRT has assessed that the intent of this recommendation has been substantially met.

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, the CDRT released a report detailing its findings from a review of the deaths of 66 children who died as passengers in NSW during the period 2007-2016.[20] 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:

[18] NSW Government/Clinical Excellence Commission, *Sepsis: Education*

[19] NSW Government/NSW Health, *Sepsis fact sheet*

[20] 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.

- 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. In July 2022, TfNSW advised that the new study 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 (George Institute) had been engaged to conduct the new study of child restraint practices in rural and remote areas. The study has required new methods for data collection, including tailored and community specific approaches in remote and very remote LGAs. An Aboriginal Reference Group was formed to coordinate this approach, with the Terms of Reference under review by the Guuna-maana team at the George Institute. TfNSW estimated a revised completion date for the study of March 2024.

On 19 July 2024, TfNSW advised that the George Institute had completed the new study and provided us with a summary of the review. The CDRT sought a full report of the findings of the 2024 study which was provided to the CDRT on 6 September 2024. The study compared the findings of the current study with previous observations of child restraint practices recorded in 2008, prior to the introduction of legislation mandating age-appropriate child restraint use for children up to age seven.

The study distinguishes between appropriate restraint use[21] and optimal restraint use.[22] Statewide, 98% of children aged 0-12 years were using restraints appropriate for their age, compared to 48.8% in 2008. 56% of children were optimally restrained, compared to 25% in 2008. However, 65.5% had a restraint error of some kind in the current study compared to 51.4% in 2008; and 40.7% had at least one serious error in the current study compared with 38.3% in 2008. In summary, there has been a substantial increase in appropriate restraint use, but no improvement in rates of correct use. The report mentions the 'shift into more dedicated child restraint systems with more complex designs'[23] may be a factor in this result.

No significant differences in restraint practices were observed among children living in different geographical areas of NSW (metropolitan, inner regional, outer regional, remote and very remote), noting a tendency to more inappropriate restraint usage outside of metropolitan areas, and errors likely to negatively impact crash protection being twice as likely in regional areas than greater

[21] An age-appropriate restraint is in use.

[22] Correct use of an appropriate restraint.

[23] The George Institute for Global Health (2024) *Child restraint practices in NSW – 30th July, 2024*, p.20

metropolitan areas. The report notes that the results 'do not indicate a substantial difference in restraint practices in regional NSW compared to metropolitan areas. However, they do clearly indicate a need for efforts to reduce rates of incorrect use to be extended into regional areas.'[24]

There were significant differences in restraint practices across different areas of relative socioeconomic disadvantage. Children in the most disadvantaged areas were greater than six times more likely to have serious errors in restraint use than those in least disadvantaged areas, and children in least disadvantaged areas were greater than seven times more likely to be optimally restrained than those in the most disadvantaged areas.[25] The report notes that this 'indicates a stark disparity in child restraint practices and an urgent need for targeted action to improve restraint practices in these areas.'[26]

In response to the study's findings, TfNSW has advised that it will:

- widely share the findings of the research with relevant stakeholders and update all child restraint communications and education campaigns to reflect the data
- review messaging and appropriate interventions to support improvement of restraint practices in outer regional areas and areas of socio-economic disadvantage, and
- review implications for its scheme of authorised child restraint fitting stations.

Has the intent of the recommendation been met?

The CDRT acknowledges efforts by TfNSW to complete this work. It is useful to understand the relative similarity in restraint practices across geographic areas of NSW, and the improvement in appropriate restraint use over the past decade is positive. However, the increase in errors in restraint use (and the persistence of serious errors), and notable disparity in both appropriate and optimal restraint usage between areas of least and most socioeconomic disadvantage, is concerning.

The CDRT welcomes TfNSW's intention to update its child restraint communications and education campaigns to incorporate the study findings, review its messaging to support improvements to restraint practices in outer regional areas and areas of socio-economic disadvantage, and review implications for the authorised child restraint fitting stations scheme. The CDRT will seek information from TfNSW on the progress of this work while preparing its next biennial report (*Biennial report of the deaths of children in New South Wales: 2022 and 2023).*[27]

The CDRT will also seek TfNSW's response to the George Institute's suggestion to implement the *Buckle Up Safely* program piloted in 2010.[28]

The data collected provides a nuanced picture of the differences in child restraint use in different geographic and socioeconomic areas in NSW, and the comparison with 2008 data allows trends in use over time to be understood. The CDRT considers that its recommendation has been substantially implemented and can be closed.

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[24] The George Institute for Global Health (2024) *Child restraint practices in NSW – 30th July, 2024*, p.18

[25] Serious errors include a harness or buckle not being used/engaged correctly, a slack harness, the arms of the child not being within the harness, and a carrier not being correctly engaged with the base. A serious error is likely to cause a negative impact on crash protection, based on crash testing.

[26] The George Institute for Global Health (2024) *Child restraint practices in NSW – 30th July, 2024*, p.2

[27] This report is due to be tabled in 2025.

[28] The Buckle Up Safely program involved education sessions by Macquarie University with preschool centre staff to see optimal restraint principles embedded in curriculum and policies at centres, an education pack and information sessions for parents, vouchers for free restraint fitting checks, and some subsidised restraints for families most in need.

Recommendation: 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. *(element met and closed)*

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.

Why the recommendation was 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)[29] 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 the recommendation.

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 the NSW Government continues to deliver the *Got It!* and Aboriginal *Got It!* programs in schools. The government was also establishing 25 Safeguards Teams across NSW to provide care to children and adolescents experiencing acute mental health distress. A new pilot Youth Aftercare Pilot (YAP) program (branded "i.am") would provide community-based support to children and young people at high risk in selected areas until June 2023. NSW Health noted other *Towards Zero Suicides* strategies and initiatives focused on connecting suicide

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

prevention planning to child and youth specific needs, including Zero Suicides in Care, Suicide Prevention Outreach Teams, and 11 Safe Havens.

On 18 July 2023, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation. NSW Health provided information about new initiatives co-funded under the National Mental Health and Suicide Prevention Agreement and Bilateral Agreement between NSW and the Commonwealth (both agreed in 2022), the development of an Out of Home Care Mental Health Framework to ensure appropriate mental health services for children in care, as well as updates on existing programs and infrastructure.

On 1 September 2023, NSW Health provided written advice about its progress, including details about the new teen *Got It!* program, the extended Project Air Schools initiative, Head to Health Kids Hubs, implementation of the Enhancement and Integration of Youth Mental Health Services Initiative, Youth Community Living Support Services, and other existing programs.

On 17 June 2024, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation, as well as recent media on mental health care for adolescents, including reports of shortages of beds and psychiatrists and increasing presentations. NSW Health advised about initiatives including:

- funding commitments in the NSW state and Federal budgets for mental health care
- a gap analysis on community mental health services conducted by the NSW Mental Health Minister (December 2023),[30] to be followed by in-depth service mapping
- the June 2024 report of the NSW Parliament Legislative Council inquiry into equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW,[31] to which Health will respond, and
- other programs aimed at addressing identified issues in the mental health care sector such as a revised psychiatry workforce plan and the federal government's National Mental Health Workforce Strategy 2022-2023.

The gap analysis report identified children and young people as a vulnerable priority group due to experiencing significant inequities in accessing community mental health services. The report noted that since June 2020, approximately $22 million in annual funding for assertive community care has been directed to vulnerable priority groups as a whole, but also that access to specialist services for these groups is not always equitable within and between Local Health Districts.[32] The report noted feedback from Local Health Districts of the importance of increased funding and upskilling for Community Mental Health Teams including those delivering child, adolescent and youth services.[33] The report's glossary provided high-level information about Whole of Family Teams, providing specialist in-home and community-based interventions for children and families with complex mental health and/or drug and alcohol issues where the children have been identified by DCJ as at risk of significant harm.[34]

[30] The Hon. Rose Jackson, MLC

[31] Report No. 64 - PC2 - Equity, accessibility and appropriate delivery of outpatient and community mental health care in NSW

[32] NSW Ministry of Health (2023) *NSW Community Mental Health Services Priority Issues Paper*, published December 2023, pp.11-12

[33] NSW Ministry of Health (2023) *NSW Community Mental Health Services Priority Issues Paper*, published December 2023, pp.8-9

[34] NSW Ministry of Health (2023) *NSW Community Mental Health Services Priority Issues Paper*, published December 2023, p.xviii

On 30 August 2024, NSW Health provided formal advice of its progress. It reiterated the role of Safeguards teams in assessing and linking patients with appropriate longer term care services such as CAMHS, private practice clinicians, psychosocial support services, and housing and education, and noted the key role that CAMHS plays in the provision of sustained mental health support for young people. They advised Safeguards teams are required to employ an Aboriginal mental health worker to target the Aboriginal population and facilitate their access to the service. They advised of the recurrent funding provided to CAMHS, the Safeguards teams and to Youth Community Living Support Services, which support young people recovering from severe and complex mental illness.

They provided further information about the Out of Home Care Mental Health Framework developed in partnership with DCJ and it's three strategic priorities of improving collaboration between Health and DCJ staff, integrated assessment and early intervention, and enhancing staff skills to respond to the mental health needs of children in out of home care. The Framework is due to be released December 2024.

Some new mental health initiatives were outlined:

- CICADA,[35] a specialty alcohol and other drugs service run by the Sydney Children's Hospitals Network providing consultation for treating mental health clinicians
- ACACIA,[36] an alcohol and other drugs service in the Northern Sydney Local Health District staffed with a child and adolescent psychiatrist, and
- Sydney Children's Hospitals Network Mental Health and Intellectual Disability Hub, providing comprehensive assessment and short-term support from specialised clinicians for children with intellectual or developmental disability.

NSW Health also highlighted other suicide prevention work:

- funding from the Bilateral Agreement for each Primary Health Network to continue Community Collaboratives, initiatives that assist communities impacted by suicide to develop Incident Communication Protocols and postvention, recovery and prevention strategies including training
- consultation about a Suicide Prevention Act with the release of the NSW Suicide Prevention Legislation Discussion Paper in June 2024. The new legislation will be aimed at increasing government accountability for suicide prevention and is expected to be introduced into NSW Parliament in mid-2025, and
- a suicide prevention forum targeting young men held at Parliament House on 5 August 2024.

Has the intent of the recommendation been met?

The CDRT acknowledges NSW Health's continued endeavours to enhance child and adolescent mental health services and that its programs and initiatives provide a foundation for targeted, sustained and intensive therapeutic support to young people at high risk of suicide.

CAMHS is the core NSW Health service providing comprehensive, needs-based specialist care to children and young people at high risk and with complex, ongoing mental health needs, noting that eligible psychosocial disabilities may be funded by the NDIS and provided by private community health care providers. It is encouraging that CAMHS, the Safeguards teams and Youth Community

[35] CICADA Centre NSW

[36] Royal North Shore Hospital Drug and Alcohol Service (including ACACIA)

Living Support Services are receiving recurrent NSW Health funding. It is also encouraging that Health has a range of mental health care initiatives targeted at children in out of home care, Aboriginal children, children with disabilities and who use alcohol and other drugs.

However, we note the gap analysis identified the challenges for children and young people in accessing community mental health services, the increasing need and demand for the provision of mental health care for young people,[37] and that the qualification timeframes for specialists means that the required workforce will take years to build. The CDRT will continue to monitor this recommendation noting that over the next 12 months, the Government will be conducting service mapping, responding to the community mental health services gap analysis and NSW Parliament Legislative Council inquiry.

7.3 New recommendations

The CDRT did not make any new recommendations during the 2023-24 reporting year. The CDRT has made one new recommendation in this report.

[37] NSW Ministry of Health (2023) *NSW Community Mental Health Services Priority Issues Paper*, published December 2023: see data on increased community mental health patients and service contacts over the last 10 years, p.viii, data on increasing mental health related presentations to emergency departments, p. 25; NSW CDRT (2023) *Biennial report of the deaths of children in New South Wales: 2020 and 2021*, published November 2023: see data on increasing suicide deaths of children and young people and intentional self-harm hospitalisations, p.108; Sydney Morning Herald (2024) *Children in adult wards, 27-hour emergency waits: the mental health crisis in NSW*, published 10 March 2024: see reporting on rising demand for adolescent mental health care in NSW.

Appendix 1: CDRT Strategic Priorities 2022-2025

The CDRT agreed upon its Strategic Priorities 2022-2025 in February 2022 and developed an Action Plan setting out actions and associated tasks for the three-year period against the strategic priorities identified.

Progress against those actions as of 30 June 2024 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 *Focus initiative: stakeholder network mapping*	Completed (ongoing)	An initial review identified three priority stakeholders for stakeholder engagement on the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*: NSW Coroner, Sydney Children's Hospital Network/ The Children's Hospital at Westmead, and child protection units with NSW public hospitals. In addition to presentations to NSW Health stakeholders (detailed below), we are preparing to meet with the Coroners office. Identifying opportunities to deepen our engagement with stakeholders is part of the CDRT's 'business as usual' processes.
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	Completed (ongoing)	The current review of suicide deaths of Aboriginal children and young people project is led by Aboriginal members of the CDRT – Professor Kathleen Clapham (University of Wollongong), and Professor Ngiare Brown (Chair National Mental Health Commission Advisory Board, and Director and Program Manager, Ngaoara Child and Adolescent

Priority	Status	Comments
		Wellbeing). The CDRT engaged the Ngarruwan Ngadju First Peoples Health and Wellbeing Research Centre to conduct the research, overseen by the Aboriginal Suicide Prevention First Nations Advisory Group. We also established a CDRT suicide sub-committee for closer consultation with members on suicide-related issues. The committee has been consulted on matters relevant to the Aboriginal suicide prevention project and will continue to meet on an as-needs basis. We have consulted with CDRT members on the project plans for two new research projects which include partnerships with external research organisations. Closer involvement of CDRT members and external research partners is now part of our new Research Framework and other business as usual practices.
Embed a collaborative approach in our work and ways we do business	Completed (ongoing)	We have implemented additional engagement processes with stakeholders in relation to our monitoring of recommendations, including meeting with agencies to discuss progress and reflect on the purpose of recommendations prior to seeking formal updates. We sought feedback from CDRT stakeholders through the NSWO annual stakeholder survey which includes questions about whether we took the time to listen and

Priority	Status	Comments
		were professional and respectful. The CDRT's new Research Framework commits to engaging early with stakeholders to inform research projects and support impactful research and recommendations.
Proactively engage with stakeholders to ensure our recommendations are well-targeted, understood, and attainable	Completed (ongoing)	Three separate stakeholder meetings were held with relevant program areas within NSW Health to discuss Health's progress towards implementing CDRT recommendations. We will continue to meet with agencies to discuss recommendations as part of business as usual practices.
Develop strategies to improve the visibility of our work with stakeholders and community partners *Focus initiative: promoting our work*	Completed (ongoing)	NSW Ombudsman staff presented to the Senior Coroner's meeting in August 2023 on the CDRT's child death review work. Following the meeting, we developed a fact sheet on the Ombudsman's child death functions for Coronial staff which the State Coroner agreed to distribute. NSW Ombudsman staff presented on the CDRT's *Biennial report of the deaths of children in New South Wales: 2020 and 2021* to NSW Health's 'Grand Rounds' at the Children's Hospital Randwick in December 2023, and to the St George Child & Family Interagency meeting in February 2024. Additional strategies are being identified as part of the CDRT's business as usual practice.

Priority	Status	Comments
Share information and data from the Register of Child Deaths to support stakeholders in research and other work related to the prevention of child deaths	In progress	A procedure for responding to external requests for Register data is being finalised. The NSW Ombudsman website will be updated to provide information and contact details for those seeking access to information from the Register. The CDRT Research Framework also facilitates the provision of Register data to external researchers support research.
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 *Focus initiative: identifying data to be captured*	Completed (ongoing)	A definition of societal stressors has been developed and this data is captured in the Register of Child Deaths. The CDRT Research Framework considers the impact of societal stressors within its criteria for prioritising research projects.
Extract information from case records for inclusion in the Register of Child Deaths	Completed (ongoing)	Matters associated with COVID-19 were reported on 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 *Focus initiative: analysis and insight*	Completed (ongoing)	Discussion of how COVID-19 related societal stressors may have impacted children who died by suicide was included in the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*.
3 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	Completed (ongoing)	A definition of societal stressors has been developed

Priority	Status	Comments
Focus initiative: identifying data to be captured		and this data is captured in the Register of Child Deaths. The CDRT Research Framework considers the impact of societal stressors within its criteria for prioritising research projects.
Extract information from case records for inclusion in the Register of Child Deaths	Completed (ongoing)	Matters associated with COVID-19 were reported on 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 *Focus initiative: analysis and insight*	Completed (ongoing)	Discussion of how COVID-19 related societal stressors may have impacted children who died by suicide was included in the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*.
4 Undertake meaningful and well-targeted projects, and make the most of existing data		
Complete and publish reports for each of our current projects:		The status of current research projects is as follows:
Infant deaths from severe perinatal brain injury in NSW, 2016-2019: key thematic observations	Complete	Report published as an annexure to the *Biennial report of the deaths of children in New South Wales: 2020 and 2021*. Expert members of the CDRT were consulted in relation to the validity and consistency of the study's key observations with the evidence base.
Preventing the suicide deaths of Aboriginal children and young people	In progress	Substantive work on this project was completed by June 2024. We anticipate a public report of this research, including recommendations where warranted, will be tabled in 2025.
Report on agency responses to any recommendations	Ongoing	The CDRT will report on the implementation of any

Priority	Status	Comments
made in these reports, together with their progress in implementing recommendations		recommendations made in research reports. No recommendations were made in the preliminary review of infant deaths from severe perinatal brain injury.
Track, to the extent this is practicable, the direct and indirect impacts of our project work and recommendations *Focus initiative: measuring our impact*	Pending	Not yet 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, and actively leverage current work and projects.	In progress	Two new research projects approved: Suicide deaths of young people aged 10-17 who identified as LGBTIQ+ (2018-2023). Follow up review of perinatal deaths from severe brain injury (2010-2023). A list of other potential research projects and topics is currently being prepared for discussion with members. The CDRT's new Research Framework will guide all future research conducted.
Explore further opportunities for additional person-centred datasets that link numerical and qualitative data to deepen our understanding of the context of child deaths *Focus initiative: exploring opportunities*	Pending	Not yet commenced.
Develop recommendations that are both systems level and specific	In progress	Internal guidance on making recommendations will be finalised in 2024-25.

Priority	Status	Comments
5 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	Draft discussion paper prepared in relation to CDRT equity lens and used as background for consideration of 'equity lens' in the CDRT's new Research Framework. Over 2024-25, we will focus on finalising the draft discussion paper and consult with members about implications for other child deaths work, such as data collection and reviews.
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	Completed (ongoing)	The *Biennial report of child deaths in New South Wales: 2020 and 2021* included 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	Completed (ongoing)	Current priority populations and/or equity indicators identified include: • Gender • Aboriginal and Torres Strait Islander status • Remoteness • Socioeconomic status • Child protection history • Participation in out-of-home care Examples of other equity indicators and/or priority populations: • Adverse childhood experiences

Priority	Status	Comments
		• Access to services • Culturally and linguistically diverse background • Disability • Education • Housing • Vulnerable/disadvantaged families. Opportunities for collaboration will be considered as part of the CDRT's assessment of future research projects and thematic papers.
Identify and consider how to obtain/generate relevant equity-related data *Focus initiative: data generation*	Ongoing	Work in relation to principles and conceptual models has begun. Principles include collaboration, community engagement, cultural integrity, and sustainability and accountability. Conceptual models include socio-ecological, life course, and systems approach. In addition, obtaining/generating relevant equity-related data is now part of the CDRT's new Research Framework which will guide all new and relevant CDRT research.
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 *Focus initiative: Closing the Gap*	In progress	Aboriginal and Torres Strait Islander families are identified as a priority population. The *Biennial report of child deaths in New South Wales: 2020 and 2021* discussed commitments in the National Agreement on Closing the Gap. In 2024-25, we will consider the NSW Government commitments

Priority	Status	Comments
		in the Closing the Gap 2022-24 Implementation Plan.[38]
6 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 *Focus initiative: review of unsuccessful recommendations*	In progress	CDRT recommendations for the period 2017-2022 have been reviewed, and initial learnings presented to the CDRT. The results of this review will inform future recommendations as well as the finalisation of internal guidance on making recommendations.
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 *Focus initiative: broadening our reach*	Completed (ongoing)	Changes to our engagement processes with stakeholders have been implemented, including additional opportunities for targeted consultation about the intent and implementation of recommendations.
Develop strategies to track the impact of our recommendations in future data, including beyond 2025	Pending	Not yet commenced.
Review our public reporting *Focus initiative: review of public reporting*	Completed	A revised format for the CDRT's biennial reporting has been endorsed and will be used in the upcoming *Biennial report of the deaths of children in New South Wales: 2022 and 2023* (due to be published in 2025).

[38] Closing the Gap 2022-24 Implementation Plan | NSW Government

Appendix 2: Member meeting attendance

Member	8 August 2023	5 September 2023	14 November 2023	27 February 2024	28 May 2024
Mr Paul Miller (Convenor)	Y	N	Y	Y	N
Prof Kathleen Clapham (Deputy Convenor)[39]	N	Y	Y	Y	Y
Ms Monica Wolf	Y	Y	Y	Y	Y
Ms Zoë Robinson	Y	N	N	Part attend	Part attend
Ms Sarah Bramwell	Y	Y	Y	Y	Y
Ms Vanessa Chan[40]	N/A	N/A	N/A	N/A	N/A
Det Super Danny Doherty	Y	Y	Y	Y	Y
Mr Matthew Karpin[41]	Y	Y	N/A	N/A	N/A
Dr Matthew O'Meara	Y	Y	Y	Y	Y
Ms Anne Reddie	Y	N	Y	N	Y
Ms Eloise Sheldrick	On leave[42]	On leave	On leave	On leave	On leave
Ms Alison Sweep	Y	N	N	Y	N
Dr Susan Adams	Y	Y	Y	Y	Y
Dr Susan Arbuckle	Y	N	Y	Y	Y
Prof Ngiare Brown	Y	N	Y	Y	N

[39] Professor Clapham has stepped aside from the position of Deputy Convenor until the conclusion of the Review of the suicide deaths of Aboriginal children and young people.

[40] Vanessa Chan's CDRT membership commenced on 29 May 2024.

[41] Matt Karpin's CDRT membership ceased on 18 October 2023.

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

Member	8 August 2023	5 September 2023	14 November 2023	27 February 2024	28 May 2024
Dr Luciano Dalla-Pozza	Y	Y	Y	Y	Y
Dr Bronwyn Gould	Y	Y	Y	Y	Y
Prof Philip Hazell[43]	N	Y	Y	Y	N/A
Prof Heather Jeffery[44]	Y	Y	Y	N/A	N/A
Prof Ilan Katz	Y	Y	Y	Y	Y
Ms Catherine Lourey[45]	N	N	N	N/A	N/A
Dr Lorraine du Toit-Prinsloo[46]	N/A	Y	N	Y	Y
Prof Kathleen Clapham (Deputy Convenor)[47]	N	Y	Y	Y	Y
Ms Monica Wolf	Y	Y	Y	Y	Y

[43] Philip Hazell's membership ceased on 30 April 2024 and he was appointed as an expert adviser from 1 May 2024.

[44] Heather Jeffery's CDRT membership ceased on 21 November 2023.

[45] Catherine Lourey's CDRT membership ceased on 16 February 2024.

[46] Lorraine du Toit-Prinsloo's CDRT membership commenced on 24 August 2023. Prior to that date she was appointed as an expert adviser and attended meetings in that capacity.

[47] Professor Clapham has stepped aside from the position of Deputy Convenor until the conclusion of the Review of the suicide deaths of Aboriginal children and young people.

Appendix 3: Agency advice regarding recommendations

Letter from NSW Health dated 30 August 2024 regarding CDRT recommendations (SUDI – safe sleeping, SUDI – medical history protocol, Identification of illness in infants, Suicide – targeted prevention measures) 48

Letter from Transport for NSW dated 19 July 2024 regarding CDRT recommendation (child restraints and seatbelts) 65

Letter from Transport for NSW dated 5 September 2024 regarding CDRT recommendation (child restraints and seatbelts) 67

NSW Health

NSW GOVERNMENT

Ref: O24/1

Ms Helen Wodak
Deputy Ombudsman
Monitoring and Review
Ombudsman NSW

Status update on the Implementation of the CDRT Recommendation

Dear Ms Wodak

I refer to your letter dated 4 July 2024, seeking an update on the implementation of previous recommendations made by the Child Death Review Team.

Please find attached a table outlining the updates sought by your office. I am pleased to advise that significant progress has been made against the recommendations and several of the new policy initiatives are currently being implemented by NSW Health.

In addition to the attached updates, I seek your consideration of the need for ongoing monitoring with respect to Recommendation 1. There has been strong engagement between senior officers from the Ministry of Health and your office with discussions focused on the range of programs established to implement strategies to promote safe infant sleep practices to vulnerable families, as detailed in the attached update.

Considering the robustness of these discussions and the transition of these important programs to regular operational activity for NSW Health, it may be appropriate to consider the need for ongoing monitoring related to this recommendation.

Thank you for your support of NSW Health and for the ongoing work of the Child Death Review Team. If you have any further queries, please contact Paul Giunta, Director, Corporate Governance at [redacted] or on [redacted].

Yours sincerely

Susan Pearce AM
Secretary, NSW Health
30 August 2024

Encl. NSW Health response to requests for further information

1 Reserve Road, St Leonards NSW 2065
Locked Mail Bag 2030, St Leonards NSW 1590

02 9391 9000
health.nsw.gov.au

Schedule of recommendations: progress in implementing recommendations and next steps and NSW Health response

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
SUDI – safe sleeping **Recommendation 1, Biennial report of the deaths of children in NSW: 2016 and 2017** NSW Health should develop and implement strategies to promote safe infant sleep practices to vulnerable families. In particular, NSW Health should target: • in consultation with the Department of Family and Community Services, families known to child protection services, • families living in remote areas of the state, and • families living in areas of greatest socio-economic disadvantage.	NSW Health supported the recommendation. 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. 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. 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. In October 2022, the CDRT reported it would continue to monitor implementation of this recommendation.[1] In August 2023 representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation. During this meeting and in the month following NSW Health provided advice about SAFE START, Sustaining NSW Families (SNF) and Pregnancy Family Conferencing (PFC), the expansion of Aboriginal Child and Family Centres and the Brighter Beginnings program. In October 2023 we acknowledged the ongoing expansion of the SNF and PFC programs and our desire to better understand the PFC program's process and criteria for referral	NSW Health is asked to provide the following information: **The locations for the PFC program expansion and why they were selected.** PFC has been operating in six metro Health/DCJ districts for a number of years, with the first program starting in Sydney Health/DCJ district in 2012. In 2022-23, the NSW Government committed to the expansion of PFC to 9 rural and regional local health districts to make the program available statewide. Local health districts have flexibility in where the program (facilitated meetings) is delivered. **Whether any other services or programs delivering safe sleep messaging use modelling tools to target recipients.** Child and Family Health are unaware of any modelling tools in this area. **Whether there has been any consideration of changes to the delivery of safe sleep messaging through the Blue Book in the context of the Blue Book digitisation project.** As the Blue Book becomes digitised, consistent safe sleep messaging will be incorporated – the appropriate messaging will be determined as the project progresses.

Schedule of recommendations: progress in implementing recommendations and next steps and NSW Health response

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
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Recommendation	Summary of advice to date	NSW Health's response to requests for further information
	for targeted support, the number of infants and families involved, and any evaluations conducted, as well as any planned strategies for accessing vulnerable families not reached by these programs.[2] In May 2024 we met with NSW Health who provided an update on the expansion of the PFC program, and detailed information about the delivery of safe sleep messaging as part of the clinical care offered to families assessed at each level of care through the SAFE START model, including universal and early intervention/prevention services and targeted programs (SNF and PFC). Health also shared information on its work building trust in Aboriginal communities. We have separately contacted DCJ for more information about the expansion of Aboriginal Child and Family Health Centres.	**Any other information relevant to the implementation of the recommendation not already shared.** The consumer Safe sleeping recommendations flyer located on the NSW Health website is available to download in 21 community languages. NSW Health is working with Department of Customer Services (DCS) to review of the DCS Parent and Carer Hub website to ensure consistent messaging about 'Safe sleeping recommendations' (Safe sleeping recommendations - First five years (nsw.gov.au)). This messaging will be consistent in the My Personal Health Record (Blue Book), and in the digital Blue Book (currently under development).

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

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
SUDI – medical history protocol **Recommendation 1, Biennial report of the deaths of children in NSW: 2018 and 2019** NSW Health complete a detailed audit of compliance with the revised SUDI medical history protocol. The audit should include information and analysis about: • The number of infants presented to emergency departments following their sudden and unexpected death. • The number of medical history interviews conducted in response to these deaths. • An assessment of whether the intent of the policy directive has been met and is reflected in the information gathered. • 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. • 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). • Where SUDI medical history interviews are not conducted,	NSW Health supported the recommendation. 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. 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. In October 2022, the CDRT reported it would continue to monitor the recommendation, pending further advice from NSW Health.[3] The NSW Health representative on the CDRT provided verbal updates to the CDRT on the audit's progress, and written advice from NSW Health was provided in September 2023 and reported in October 2023.[4] Formal advice of the audit findings and outcomes was received in October 2023 following reporting. The audit found that compliance with the protocol in the PD2019_035 *Management of Sudden Unexpected Death in Infancy* (the **PD**) was below expectations. NSW Health advised there would be a policy review of the PD and a revised PD was expected to be published by the end of 2024. In April 2024 the CDRT offered its support with the PD review. In May 2024 NSW Health advised that it would be contacting NSW Ombudsman staff in the coming months to seek their involvement	**NSW Health is asked to provide an update on the progress of the review of the PD by 2 August 2024. NSW Health is invited to meet with NSW Ombudsman staff to discuss the recommendation if that would be of assistance.** NSW Health is currently planning the review of policy directive *PPD2019_035 Management of Sudden Unexpected Death in Infancy,* to be undertaken in the second half of 2024. The offer for involvement in the process by staff of the NSW Ombudsman's office is appreciated and staff will be approached as part of the review process.

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Recommendation	Summary of advice to date	NSW Health's response to requests for further information
whether relevant staff are aware of health's policy, and reasons why the interview was not completed. • Details about any strategies or outcomes arising from the audit.	once the plans for review were finalised.	

[2] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (30 October 2022) pp. 19-21

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

[4] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (30 October 2022) pp. 29-30

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
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. In 2019 NSW Health provided advice that it would be contacting Red Nose to work collaboratively to promote evidence-based and evaluated resources for parents and carers. Subsequent updates in 2021 and February 2022 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. 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 October 2022, the CDRT reported it would continue to monitor the recommendation and would seek to meet with NSW Health.[5] In December 2022, we met with representatives from NSW Health 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. In October 2023 we reported the advice received on the project to digitise the Blue Book including a survey and focus groups on	NSW Health is asked to provide the following information: **The most recent available data on the use/reach and effectiveness of the virtualKIDS service.** virtualKIDS Urgent Care Service expanded statewide under the NSW Urgent Care Service on 19 December 2023, opening the service to all families in NSW. It is designed to help keep children out of emergency departments and provide care closer to home in addition to providing access to specialist paediatric advice for clinicians in rural and regional hospitals. The statewide availability of the service means: • parents with seriously ill children who need urgent medical attention can be seen faster in EDs • parents with children who have a less serious illness can be cared for safely by the virtualKIDS service in the comfort of home without an unnecessary trip to their local hospital, and potentially a long wait to be seen. To date, more than 60 per cent of children referred to virtualKIDS have avoided the need to visit an ED. The service received 1156 referral from Healthdirect to virtualKIDS in May 2024 – the highest ever numbers for this

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
	parents accessing information about unwell children, website updates, and public use of Healthdirect. We expressed interest in the results of the survey and focus groups and our ongoing desire to see strategies aimed at families specifically overrepresented in SUDI deaths.[6] In June 2024 we met with NSW Health and discussed the impact of the single digital patient record project on the Blue Book digitisation project, how safe sleeping resources are made available to families in various formats (hard copy and digital) and languages, and how the various available resources are linked. Health provided advice about virtualKIDS, outcomes from the Blue Book review surveys and focus groups, and work specifically targeting sepsis, influenza and RSV.	service (an 5.5% increase from April which logged 1097 referrals). Referrals received in May where widespread across the state with more than 30% of referrals received from rural LHDs. **Whether the updates to and features of the digital Blue Book will be replicated in the paper Blue Book, and how the paper Blue Book will be made available in families.** An *Urgent Actions in Emergencies* section for parents/carers has been drafted and is in the process of being reviewed by clinical experts. It will be placed in a prominent location in the Blue Book. **Any further information on the proposed changes to the Blue Book arising from the survey and focus group results relating to the identification of illness in infants.** Information on the proposed changes to the Blue Book, regarding identification of illness in infants, will be considered using the 2024 DCS consumer and health professional survey report. **Any updates on the planned promotion of the digital Blue Book.** The digital Blue Book is under development, the promotion approach will be determined closer to release.

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
		Any other information relevant to the implementation of the recommendation not already shared. NSW Health will ensure that all messages directed at parents/carers are consistent with 'Safe sleeping recommendations'. This includes the NSW Health website, Blue Book, digitisation of the Blue Book and any other safe sleeping resources.

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

[6] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (30 October 2022) pp. 21-22

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Recommendation	Summary of advice to date	NSW Health's response to requests for further information
Suicide – targeted prevention measures **Recommendation 10, Biennial report of the deaths of children in NSW: 2016 and 2017.** 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 closed] b) [element closed] c) The provision of targeted, sustained and intensive therapeutic support to young people at high risk – including strategies for reaching those who are hard to engage.	The NSW Government supported the recommendation. In June 2020, the Department of Premier and Cabinet advised 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 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. 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. 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. In October 2022, the CDRT reported that it would continue to monitor elements b and c of the recommendation. In July 2023, representatives from the NSW Ombudsman and NSW Health met to discuss the recommendation. Health shared information about the initiatives co-funded under the National Mental Health and Suicide Prevention Agreement and Bilateral Agreement between NSW and the Commonwealth, the OOHC	**Any specific initiatives aimed at 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 – in the following work areas:** • **LGBTQIA+ strategy** • **OOHC mental health framework** • **Recurrent funding for specialist services for addressing complex needs** • **Work with priority populations.** LGBTQIA+ strategy The NSW LGBTIQ+ Health Strategy 2022-2027 provides direction to all NSW Health organisations and staff, so the system can collectively deliver the best care to LGBTIQ+ people. The strategy has committed funding to strengthen community partnerships to enhance mental health and suicide prevention initiatives in LGBTIQ+ communities. The Ministry works with ACON to deliver a suite of suicide prevention activities to LGBTQIA+ communities. They deliver the following: • LGBTQ+ Crisis Support and Aftercare Service. This service contributes to reducing the number of people who die by suicide, and decrease the number of individuals who attempt suicide or experience suicidal crisis in NSW by providing compassionate and appropriate support to individuals who are experiencing suicidal crisis, have

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
	mental health framework, and updates on existing programs including Safeguards and the Youth Aftercare Pilot. Further written advice on these and other programs was provided in September and based on this advice monitoring of element b of recommendation 10 and recommendation 11 was closed. Monitoring of element c of recommendation 10 continued pending further advice regarding support for disengaged young people, and those with additional risk factors such as drug and alcohol use and offending behaviour. In June 2024 we met with NSW Health who provided information on state and federal budget funding for child and youth mental health, Safeguards teams, CAMHS, specialty treatment services, use of suicide monitoring system data, and plans to address current system challenges such as bed and psychiatrist shortages. Information specific to suicide prevention including Community Collaboratives, suicide prevention legislation, and an upcoming suicide prevention forum targeting young men was also provided. Since the meeting, state budget funding of $111.8 million for mental health care including reducing long stay hospitalisation through a Pathways to Community Living Initiative ($40 million), a dedicated mental health single front door ($38.9 million), and expansion of community mental health teams ($30.4 million) has been announced. At the meeting Health described four key work areas for the Mental Health Branch: • LGBTQIA+ strategy • OOHC mental health framework • Recurrent funding for specialist services for addressing complex needs	been bereaved by suicide or have made a recent suicide attempt. • Trans Mental Health & Wellbeing Service. This service aims to reduce the psychological distress and improve the quality of life of trans and gender diverse individuals living in NSW through the delivery of various specialist service options. The service involves the provision of free, targeted, person-centered and evidenced informed interventions delivered collaboratively with the client through a variety of contact settings and contexts. • HERE health promotion is information and workshops related to suicide, including aftercare and postvention. • Trans Vitality is an initiative from Trans Health Equity that was developed by and for trans people of all genders in NSW. The program includes a set of workshops, facilitated by trans peers, and a digital toolkit. The workshops and digital toolkit were developed by trans people for trans people and focus on enhancing community well-being by promoting protective factors against suicidality. Out of Home Care Mental Health Framework An Out of Home Care Mental Health Framework is being developed in partnership with the NSW Department of Communities and Justice (DCJ), to improve the mental health, social and emotional

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
	• Work with priority populations. Health also described the following initiatives: • Funding from the bilateral agreement for each Primary Health Network to continue Community Collaboratives • 9 Primary Health Services funded to provide suicide prevention training in community organisations • Suicide prevention legislation aimed at increasing government accountability for suicide prevention, utilising contact points outside of Health such as Service NSW, Centrelink. • A consultation discussion paper for people with experience of suicide. • A suicide prevention forum targeting young men scheduled for August.	wellbeing of children and young people living in Out of Home Care. This framework focuses on three strategic priority areas, including: • Multi-sector collaboration and partnerships (focusing on improved collaboration between Health and DCJ staff) • Integrated care, prevention and early detection (focusing on integration across services and early access to comprehensive and multidisciplinary assessment and early intervention) • Enhanced knowledge environments (focusing on the knowledge, resources and skills of staff across agencies to respond to the need of children in OOHC. The Framework is due to be released by December 2024. Recurrent funding for specialist services for addressing complex needs Core CAMHS and Youth Mental Health Services are recurrently funded and provide comprehensive, needs based specialist care to children and young people at high-risk and with complex mental health needs. CAMHS support is based on individual clinical needs that will continue until the patient turns 18 and transitions to adult services if required. Many young people present with time limited conditions, such as

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		anxiety or depression. Longer term conditions such as ASD are usually managed in the NDIS system by private community health care providers rather than through public health services. Given their short-term role, CAMHS integrates with other services to ensure continuity of care. Safeguards is an early intervention program providing a rapid response to children and young people aged 0 - 17 who are in acute distress, and transition to longer term care if needed. While Safeguards is not currently a recurrent program, recurrent funding has been allocated. Ten Local Health Districts will be establishing the Enhancement and Integration of Youth Mental Health Services Initiative (YMH Initiative) in 2023-24 and 2024-25 under the NSW Bilateral Schedule of the National Mental Health and Suicide Prevention Agreement. Findings of the program evaluation will inform future decisions about ongoing funding. Youth Community Living Support Services (YCLSS) are delivered by community managed organisations and provide psychosocial outreach support for young people (aged 15 to 25 years) with moderate to severe mental health issues to promote recovery and positive change. YCLSS is recurrently funded. The Sydney Children's Hospitals Network Mental Health and Intellectual Disability Hub (MHID Hub)

Recommendation	Summary of advice to date	NSW Health's response to requests for further information
		works with children, young people and their families with intellectual or developmental disability and co-occurring mental health problems, as well as support systems, health services and disability providers to provide comprehensive assessment and short-term support by specialised clinicians. with the aim of returning the patient back to their treating clinician and providing ongoing training and supervision for the clinician. Work with priority populations The Safeguards teams are required to employ an Aboriginal mental health worker, targeting that vulnerable population and facilitating their access to the service. The mobility of Safeguards teams allows them to meet children and their families at any suitable location which also assists with engagement and access. **Any work providing targeted, sustained and intensive therapeutic support to young people at high risk – including strategies for reaching those who are hard to engage – as part of the following:** • **Funding from the bilateral agreement for each Primary Health Network to continue Community Collaboratives** • **9 Primary Health Services funded to provide suicide prevention training in community organisations** • **Suicide prevention legislation aimed at increasing government accountability for**

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Recommendation	Summary of advice to date	NSW Health's response to requests for further information
		suicide prevention, utilising contact points outside of Health such as Service NSW, Centrelink. • **A consultation discussion paper for people with experience of suicide.** • **A suicide prevention forum targeting young men scheduled for August.** **A copy of the report of the first gap analysis on community mental health services in NSW, the NSW Community Mental Health Services Priority Issues Paper.** <u>Community Collaboratives & Suicide Prevention Training</u> NSW Health in partnership with headspace National support the delivery of the NSW Community Collaboratives. In February 2025, this initiative will be transitioning to a PHN-led model. Community Collaboratives empower local organisations to effectively respond to suicide and individuals at risk of suicide within their communities. These collaboratives include diverse community groups, sporting clubs, welfare agencies, educational institutions, community organisations, local councils, local health districts, PHNs and primary health care providers. By coordinating local responses to suicide and providing access to training and resources, these collaboratives raise awareness and create more visible pathways to support.

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Recommendation	Summary of advice to date	NSW Health's response to requests for further information
		The NSW Government has concluded a time limited suicide prevention training initiative, launched in response to the Covid-19 pandemic. Delivered by LivingWorks Australia, this initiative focused on individuals supporting young people, including teachers, sporting coaches, and parents/carers. Moving forward, suicide prevention training under the new Community Collaboratives model will be available to everyone, with local decision-making guiding who needs training and at what intensity. Suicide Prevention Legislation The NSW Government made an election commitment to introduce whole of government suicide prevention legislation. The aim of the legislation is to instigate a cultural shift within Government where suicide prevention becomes a collective responsibility, with established mechanisms for ensuring accountability. Legislation will seek to embed cross-government portfolio action for suicide prevention, and the voices of lived and living experience of suicide. The following milestones have been achieved: • A cross-government Working Group with senior leadership level representation from across the NSW Government was established at the start of 2024. It is co-chaired by NSW Health and The Cabinet Office. The group will meet monthly until

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

[8] NSW Ombudsman, *NSW Child Death Review Team Annual Report 2021-22* (25 October 2022) p. 24-27

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

19 July 2024

Dear Deputy Ombudsman

Child death-related recommendation

Thank you for your letter to the Secretary dated 24 June 2024 seeking advice in relation to a recommendation made in the *Biennial report of the deaths of children in NSW: 2016 and 2017*, published in June 2019. The recommendation was that Transport for NSW (Transport) 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. Transport supported the recommendation and has provided regular updates to the NSW Ombudsman.

Since our last update, The George Institute for Global Health has collected and undertaken analysis of the new study of child restraint practices in rural and remote NSW and compared the observations to the previous study carried out in metropolitan areas in 2020. The results were also compared to previous observations of child restraint practices recorded in 2008 prior to the introduction of legislation mandating appropriate child restraint use for children up to age 7. The new data showed that across NSW, 98% of children were observed to be using a restraint appropriate to their age. This is a substantial increase compared to 48.8% appropriate use observed in 2008. However, errors in restraint use continue to be widespread with statewide estimates remaining very similar, if not slightly higher, than those reported from the 2008 data (51.4% had an error in 2008, 65.5% in the current study; 38.3% had at least one serious error in 2008, 40.7% in this current study).

Importantly, the new study provided a larger sample size of observations in regional and remote NSW compared to the 2008 study allowing restraint practices to be compared across regions which was not possible with the 2008 data. The results indicate that generally appropriate restraint use is high across NSW, however there is a tendency towards more inappropriate restraint use in outer regional areas. Similarly, errors in restraint use are problematic across the state. There was twice the likelihood of any error in inner regional areas (OR 2.116, 95% CI 1.155-3.879) and three times the likelihood of any error in remote/very remote areas (OR 3.159, 95% CI 1.803-5.533) compared to the greater metropolitan area however there was no difference in the likelihood of serious errors for these regional comparisons. There was a 65% less likelihood of serious errors in outer regional areas compared to the greater metropolitan area (OR 0.649, 95% CI 0.446-0.945).

The results of this work do not indicate a substantial difference in restraint practices in rural and remote NSW compared to metropolitan areas. However, they do clearly indicate a need for efforts to reduce rates of incorrect use to be extended into regional areas. Furthermore, while appropriate use was high in all regions, there were anecdotal observations made suggesting that when inappropriate use does occur in regional and rural areas, it may be more likely to involve premature

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graduation to seat belts. This suggests there may be ongoing need for messaging about the importance of appropriate restraint use, particular in the more outer regional areas.

In response to these findings Transport is exploring opportunities to further enhance community education on correct child car seat selection and use particularly in regional areas and engage key stakeholders and partners to raise awareness and seek opportunities to extend safety messaging.

If you require any further information, please contact Greg Dikranian, Senior Manager Safer Vehicles on [redacted] or [redacted].

Thank you again for monitoring our progress in implementing the recommendation.

Yours sincerely

Sally Webb
Deputy Secretary
Safety, Environment and Regulation
Transport for NSW

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

5 September 2024

Dear Deputy Ombudsman

Re: Provision of research report - Child death-related recommendation

Thank you for your letter to the Secretary dated 23 August 2024 in relation to the implementation of the recommendation made in the *Biennial report of the deaths of children in NSW: 2016 and 2017*, published in June 2019. The recommendation was that Transport for NSW (Transport) 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. Transport supported the recommendation and has provided regular updates to the NSW Ombudsman.

In response to your request for Transport to provide a copy of the full study results, please find attached the final report from the George Institute for Global Health, dated 30 July 2024, titled *Child restraint practices in NSW*.

Transport intends to widely share the findings of the research with relevant stakeholders and will be updating all child restraint communications and education campaigns to reflect this most up-to-date data.

In response to the report's recommendations, Transport will review messaging and appropriate interventions to support improvement of restraint practices in outer regional areas and areas of most socioeconomic disadvantage as well as implications for Transport's scheme of authorised child restraint fitting stations.

If you require any further information, please contact Greg Dikranian, Senior Manager Safer Vehicles on [redacted] or [redacted].

Thank you again for monitoring our progress in implementing the recommendation.

Yours sincerely

Sally Webb
Deputy Secretary
Safety, Environment and Regulation
Transport for NSW

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