Ombudsman
New South Wales

NSW Child Death Review Team Annual Report 2017-18

22 October 2018

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22 October 2018

The Hon John Ajaka MLC President Legislative Council Parliament House SYDNEY NSW 2000	The Hon Shelley E Hancock MP Speaker Legislative Assembly Parliament House SYDNEY NSW 2000

Dear Mr President and Madam Speaker

NSW Child Death Review Team annual report 2017-18

As convenor of the NSW Child Death Review Team (CDRT), I am pleased to present the *NSW Child death review team annual report 2017-18* for tabling in Parliament.

This is a report under s 34G(1) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA).

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

Yours sincerely

Michael Barnes
Ombudsman

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About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during 2017–18.

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

The report is arranged in the following chapters:

- Chapter 1 and 2: The NSW Child Death Review Team – an overview of the CDRT, its members and the functions of the Team.
- Chapter 3: Research to help reduce child deaths – details of our research and projects to meet our purpose and functions.
- Chapter 4: Our plans – progress against our strategic priorities and our future priorities.
- Chapter 5: Disclosure of information – details of the disclosure of information for the purpose of research.
- Chapter 6: Our recommendations – details the acceptance by agencies of the CDRT's recommendations, and progress towards implementation. The appendix provides copies of agency advice in relation to recommendations.

Chapter 1. The NSW Child Death Review Team

Who we are

Since 1996, the CDRT has been responsible for registering, reviewing and reporting to the NSW Parliament on all deaths of children aged less than 18 years in NSW. Our purpose is to prevent or reduce the deaths of children in NSW through the exercise of our functions under Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act*.

CDRT membership is prescribed by the Act. Members are:

- the NSW Ombudsman, who is Convenor of the CDRT
- the Advocate for Children and Young People
- the Community and Disability Services Commissioner
- two persons who are Aboriginal
- representatives from NSW Government agencies:
  - NSW Health
  - NSW Police Force
  - Department of Family and Community Services
  - Department of Education
  - Department of Attorney General and Justice
- experts in health care, research methodology, child development or child protection, or persons who are likely to make a valuable contribution to the CDRT.

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

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

CDRT members in 2017-18

Statutory members

Mr Michael Barnes (from December 2017)

Convenor
NSW Ombudsman

Professor John McMillan AO (to November 2017)

Convenor
Acting NSW Ombudsman

Mr Steve Kinmond

Community and Disability Services Commissioner
Deputy Ombudsman

Mr Andrew Johnson

NSW Advocate for Children and Young People

Agency representatives

Ms Kate Alexander

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

Ms Robyn Bale

Director, Student Engagement and Interagency Partnerships, Department of Education

Ms Clare Donnellan

District Director, South Western Sydney
Department of Family and Community Services

Ms Jane Gladman (on leave from November 2017)

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

Associate Professor Elisabeth Murphy

Senior Clinical Adviser, Child and Family Health
NSW Health

Mr Daniel Noll (from May 2017)

Director Criminal Law Specialist
Department of Attorney General and Justice

Detective Superintendent Michael Willing
(to March 2018)

Commander Homicide
NSW Police Force

Detective Superintendent Scott Cook
(from May 2018)

Commander Homicide
NSW Police Force

Independent experts

Professor Ngiare Brown

Executive Manager, Research
National Aboriginal Community Controlled Health Organisation

Professor Kathleen Clapham

Australian Health Services Research Institute
University of Wollongong

Dr Susan Adams

Director, Division of Surgery and Senior Staff Specialist, Paediatric General Surgeon,
Sydney Children's Hospital

Dr Susan Arbuckle

Paediatric/Perinatal pathologist,
The Children's Hospital at Westmead

Dr Isabel Brouwer

Statewide Clinical Director
Department of Forensic Medicine

Dr Luciano Dalla-Pozza

Head of Department and Senior Staff Specialist (Oncology)
The Children's Hospital at Westmead

Dr Jonathan Gillis (to April 2018)

Deputy Convenor
Paediatrician

Dr Bronwyn Gould

General Practitioner

Professor Philip Hazell

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

Professor Heather Jeffery

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

Professor Ilan Katz

Director, Social Policy Research Centre
University of NSW

Dr Helen Somerville

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

Expert advisers

Our legislation provides for the Convenor to appoint persons with relevant qualifications and experience to advise the CDRT in the exercise of its functions. In 2016-17, the Convenor appointed expert advisers to assist the CDRT in its work, and to undertake research on behalf of the CDRT:

- Professor Les White, former NSW Chief Paediatrician and CDRT member for NSW Health
- Ms Eloise Sheldrick, Office of the NSW State Coroner
- Associate Professor Rebecca Mitchell, Australian Institute of Health Innovation, Macquarie University
- Dr Daniel Challis, Executive Medical Advisor Obstetrics, NSW Perinatal Services Network; Director Women's and Children's Health South East Sydney Local Health District; Conjoint Associate Professor University of NSW.

Researchers undertaking projects on our behalf may also be appointed as expert advisers. Chapter 3 below provides details of researchers undertaking projects for the CDRT.

Chapter 2. Our functions

Under the Act, our functions are to:

- maintain a register of child deaths occurring in NSW
- classify those deaths according to cause, demographic criteria and other relevant factors, and to identify trends and patterns relating to those deaths
- undertake, alone or with others, research that aims to help prevent or reduce the likelihood of child deaths, and to identify areas requiring further research, and
- make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.

CDRT reports of child deaths are available at:
http://www.ombo.nsw.gov.au/what-we-do/coordinating-responsibilities/child-death-review-team

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

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

Reports of reviewable deaths of children are available at:
http://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths-vol-1

The Register of Child Deaths

Between July 2017 and June 2018, we registered the deaths of 495 children that occurred in NSW. Twenty of the deaths were reviewable by the Ombudsman.

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

In June 2017, we completed a design review for the Register. The review led to a major revision of our data capture. The changes were tested and implemented in June 2018. The enhanced system represents a significant improvement in the scope and functionality of the Register, and provides for better support of the CDRT's work to prevent the deaths of children in NSW.

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 *Community Services (Complaints, Reviews and Monitoring) Act 1993* under which the CDRT is required to report to Parliament:

- The *annual report* (s 34F), which details the activities of the CDRT and progress of the Team's recommendations.

- The *biennial* child death review report (s 34G), which consists of data collected and analysed in relation to child deaths. Until 2016, this report was prepared and tabled on an annual basis. Legislative amendments passed in November 2015 changed this reporting requirement to biennial. Our most recent (and final annual) child death review report was tabled in November 2016. Our next report will cover deaths of children that occurred in 2016 and 2017 and will be tabled in Parliament in early 2019.
- *Other reports* (s 34H), which provides for the CDRT to report to Parliament the results of research undertaken in the exercise of our research functions. The team is expected to report on its research at least triennially. Details of recent and current research are provided in chapter 3.

Changes to biennial reporting

The change to the timing of the biennial child death review report has aligned the CDRT and Ombudsman reporting requirements. From 2018, both the CDRT and reports of reviewable child deaths will be provided to Parliament biennially, as soon as practicable after 30 June each second year.

From 2018, we will combine the reports and table them as one document.

In weighing the advantages of a single report against two separate reports, there are considerable benefits in a combined approach. In particular, including deaths that are reviewable in a report of all child deaths provides for a holistic and contextual approach to analysis and consideration of trends and issues.

Combined reporting will also assist in resolving issues related to the sensitive and confidential reporting of a very small number of reviewable child deaths, and the fact that the deaths of children in care, and abuse and neglect-related deaths, raise distinct issues and prevention opportunities. Most children in care die as a result of natural causes, and these causes are well-considered by the CDRT, as are suicide deaths of children in care.

Bringing together our work and findings will help strengthen a public health approach to reviews of child deaths in NSW by ensuring the focus is on modifiable risk factors and whole of population measures for prevention. In addition, inclusion of abuse and neglect in this report will also highlight issues and strategies relating to the delivery of services to children, families, providers and community members, and assist in the identification of barriers and system issues involved in maltreatment-related deaths.

Chapter 3. Research to help reduce child deaths

Our research – both commissioned and internal – is an important way of examining causes and trends in child deaths in detail, and to examine measures that go to preventing or reducing the likelihood of child deaths. Information from research assists us in identifying and targeting recommendations for prevention.

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

- Is the project significant and does it link to the objectives of the CDRT to prevent and reduce deaths of children in NSW?
  - Does the Register indicate a high number of deaths / a spike in a particular cause of death / a particular lack of decrease in the rate of death?
  - Is there a sentinel event that highlights a systemic issue?
  - Is there a particular trend emerging from death reviews?
  - Is there evidence of gaps in knowledge / policy / legislation that presents a risk to children?
  - Is the project timely? Will it add value and provide important information about this particular issue and inform prevention strategies?
- Is any other agency or body already considering or researching the issue? If so, how would our work at this time add value?
  - Are there developments in public policy (for example, legislative review, government inquiry) that the project could directly contribute to and influence?
  - Is there a body or agency that might be better placed to undertake the work – either alone, or jointly with the CDRT?
  - Is the project achievable?
- Are resources available and if so, is this the best use of our time and funds?
  - Will the scope of the project allow delivery of a report in a reasonable timeframe?

Completed research in 2017-18

In 2017-18, we tabled reports from two research projects:

- Childhood injury prevention: Strategic directions for coordination in NSW, and
- Spatial analysis of child deaths in NSW.

Childhood Injury Prevention

We have a strong interest in childhood injury prevention in the context of our work to help prevent or reduce the likelihood of child deaths.

In November 2017, we tabled a report *Childhood injury prevention: Strategic directions for coordination in NSW*. The research was undertaken for the CDRT by Professor Kathleen Clapham (a CDRT member), and Cristina Thompson and Darcy Morris from the Centre for Health Service Development (CHSD) at the Australian Health Services Research Institute, University of Wollongong.

The work is the second phase of an earlier project we tabled in Parliament in 2015: *A scan of childhood injury and disease prevention infrastructure in NSW*. This project was also undertaken on our behalf by the CHSD. The scan confirmed that there was a need for stronger leadership and coordination to deliver improvements in childhood injury and disease prevention in NSW.

Addressing that finding, *Childhood Injury prevention: Strategic directions for coordination in NSW* explores the key components of a coordinated approach to childhood injury prevention. The four key components are identified as:

- *Policy leadership* to ensure that childhood injury is tackled using multiple strategies which support each other, including legislation, policy, regulation, education, awareness and behaviour change.
- *Data and information systems* to ensure that injury prevention activities are evidence-based and data-driven.
- *Research and knowledge translation networks* to bring researchers together to support greater collaboration in the advancement and translation of knowledge in childhood injury prevention.
- *Coalitions, collaborations and partnerships* to ensure that the very broad range of stakeholders involved in action to prevent injury to children makes coalitions, collaborations and partnerships an essential component of the way most organisations and individuals work in this field.

The key strategic observations made in the report were:

- Strong partnerships among key stakeholders and robust inter-agency and cross-organisational relationships provide the foundation for effective coordination.
- Coordination of childhood injury prevention is complex and not achieved through a single initiative but through action on multiple fronts (for example, leadership resulting in clear policy direction, robust data from effective surveillance systems used to underpin evidence-based approaches, support for high quality research, and knowledge translation and collaborative mechanisms to bring people together, that are funded, supported and sustained over time).
- There is no 'magic bullet' that generates policy leadership; this comes from political will and is articulated by committed policy officers through strategic frameworks and plans that identify priorities for action and set the agenda for change. As preventing unintentional injuries cuts across the responsibility of a number of government departments, one department must take the lead and coordinate activities to ensure that effort is not duplicated or, worse still, not undertaken.
- Effective child injury prevention efforts must be data-driven and evidence-based. Strengthening surveillance systems, particularly through the more effective use of existing datasets has been successfully demonstrated internationally, as has the use of state or national "action indicators" to monitor progress in childhood injury prevention efforts. There are opportunities to increase the use of data linkage to better target injury prevention interventions for the most vulnerable populations. The NSW Ministry of Health is already leading the way in the coordination of data and information access on injuries involving children and young people.
- The most effective strategies to support research coordination centre on clear government priorities supported by adequate funding and mechanisms to facilitate research dissemination and translation. Networks and collaborations are useful in bringing researchers together.
- There need to be clear mechanisms to bring people together that are funded, supported and sustained over time. The Australian Injury Prevention Network and the Injury Prevention Reference Group Committee (which is supported by the NSW Ministry of Health) provide a mechanism to foster research collaborations.

The authors of the report recommended that the report be referred by the CDRT to the Ministry of Health, for discussion about the way forward for childhood injury prevention.

In April 2018, the Ombudsman and Convenor of the CDRT met with the Secretary, NSW Health and the NSW Advocate for Children and Young People to discuss the report and a way forward.

It was noted that the CDRT necessarily focuses on serious injury and was not therefore best placed to lead broader efforts in childhood injury prevention. Childhood injury prevention also crosses over the interests of numerous government agencies and non-government stakeholders.

Against that background, the Advocate for Children and Young People agreed to take on the role of facilitating and supporting a forum to bring together government and non-government agencies with an interest in childhood injury prevention. The initial meeting of the NSW Child and Young Person Injury Prevention Working Group will be held in July 2018. The purpose of the Working Group is to:

- provide a forum for the discussion of child injury prevention priorities in NSW
- facilitate collaboration on child injury prevention projects by members, and
- discuss future child injury prevention planning, research and policy.

The long-term goal of the Working Group is to facilitate the reduction of risk, severity and frequency of injury to children and young people.

Spatial analysis of child deaths in NSW

In 2016, we commissioned the Australian Institute of Health and Welfare to undertake geospatial analyses of child deaths in NSW, in order to assist understanding of how child deaths vary across NSW and how area-level characteristics are related to the risk of death. Dr Deanna Pagnini led this work. We tabled a report of the analysis in April 2018.

The report focused on two key issues – the geographic distribution of child deaths across NSW, and how the risk of death varies by area-level characteristics. The report covered the 15 years between 2001 and 2015 and the 8,657 children who died in that period.

The report analysed the number and rate of child deaths, and presented the data at Statistical Area 3 level (SA3). SA3 in NSW relates to 92 areas with average populations between 30,000 and 130,000.

The key findings of the research included:

Overall, analysis found that the number and rate of child deaths in NSW are reducing. The child mortality rate has declined in NSW, and no area in NSW has seen a significant increase in its child mortality rate. The differences in mortality rates between areas have also declined over time.

However, some areas were identified as having experienced higher actual numbers of child deaths than others, or higher mortality rates. This is important information for area level planning, and identifying where location-based interventions or risk reduction strategies could be helpful.

One particularly important finding is that certain area characteristics are associated with an increased risk of death for children. The report provided an analysis of area-level characteristics and child mortality rates, focusing on four domains: socio-economic context, social capital, housing, and child health and development. Overall, child mortality rates are higher in areas of greater socio-economic disadvantage, in areas with higher levels of social exclusion, and in more remote areas.

The risk of dying during childhood was greater for children living in more disadvantaged areas, and that pattern was consistent across all included indicators. The likelihood of dying during childhood in New South Wales in 2011-15 was:

- 1.7 times as high for children in high poverty areas as for those in low poverty areas
- 1.8 times as high for children in areas with the lowest levels of school engagement among 16 year olds as for those in the areas with the highest levels of school engagement
- 1.5 times as high for children in areas with the highest levels of overcrowded housing as for those in the areas with the lowest levels of overcrowded housing
- 2.0 times as high for children in areas where 15% or more of children had been assessed as developmentally vulnerable on at least 2 of the 5 domains of the Australian Early Development Census (AEDC). This difference persists across all causes of death, where those in the areas of highest vulnerability were 1.8 times as likely to die of natural causes and 1.9 times as likely to die from external (injury-related) causes (for example, transport-related accidents, accidental poisoning, drowning).

The analysis is an important first step in examining the geographic distribution of child deaths in NSW, and some of the area characteristics associated with that variation.

The analysis provides important information for government and area level service providers. It will also be a key driver of the CDRT's work in analysing patterns and trends in child deaths and in assisting and promoting research that may reduce the likelihood of child deaths.

Ongoing research in 2017-18

Review of seatbelts and child restraints in car crashes

In 2017-18, Dr Julie Brown from Neuroscience Australia continued her review of child deaths resulting from motor vehicle crashes, and the possible contribution of inadequate or inappropriate restraints in these deaths. The review is examining the role or possible role of child restraints and seatbelts in 67 deaths of children 12 years of age and under in car and truck crashes in NSW.

In this period, Dr Brown finalised a literature review detailing key issues relating to child restraints and seatbelts and prevention of child injury and death in car crashes.

The review will be finalised in 2018.

Review and analysis of suicide clustering and evidence-based prevention strategies

In October 2017, we commissioned Dr Kairi Kolves from the Australian Institute for Suicide Research and Prevention at Griffith University to undertake a review and analysis of suicide clustering and evidence-based prevention strategies.

The research, based on literature and policy review, will:

- describe the phenomenon of suicide clusters with reference to school-aged young people (less than 18 years)
- examine risk factors relating to cluster suicides, and
- decribe evidence-based prevention/postvention strategies, and review existing youth suicide prevention strategies in NSW.

The impetus for this research was our identification of the suicide deaths of five young people that appear to be part of a suicide cluster in NSW. The deaths of these young people have received wide media and public attention. In this context, it is difficult for the CDRT to report in a manner that preserves the privacy of the young people and their families. At the same time, it is our role and in the public interest to identify patterns and trends and to make recommendations that may prevent or reduce the likelihood of deaths.

A research approach to the issue of cluster suicide, as described in the project focus above, will enable the CDRT to address and report on the issue more broadly, including possible recommendations to the NSW Government and relevant service providers.

The review will be completed by August 2018.

Other research and related activity

During 2017-18, CDRT expert members and advisers commenced two focused project reviews; a trial review of child deaths from brain cancer, and systematic review of the deaths of infants.

Review of child deaths from brain cancer

Cancers and tumours are consistently a leading cause of death for children aged 5-14 years. A main type of cancer causing the deaths of children is malignant tumours of the brain. The purpose of the review was to ensure optimum information was being collected through the Register of Child Deaths and analysed by the CDRT.

CDRT member Dr Luciano Dalla-Pozza and expert adviser Professor Les White assisted staff in a review of 20 of 38 children aged 1-17 years who died as a result of brain cancer in 2016 and 2017.

In undertaking the reviews, we trialled a revised review tool that expands the information collected to include the duration of disease, details of active treatment and palliative care, clinical trials and adverse events.

The work will assist the CDRT's monitoring and reporting of cancer-related deaths of children.

Review of infant deaths

The majority of children who die in NSW are infants aged less than 12 months. Over the 15 years to 2015, almost three quarters of the deaths of infants occurred in the neonatal period (the first 28 days of life).

CDRT member Dr Bronwyn Gould led a review of 480 infants who died from natural causes in 2016 and 2017. Expert adviser to the CDRT Dr Daniel Challis provided advice to the review on clinical issues.

The purpose of the review was to examine in more depth the information available to the CDRT on infant deaths, and to identify possible areas for prevention.

The review looked at a range of factors, including prematurity, infection and birth trauma. As a result of the review, we have expanded the information collected in the Register of Child Deaths to include the duration of the medical condition, preceding infection and diagnosis of congenital abnormalities. The review has identified birth asphyxia as an area for future detailed review.

This work will assist the CDRT's reporting on infant deaths and identification of areas for possible prevention.

Submissions and inquiries

We provided information and advice to a number of relevant inquiries in 2017-18.

- In September 2017, we provided a submission to the NSW Parliamentary Inquiry into prevention of youth suicide in NSW (Committee for Children and Young People). In addition to our submission, CDRT Convenor Mr Michael Barnes and member Professor Philip Hazell gave evidence before the Inquiry in February 2018.
- In November 2017, we provided a submission to the Parliamentary Inquiry into support for new parents and babies in NSW (Committee on Community Services).
- In May 2018, we provided a report to the National Children's Commissioner to assist in her preparation of Australia's report to the UN Committee on the Rights of the Child.
- In June 2018, we provided a submission to the NSW Government's proposed Swimming Pools Regulation 2018 and Regulatory Impact Statement. We also attended consultations on the changes.

Sudden Unexpected Death in Infancy

Last year, we reported on work to improve the investigation of sudden unexpected death in infancy (SUDI), and to develop an alternative classification for SUDI. This work progressed in 2017-18.

Every year in NSW, between 40 and 50 infants under the age of 12 months die suddenly and unexpectedly, where a cause is not able to be determined immediately. Consistent classification can help to identify factors that may contribute to these infant deaths, which is a key first step toward preventing future deaths.

The most commonly accepted framework for classifying SUDI is that proposed by Krous et al in 2004 (the San Diego definition), which was broadly adopted at the SIDS and Kids Pathology Workshop in.[1] Since that time, there have been significant shifts in the epidemiology of SUDI and significant advances in our understanding and identification of 'modifiable risk factors'.[2]

1. http://www.sidsandkids.org/research/sids-and-kids-2004-pathology-workshop/
2. Mitchell, E and Krous, H 2015, 'Sudden unexpected death in infancy: a historical perspective', *Journal of Paediatrics and Child Health*, pp 51, 108-112.

In 2017, we developed an alternative classification – drawing on the earlier framework – that emphasises the identification of risk factors present in the child's environment and background. During 2017-18, the classification was trialled by the NSW Coroner's Office and the Department of Forensic Medicine. Interstate child death review committees (South Australia, Queensland, Northern Territory, Tasmania) also trialled the classification using 2015 data. As a result of feedback from these trials, we have amended the classification. This is described in Figure 1.

In other activities related to SUDI, CDRT members Professor Heather Jeffery and Dr Susan Arbuckle continued throughout the year to participate in the State Coroner's Office/Forensic Medicine multidisciplinary review, which provides expert advice to pathologists and the Coroner to assist with identification of cause of death for infants who died suddenly and unexpectedly. The state government has also continued work with key agencies to revise the SUDI investigation process in NSW. This process is detailed in chapter 6.

Moving forward, we will continue to work with key stakeholders to achieve a consistent and meaningful approach to understanding and preventing SUDI.

Figure 1: CDRT Classification for Sudden Unexpected Death in Infancy [4]

Classification	Definition
SUDI 0	Post-death investigation is not sufficient, and a cause of death cannot be determined or excluded with certainty because of lack of information: • Death scene examination is undocumented or insufficient[3] • No or insufficient review of medical history of the child / family, including family interview (as per protocol) and review of clinical records • Autopsy not in compliance with the SUDI protocol, or missing tests or screens necessary to confirm or exclude a cause
SUDI 0 +	As above AND one or more intrinsic and/or extrinsic risk factor(s) were able to be identified
SUDI 1	The infant was found in a safe environment with no evidence of accidental death, unexplained trauma, or abnormal presentation prior to death. Following thorough investigation, all other possible causes have been excluded. ***Safe environment*** *in this context means that the infant was:* • placed to sleep on their back – not on their front or side • for the first six months after birth, placed on their own safe infant-specific bedding that, where standards exist, is compliant with those standards. • in an environment free from tobacco smoke • dressed appropriately for the conditions (not over dressed) and their head and face are uncovered • in an environment free from pillows or other soft objects that pose a suffocation risk – such as adult blankets or quilts, pillows and soft toys ***Thorough investigation*** *includes a minimum of:* • sufficient and documented death scene examination • review of medical, social and family history of the child/family, including family interview with protocol and review of birth and clinical records • autopsy sufficient[4] and in compliance with the SUDI protocol

...continued over page

3. 'Sufficient' to be determined in NSW, pending review of SUDI investigation. Complete history includes detailed history of events leading up to the death, together with medical, social and family history, plus an explicit review of any evidence suggesting past neglect or abuse of this child or other children in the family.
4. 'Sufficient' to be determined in NSW, pending review of SUDI investigation. Currently as per SUDI protocol.

Classification	Definition
SUDI 2	As above, with the exception that non-modifiable (intrinsic) risk factors are identified: • low birth weight (less than 2500g) • pre-term birth (less than 37 weeks) • small for gestational age (less than 10th percentile weight for age at birth) or small for age on relevant intergrowth 21 or WHO charts respectively • preceding infectious illness (within the last two weeks) • maternal smoking during pregnancy
SUDI 3	The infant was found in an unsafe environment with modifiable (extrinsic) risk factors present, and following thorough investigation, mechanical asphyxia or suffocation cannot be determined or excluded with certainty. ***Unsafe environment*** *in this context means the infant was:* • placed to sleep prone or on their side • bed sharing with an adult (if aged less than six months),[5] or bed sharing with an adult at any age if the adult is under the influence or likely influence of alcohol or other drugs • placed on their own in bedding not specifically designed for infant sleep (for example, adult mattress, pram, sofa), in infant-specific bedding that was non-compliant with existing standards or was otherwise unsafe • exposed to tobacco smoke after birth • dressed inappropriately for the conditions (over dressed) and/or their head and/or face was covered • placed in an environment with pillows or other soft objects that pose a suffocation risk
SUDI Explained	Regardless of sufficiency of post-death investigation, a cause of death can be determined with certainty
SUDI Explained +	A cause of death can be determined with certainty AND post-death investigation identified one or more intrinsic and/or extrinsic risk factor(s)
Undetermined	A finding of undetermined should only be applied in a SUDI context where the above classifications are insufficient. This would include where there was abnormal acute presentation prior to death (for example, sudden onset illness) but this is not sufficient to explain a cause of death

5. This is a conservative threshold. Some studies suggest an independent risk of bed sharing (in the absence of any other risk factor) applies to infants aged less than three months. We will monitor this threshold over time.

Chapter 4. Our strategic priorities

The CDRT's practice is to develop a triennial plan of strategic priorities to guide our work and prioritise our resources. This year, we continued to put in place the actions agreed in our Strategic Priorities Plan 2016-19. We also held our triennial planning meeting, to determine future areas of focus.

Meeting our priorities

Figure 2 details progress against our key strategic priorities 2016-19.

Overall, we achieved our goals or are on track to achieve them by 2019. Some proposed actions will be progressed over time. For example, the CDRT is keen to explore options for data sharing through record linkage. This will require work to consolidate our Register (in train), consultation with agencies from whom we collect information, and further discussion with the NSW Centre for Health Record Linkage.

Figure 2: Progress report: CDRT strategic priorities 2016–19 (at June 2018)

Priority	Status	Comments
Annual/biennial reports		
Child death review report – deaths in 2015	Completed 2016	
CDRT Annual Report 2016-17	Completed 2017	
CDRT biennial Child death review report – deaths in 2016 and 2017	Pending – 2019	First CDRT biennial report
Projects		
Between 2016 and 2019, we will deliver at least three research reports:		
• Child deaths from infectious disease : a ten year review	Completed 2016	
• Childhood Injury Prevention: Strategic directions for NSW	Completed 2017	
• Geospatial analysis of child deaths in NSW	Completed 2018	
• Suicide clusters and evidence-based prevention strategies	Current – to be tabled 2019	
Between 2016 and 2019, we will undertake and report on at least two detailed group reviews, which will be included as areas of focus in our biennial report:		
• Transport deaths – preventable deaths linked to the absence or misuse of child restraint	Current – to be tabled 2019	To be tabled as a stand-alone report
• Quad bike and side-by-side vehicle fatalities 2006-2015	Completed 2016 – reported in annual report (2015 deaths)	
• Drowning deaths in private swimming pools 2006-2015	Completed 2016 – reported in annual report (2015 deaths)	
• Cancer deaths (trial review)	Completed 2018	

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Priority	Status	Comments
Infrastructure		
Finalise fixes required following the implementation of the revised Register of Child Deaths (database)	Completed 2018	Revised Register in operation at 1 July 2018
Establish a dashboard of key data	Current – will be completed by July 2018	Data is available now – the dashboard will be final in July
Develop a detailed data dictionary for the Death Review System (DRS)	Current– will be completed by end July	We have engaged Professor Rebecca Mitchell to write the dictionary after production of the revised Register
Liaise with the Centre for Health Record Linkage – aiming for an appropriate set of data from DRS becoming a Data Linkage Key	Under ongoing consideration	Any linkage is pending revision of the Register and consideration of CDRT vs other agency information
Identify relevant external datasets and strategies to link the information (including the Perinatal Data Collection)	Ongoing	Perinatal data collections are now being provided by NSW Health Arrangements have been made for regular information exchange with NSW Health regarding deaths from infectious disease
Engagement and communication		
Continue and strengthen our involvement with the Paediatric injury research and management forum	Progressed	CDRT, NSW Health and the NSW Advocate for Children and Young People agreed on establishment of an alternative forum by the NSW Advocate – first meeting scheduled July 2018
Join and actively participate in the Australian Injury Prevention Network	Partly progressed	Joined. Attend/participate as possible
Identify key stakeholders and consult/liaise in regard to common issues and collaboration	Ongoing	When possible/appropriate
Prepare fact sheets from our annual report 2016 and biennial report 2018 and research reports, and publish these on our website	Ongoing	Fact sheets prepared and distributed for last annual report.
Prepare fact sheets on high fatality rate deaths and/or other topical issues	Ongoing	Fact sheets associated with the CDRT annual report have been produced
Provide data and advice through submissions to relevant external reviews and inquiries	Ongoing	Submissions to Suicide Prevention Inquiry and Support to New Parents and Newborn Babies Inquiry (both 2017)
Work with the State Coroner's Office and other relevant stakeholders to achieve a consistent approach to defining SUDI	Ongoing	Meetings with Coroner's office and forensic services in 2017. Revision of classification and trial in forensic services.

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Priority	Status	Comments
Scope of our work		
Develop a CDRT position paper on the role of the CDRT in injury and disease prevention, including the capacity of the CDRT to examine morbidity as well as mortality	Completed	Final position paper 2017
Develop a CDRT position paper on the role of the CDRT in relation to stillbirths, including the capacity of the CDRT to review or include stillbirths in child death review and reporting	Not progressed	Planned for 2019
Develop strategies to implement the recommendations of the Ombudsman's review of journalism of fatal neglect	Ongoing	Change to biennial report agreed; changes to neglect will be implemented

Strategic priorities meeting – June 2018

In June 2018, we held a planning meeting to consider our future from 2019.

Overall, the CDRT reaffirmed its commitment to ensuring that careful consideration is given to working out where we can have the most impact, our capacity to do identified work, and where we can add to the body of knowledge (rather than duplicate the work of others).

Six important themes emerged from the discussion, and will form the basis of our plan for 2019-21:

- The role of social determinants in child deaths, predominantly poverty and disadvantage. Members agreed these factors are crucial in understanding child deaths, and are relevant to all death types.
- Linked to social determinants, the potential for examining more deeply social and other factors that are evident in the deaths of children, particularly injury-related deaths.
- Following on from the *Spatial analysis of child deaths in NSW*, and building on the other key themes above, comparative analysis was identified as a useful approach to develop in future work. For example, perinatal data may provide the capacity to compare which infants died and those who did not, to better understand factors that might be predictors of child mortality.
- In specific and targeted projects, including analysis of cases where children have been seriously injured in similar circumstances to which children have died. Current legislation allows for this broadening as it specifically states the CDRT's role is to prevent or reduce the likelihood of child deaths [s34D(e)].
- Exploring the value of a focus on protective factors – what is working well, as well as what is not working. The issue was raised in various contexts, but notably in the context of Aboriginal communities and would seek to address what it is about communities that are otherwise the same, but have lower rates of child deaths. This would identify and build on strengths (such as capacity, resilience, community leadership) to inform prevention efforts.

Members considered that the CDRT is now in a position (due to its experience and credibility) to 'shine a light' on important issues within the community and this was put forward as a useful approach and way to start conversations about prevention.

The outcomes of the planning session will be the subject of further discussion by the CDRT in 2018. A new strategic priorities plan will be finalised by 2019.

Chapter 5. Disclosure of information

We are required to include in our annual report to Parliament whether any information has been disclosed by the Convenor under s 34L(1)(b) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. This chapter allows the Convenor to authorise the release of information acquired by the CDRT in connection with research 'that is undertaken for the purpose of helping to prevent or reduce the likelihood of deaths of children in NSW'.

Disclosure under s 34L(1)(b)

In 2016-17, we released information under this provision to the Children's Hospital at Westmead/University of Sydney. The information provided was place of death location for research being undertaken on the epidemiology of childhood death in intensive care units.

Other information disclosure

As described in chapter 3, the CDRT commissioned or conducted its own research. Information was released to researchers who were engaged as 'team-related persons' and appointed as expert advisers to the CDRT to conduct analysis of data on behalf of the Team.

In addition, s 34D (3) of the Act allows the Convenor to enter into an arrangement for the exchange of information between the CDRT and a person or body having similar functions in another state or territory, relevant to the exercise of the CDRT's functions and those of the interstate body. In this context, we provided information to agencies in Queensland and the Australian Capital Territory:

- On behalf of the Australia and New Zealand Child Death Review and Prevention Group, Queensland has taken on the role of co-ordinating high-level data from all state and territory CDRTs to provide a basic national data set. In August 2017, we provided information to the Queensland Family and Child Commission on the number of deaths of children in NSW by age, sex, Aboriginal status and broad cause of death (disease or morbid conditions, injury or SUDI). This was reported in the *Annual Report: Deaths of children and young people, Queensland, 2016-2017.*
- The ACT child death register includes children who normally live in the ACT, but whose death occurs outside of the ACT. In March 2018, we provided the ACT Children and Young People Death Review Committee (CYPDRC) with information about the deaths of ACT resident children who died in NSW. In June 2018, we developed an information exchange agreement with the CYPDRC under s 34D(3) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993.*

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

Chapter 6. Our recommendations

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

Our legislation requires that our annual report to Parliament includes details of the extent to which our previous recommendations have been implemented.

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

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

At present, we have 13 open recommendations, relating to vaccine preventable infectious disease, SUDI, quad bikes and side-by-side vehicles, private swimming pools, asthma and house fires. These are detailed below, along with a summary of agency responses and our comments on progress.

Original correspondence from agencies is included at appendix 1.

Vaccine preventable infectious diseases

Our recommendation

We recommended that:

> **NSW Health should consider the observations and recommendations made in the report, Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005-14 and advise us of existing or planned strategies to address these.**
>
> **(Recommendation 1, Child Death Review Report 2015)**

Background to the recommendation

In October 2016 we tabled a report Child Deaths from *Vaccine Preventable Infectious Diseases, NSW 2005-2014*. The report was the outcome of research we commissioned from the National Centre for Immunisation Research and Surveillance (NCIRS). The research analysed data held in the NSW Register of Child Deaths in relation to the deaths of children resulting from infectious diseases in NSW over the 10 year period.

The NCIRS identified 54 cases where the confirmed or probable cause of death was a disease for which a vaccine is currently provided by the National Immunisation Program. The report concluded that 23 deaths over the 10 years were preventable or potentially preventable by vaccination, with influenza and meningococcal the most common causes of preventable or potentially preventable deaths. Young infants were particularly at risk.

The report highlighted the importance of maintaining a high rate of vaccination, and made a number of critical observations about ensuring that children at high risk have full access to immunisation, and promoting immunisation for those in contact with infants and children at high risk.

In July 2017, NSW Health advised us that it supported the recommendation and provided information about a range of strategies and initiatives currently being implemented by Health Protection NSW to increase immunisation access and coverage among children.[6]

Progress in 2017-18

In June 2018, we received a further update from NSW Health. Key strategies include:

- electronic medical record alerts at two children's hospitals to identify high risk children requiring vaccination, and establishment of influenza drop-in vaccination clinics
- provision of free influenza vaccination to all children aged six months to less than five years
- strategies to promote pertussis and influenza vaccination during pregnancy, including development of an online education module for maternity staff and midwives, and other promotional materials
- conduct of a webinar to inform GPs about the extended National Immunisation Program catch-up vaccine program for 10-19 year olds

The NCIRS also directed recommendations to us and Health Protection NSW aimed at enhancing data collection in relation to child deaths due to infectious disease, specifically through communication and cross-checking of vaccine preventable deaths of children. In 2017, we started a process of information exchange with Health Protection NSW to ensure that all vaccine preventable deaths of children in NSW are identified, and any discrepancies in data addressed. This exchange will take place annually.

We welcome the actions undertaken by NSW Health to increase vaccination rates among children. The intent of our broad recommendation has been substantially met, and we will now close monitoring of this recommendation. We will continue to monitor strategies to address prevention of vaccine preventable disease in the context of our ongoing work.

Sudden Unexpected Death in Infancy (SUDI)

Our recommendation: SUDI investigation

We recommended that the NSW Government, in the context of previous CDRT recommendations and the work of Garstang et al:[7]

> **Consider a centralised model for SUDI response and investigation in NSW. This would be staffed by specialist health professionals to work with police, the family, pathologists and the Coroner to respond immediately and consistently to SUDI.**
>
> **Devise a joint agency policy and procedure governing the individual and coordinated roles and responsibilities of NSW Health, the NSW Police Force and the NSW Coroner in SUDI investigation. The policy and procedure should incorporate all elements of a joint agency response to SUDI:**
>
> **Expert paediatric assistance in death scene investigation and interviews with the family (noting that investigation of any suspicious deaths would be the responsibility of police).**
>
> **(a) Specialised training and development of resources for police in SUDI investigation.**
>
> **(b) Identified specialists to take the SUDI medical history, and review of the SUDI medical history form and the immediate post-mortem findings to enable further specific history taking where necessary.**

6. *NSW Child Death Review Team Annual Report 2016-17*, p 13.
7. Garstang J., Ellis C., & Sidebotham, P. (2015). Reporting to Sudden Unexpected Death in Infancy (SUDI): A review of the evidence. Research compiled for NSW Kids and Families, through the Sax Institute.

(c) **Application and monitoring of standardised protocols for SUDI pathology, with specific requirements for standard screens in sudden unexpected infant death.**

(d) **The conduct of SUDI post-mortems by specialist paediatric pathologists. Minimally, where post-mortems are not conducted by paediatric pathologists, there should be consultation with paediatric specialists.**

(e) **Multi-disciplinary review following post-mortem. The review should be chaired by an informed paediatrician, and involve relevant health providers to review the case. Review should consider all available information and provide advice to assist the Coroner in determining cause of death, to advise on possible genetic issues and necessary investigations for surviving children and parents, and prevention strategies for the family in the context of identified risks.**

(f) **The introduction of clear procedures to ensure families are provided with:**

- **i. appropriate advice and referral, particularly where genetic causes are indicated or suspected, and**
- **ii. ongoing contact, including for provision of grief counselling.**

(Recommendations 2 and 3, Child Death Review Report 2015)

Background to the recommendations

Each year in NSW, around 40 infants under the age of 12 months die suddenly and unexpectedly. Identifying a cause of death for SUDI is important for a number of reasons, including for parents and carers to understand their loss; to provide information about possible medical or genetic implications for the family; and to learn from untimely deaths and help prevent future deaths.

Identifying a cause of death requires a thorough investigation, involving police, NSW Health (emergency departments and forensic services) and the Coroner's office. However, there is no whole-of-government policy in NSW to direct the cross-agency coordination of responses to SUDI, and our work identified that on average, a cause of death is able to be determined in only one quarter of SUDI that occur in NSW.

In July 2017, the NSW Government advised us that it supported improving the interagency approach to SUDI investigation in NSW, and had started consultations with agencies on options to improve the whole-of-government response to SUDI.

Progress in 2017-18

In June 2018, the Department of Premier and Cabinet (DPC) advised that the agency, with Deputy State Coroner O'Sullivan, was working with agencies to address the recommendations. A Cross-Agency Working Group has been established with NSW Police, NSW Health (including NSW Ambulance and Forensic Medicine) and the NSW State Coroner's Court.

The working group is engaged to establish a clearer and more coordinated approach to responding to incidents of SUDI, and work is tracked through interagency meetings.

DPC has noted that the work is currently in its early stages, with key deliverables in 2018 and longer-term work to progress beyond this year.

We commend the work being coordinated by DPC and the Deputy State Coroner, and acknowledge the commitment of all involved agencies.

DPC has provided us with ongoing updates and advice about outcomes from the working group's discussions and actions, and we are confident that progress is being made to substantially improve the NSW response to SUDI investigation.

We will continue to actively monitor and report on progress in developing and implementing the recommendations.

Our recommendations: SUDI classification and specialist review

We recommended that the State Coroner:

- **Should consider including specialist review of key information to assist in determining manner and cause of death for SUDI. This could include consultation with specialists in paediatric radiology, toxicology and neurology.**
- **With the Child Death Review Team, should establish a consistent approach to classifying SUDI.**

(Recommendations 4 and 5, Child Death Review Report 2015)

Background to the recommendations

In 2015 and in consultation with the Office of the NSW State Coroner, the CDRT conducted a retrospective review of SUDI where the Coronial determination of cause of death was unascertained or undetermined (including deaths attributed to Sudden Infant Death Syndrome). The purpose of the review was to consider opportunities to identify a cause of death. In regard to cause of death, the CDRT made three key observations:

- The determination of cause of death as unknown (SIDS, SUDI, unascertained, undetermined) by the Coroner was understandable given the incomplete information relating to death scene investigation, infant medical history and pathology. However, the CDRT noted that the standard of proof required of the Coroner is the balance of probabilities, and in some cases, it would appear that a cause could have been identified, at least in the context of 'likely' cause.
- The use of SUDI terms appeared to be inconsistent, with almost identical circumstances and findings variously recorded as SIDS II, SUDI with bed sharing, or undetermined. Some categories (for example, SIDS 1A) were incorrectly applied, using the standard definition for SUDI.
- Specialist review of key information could assist in determining manner and cause of death. This could include consultation with a paediatric radiologist, toxicologist, neurologist or geneticist regarding post-mortem findings.

In 2017, the Coroner advised us that both recommendations were supported.

The CDRT subsequently worked with the Deputy State Coroner and Forensic Medicine to develop and trial a classification system for SUDI that focused on identifying specific risk factors in the child's environment or relating to their health.

The Deputy State Coroner and Forensic Medicine also coordinated a multi-agency case discussion for SUDI in order to assist the forensic and coronial process.

Progress in 2017-18

In May 2018, the NSW State Coroner advised that the Coroner's Court and Department of Forensic Medicine now convene a multi-disciplinary paediatric review team meeting. The team reviews all SUDI cases.

In addition, the Coroner's Office has continued to work with the CDRT to provide advice and feedback on the SUDI classification.

We commend the work of the Coroner's Office in progressing the recommendations. CDRT members with expertise have assisted in the multidisciplinary review process and note the value of this review. We also appreciate the Deputy State Coroner's participation in developing and trialling an alternative classification for SUDI.

The substance of the recommendations has been met. We will no longer monitor the implementation of these recommendations. We will continue to work with the Coroner's Office and Forensic Medicine to progress and refine SUDI classification, and will report on the outcomes of this work.

Our recommendation: unintentional bed sharing

Noting observations from our work about risks arising from unintentional bed sharing, we recommended that NSW Health, in consultation with Red Nose, should:

> **Review current advice and educational strategies, with a view to:**
>
> - **The inclusion of advice and preventive strategies to parents and carers in relation to unintentional bed sharing as part of NSW Health education and advice programs, and the Red Nose 'Safe Sleep My Baby' public health program.**
> - **Strategies targeted to young mothers, including use of alternative avenues of advice through social media and parenting blogs, and targeting grandmothers for safe sleep education.**
>
> **(Recommendation 6, Child Death Review Report 2015)**

Background to the recommendation

In the five years 2011-15, we identified that 18 infants had died in circumstances of unintentional bed sharing. In all cases, the infant was being fed on a bed (12) or lounge (6), and the adult carer fell asleep. The majority of infants were neonates. A cause of death was identified for only two infants; in one case, asphyxia and the other pneumonia. In most cases, the cause of death was 'undetermined' or 'unascertained' (7) or SIDS Category II (2). Pathologist reports noted the possibility of overlaying and possible asphyxia for a number of the infants. We considered that safe sleep advice and education should identify and share strategies to assist parents and carers to avoid this situation.

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

In July 2017, NSW Health advised us that they supported this recommendation and had held preliminary discussions with Red Nose to discuss safe sleeping. NSW Health detailed a number of awareness raising strategies for SUDI, including development of a cot card for use in NSW Health maternity facilities.

Red Nose also stated their support for the recommendation and advised that the organisation was well placed to partner with NSW Health. Red Nose detailed a range of resources and education initiatives being planned or delivered.

Progress in 2017-18

In June 2018, NSW Health advised that safe sleeping had been further addressed through:

- revising the Child Personal Health Record including safe sleeping information, and
- completing the safe sleeping e-learning module, which includes modelling of conversations with grandparents.

NSW Health advised that Red Nose was involved in both strategies, and ongoing dialogue occurs between the two agencies.

In May 2018, Red Nose advised that it provides a range of services and supports to promote safe sleeping, and is looking to expand the avenues used to do so; for instance, through targeting resources to parents during pregnancy as well as post-partum. Red Nose has undertaken steps to target resources appropriately to young women, and is researching the safe sleep education needs of grandmothers.

We note the steps that are being individually taken by NSW Health and Red Nose to explore new ways of targeting safe sleep messages to at risk populations.

However, we will continue to monitor progress in relation to advice to, and preventive strategies for, parents and carers in relation to unintentional bed sharing.

Our recommendation: SUDI – targeting high risk populations

In addition to the new recommendations above, we continued to monitor a joint recommendation to NSW Health and Family and Community Services (FACS). In our *Child Death Review Report 2014*, we recommended that:

> **FACS and NSW Health should jointly consider initiatives in other jurisdictions that specifically target high risk populations, with a view to considering their applicability to NSW. This should include consideration of the findings emerging from safe sleep pod programs in New Zealand and Cape York.**
>
> **(Recommendation 4, Child Death Review Report 2014)**

Background to the recommendation

Our reviews have identified that Aboriginal families, families with a child protection history, and families living in areas of greatest socio-economic disadvantage were more likely to experience SUDI. In the context of risks posed by bed sharing and unsafe bedding, we noted initiatives in New Zealand and Cape York to promote the use of safe sleep pods, and the reported high levels of acceptability in communities.

While our recommendation was supported, both agencies noted the need for evidence-based practice and lack of conclusive findings about the benefits of devices such as safe sleep pods. Both agencies noted their ongoing joint work in relation to high risk populations.

Since the time of our original recommendation, further studies have been released which show benefit from programs using safe sleep pods in conjunction with safe sleep education.

Progress in 2017-18

NSW Health advised in June 2018 that it had met with FACS and agreed to continue collaborative work in relation to resources for high risk populations. NSW Health is also monitoring outcomes of trials of safe sleep pods.

In April 2018, FACS advised that the unit implementing 'Their Futures Matter' system changes will consider evidence referred to in our recommendation (findings emerging from the safe sleep pods programs in New Zealand and Cape York) along with other evidence-based programs and responses that may improve outcomes.

Since our recommendation in 2015, consideration of evidence-based strategies in other jurisdictions that could assist NSW in tackling rates of SUDI in certain populations has been largely limited to monitoring trials. We will no longer monitor this particular recommendation, but will focus on specific actions being taken by both agencies, together or separately, to prevent SUDI in Aboriginal families, in families where there is a child protection history and in families living in disadvantaged areas.

Quad bikes and side-by-side vehicles

Our recommendation

Noting the recommendations made separately by the NSW Coroner and Transport and Road Safety, University of NSW (TARS) in relation to children and quad bikes and side-by-side vehicles, we recommended that:

> **The NSW Attorney General refer to the NSW Law Reform Commission for review, the introduction of legislation to prohibit any child under 16 years of age from using an adult-sized bike or side-by-side vehicle on private property or in recreational vehicle areas.**
>
> **(Recommendation 7, Child Death Review Report 2015)**

Background to the recommendation

Each year, on average, one or two children die in NSW in quad bike or side-by-side vehicle crashes. Mostly, these crashes occur on private properties, particularly farms. There is no legislative prohibition in NSW that applies to the use of quad bikes on private properties, such as farms, by children under 16 years of age. A child over eight years of age can ride an appropriately registered motor vehicle, including a quad bike or side-by-side vehicle (SSV), in a recreation vehicle area. However, it is broadly accepted that children under the age of 16 years should not ride adult-sized quad bikes or SSVs.

The Department of Justice did not support our recommendation.

However, the Department of Justice advised that the NSW Government is committed to working with the Commonwealth, other jurisdictions and the agricultural industry to reduce quad bike deaths in the community, including those of children. Stated initiatives included:

- the NSW Quad Bike Safety Improvement Program
- the NSW Quad Bike Safety Industry Action Group, and
- the NSW Government calling for the Commonwealth Government to introduce a national five-star safety rating system for quad bikes.

Progress in 2017-18

In May 2018, the Department of Justice advised that the Quad Bike Safety Improvement Program had resulted in 'investments of more than $20.3 million from farmers improving their quad bike safety'.

In relation to children and quad bikes, the department advised that a child safety television advertisement had appeared on commercial regional stations and had received 162,000 online views.

The Department of Justice also noted the current investigation by the Australian Competition and Consumer Commission (ACCC) into safety standards for quad bikes and side-by-side vehicles.

Our reviews have consistently highlighted the inherent dangers of quad bikes and SSVs for children, including in circumstances where protective devices were used. Almost all of the fatalities in the last 10 years were from crush injuries or major head trauma as a result of vehicles rolling over. We note the ACCC Consultation Regulation Impact Statement (March 2018) identifies that 15 per cent of all recorded quad bike deaths between 2011-17 were of children below the age of 16. The ACCC also notes that as part of a holistic approach to mitigate safety risks of quad bikes and SSVs, 'appropriate complementary regulatory measures should be considered by other jurisdictions and agencies. For example, a ban on children from operating adult quad bikes and SSVs…'.[8]

In our view, there is a very strong case in favour of legislating to prohibit any child under 16 years from using an adult-sized quad bike or side-by-side vehicle on private property or in recreational vehicle areas. We acknowledge that the NSW Government does not agree with this view. On that basis, we will no longer monitor this recommendation. We will, however, continue to scrutinise the impact of measures on the number and rate of deaths of children in quad bike and SSV crashes.

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8. Australian Competition and Consumer Commission 2018, https://consultation.accc.gov.au/product-safety/quad-bike-safety-draft-regulation-impact-statement/supporting_documents/Quad%20Bike%20Safety%20%20Consultation%20Regulation%20Impact%20Statement.PDF.

Drowning: private swimming pools

Our recommendation: prioritising pool inspections

We recommended that the Office of Local Government should:

(a) Include within the prescribed information that pool owners must supply on registration of a pool, details about whether children under five years of age reside at or regularly visit the property.

(b) Work with local councils to prioritise inspection of pools at locations where children reside or regularly visit, and rental properties with pools.

(Recommendation 8, Child Death Review Report 2015)

Background to the recommendation

Children under five are most at risk of drowning in backyard pools. Around a quarter of children who drowned in private swimming pools were living in a rental property. In this context, and noting that there is no uniform approach to inspection regimes, we recommended that priority for inspections should be pools at properties where young children reside. In order for councils to identify those properties, we considered that pool owners should be required to indicate whether children under five years live at or regularly visit the property.

In 2017, the Office of Local Government (OLG) advised that the NSW Government did not support the recommendation, on the basis that 'making it compulsory to supply sensitive information may have a detrimental effect on the willingness of pool owners to register their pools, and information regarding the age of children would quickly become out of date'. The OLG advised that councils already have access to demographic information that assists them to prioritise compliance inspections to areas of risk.

Progress in 2017–18

In May 2018, the NSW Department of Finance, Services and Innovation (DFSI), which is now responsible for the swimming pools register, provided information about the demographic information available to councils. This includes Australian Bureau of Statistics data, annual birth data from the NSW Registry of Births, Deaths and Marriages, and development application information (providing information about multiple bedrooms and extensions). Councils can also gain information about rental properties from rates notices.

DFSI noted that 'This information would assist in targeting properties which have a higher likelihood of children residing, [or] visiting, as well as assisting with identifying rental properties'.

The primary purpose of swimming pool regulation is to ensure the safety of young children. Inspection regimes are determined by individual councils, with no overall guidance on prioritisation. In our view, it would make clear sense that a swimming pool inspection regime should target swimming pools on properties where children under five years live or frequent, and that should be a consistent priority across all local government areas.

We acknowledge that the NSW Government does not support this recommendation and for that reason, we will no longer monitor this proposal. However, we will continue to highlight the role of non-compliant swimming pool barriers in the swimming pool drowning deaths of children.

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

We recommended that the Office of Local Government:

> **should publish annual data from its analysis of the swimming pool register, including but not limited to:**
>
> **(a) the number of pools registered**
>
> **(b) the number of pools that have been inspected**
>
> **(c) the proportion of inspected swimming pools that were deemed non-compliant with the Act at the time of inspection**
>
> **(d) the main defects identified at the time of inspection, and**
>
> **(e) whether or not owners have rectified defects within a reasonable period of time.**
>
> **(Recommendation 10, Child Death Review Report 2015)**

Background to the recommendation

Our *Child Death Review Report 2015* noted that there is little publicly available data on the outcomes of the regulatory regime for swimming pool safety and inspection. For example, there is no available consolidated data on:

- the number of pool inspections carried out across NSW
- compliance with legislative requirements identified through inspections or orders issued to rectify non-compliance, or
- whether owners rectify faults, and within what timeframe.

In the context of transparency and outcomes measurement, we considered there should be open and regular reporting by government on these aspects of swimming pool regulation.

In 2017, the Office of Local Government supported this recommendation in principle. The OLG advised us that councils are required to include in their annual reports the number of mandatory inspections carried out, along with the number of certificates of compliance and certificates of non-compliance issued.

Progress in 2017–18

Our review of local government annual reports for 2016-17 identified a low level of compliance with this requirement. Of the 128 councils, we examined the annual reports of 108. Of these, 28 reported some information about swimming pool inspections and certificates issues. For 80 councils, we identified no relevant information. The OLG annual report provides information that at 30 June 2017, 349,961 swimming pools were registered and 58,598 total certificates of compliance have been issued. There were 32,826 certificates of compliance issued during 2016-17.[9]

In May 2018, DFSI advised that the department has been 'reviewing the IT infrastructure supporting the Swimming Pool Register', and is considering enhancements to the ability to report on defects and amalgamated data reporting across councils.

In our view, it is essential that compliance with swimming pool regulation and outcomes of the inspection regime – including issues related to non-compliance and rectification – be publicly reported. We will continue to monitor this recommendation.

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9. *Office of Local Government NSW 2017, Annual Report 2016–17*, http://www.olg.nsw.gov.au/sites/default/files/OLG%20Annual%20Report%202016-17_0.pdf.

Our recommendation: swimming pool safety barrier standards

We recommended that:

> **In the context of proposals contained in the Independent Review of *Swimming Pool Barrier Requirements for Backyard Swimming Pools in NSW*[10] (discussion paper), the NSW Government should amend the *Swimming Pools Act 1992* to:**
>
> **(a) Include a single standard for NSW for child resistant swimming pool safety barriers, aligned to national standards, in order to enable the relevant state agency or agencies to interpret and provide guidance on required standards to pool owners and the general public.**
>
> **(b) Remove automatic exemptions from swimming pool safety barrier requirements.**
>
> **(c) Require persons purchasing a portable swimming pool that is subject to the requirements of the Act to register the pool at the point of sale.**
>
> **(Recommendation 11, Child Death Review Report 2015)**

Background to the recommendation

The *Independent Review of Swimming Pool Barrier Requirements for Backyard Swimming Pools in NSW* (2015) put forward a number of proposals that concurred with our review findings. The regulatory framework for swimming pools in NSW is complex. The Swimming Pools Act requires compliance with standards established by Standards Australia, but does not include the standards. This is because the standards are licensed and available only for purchase. There are also numerous exemptions and variations to regulatory requirements that result in different safety measures for certain classes of pools.

The Office of Local Government did not support our recommendations. In 2017, the OLG advised that increased public education will be most effective in improving child safety in and around private swimming pools. OLG noted the findings of a cost-benefit analysis that indicated that any safety improvement arising from transitioning to the latest Australian Standard for swimming pool barriers as a single standard is likely to be marginal, while the upgrade cost for some pool owners is potentially significant. OLG also noted the number of pools subject to automatic exemption from barrier requirements will decrease over time as pools deteriorate and are removed, or undergo major renovations.

Progress in 2017–18

Noting OLGs previous (2017) advice that our recommendations were not supported, we asked DFSI to provide advice about any work being undertaken or planned for swimming pool safety education campaigns and development of relevant guidance material for both pool owners and certifiers.

In May 2018, DFSI advised that the NSW Government delivered the 'Be water safe. Not sorry' campaign in summer 2017-18, through print, radio, social media and Spotify. DFSI said that extensive resources are available online to pool owners, councils and certifiers, including the self-assessment checklist through the Swimming Pool Register. DFSI is also considering additional guidance material.

The main focus of our recommendation was the development of a single standard and removal of exemptions from swimming pool barrier fencing requirements. Noting that the NSW Government does not support these moves, we will no longer monitor this recommendation. We will continue to monitor the role of non-compliant safety barriers in the drowning deaths of children.

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10. Lambert, M 2015, *Independent Review of Swimming Pool Regulation Final Report*, https://www.olg.nsw.gov.au/sites/default/files/OLG%20-%20Lambert%20Swimming%20Pool%20Review%202015%20-%20Final%20Report.pdf. Accessed on 29 July 2017.

Preventing deaths from asthma

We recommended that NSW Health:

> **NSW Health should consider the findings of our review in relation to post-hospitalisation follow-up of children with asthma, and provide advice on the adequacy of processes within Health for:**
>
> - **identifying children/families who may require more assertive follow-up and asthma education**
> - **facilitating active follow-up of these children/families, and**
> - **monitoring practice and related outcomes in relation to acute management by health services of asthma in children, including links to follow-up support.**
>
> **(Recommendation 3, Child Death Review report 2013)**

Background to our recommendation

Our *Child Death Review Report 2013* included a review of the asthma deaths of 20 children over the 10-year period 2004-13. We found that most (17) of the 20 children had factors that may have increased their risk of death, including insufficient follow-up after a hospital presentation/admission for asthma.

Against this background, we made recommendations to NSW Health, the Department of Education and non-government school authorities, and are currently monitoring two recommendations directed to NSW Health.

In 2017, NSW Health advised that the *Aiming for Asthma Improvement in Children* program had created clear process maps for referral of children with complex and non-complex asthma, and was developing strategies to reduce asthma emergency department re-presentations for non-complex asthma. The program was continuing to work on strategies to facilitate assertive follow-up and overall improved asthma control.

Progress in 2017–18

In June 2018, NSW Health advised that the Sydney Children's Hospitals Network piloted the Integrated Care Asthma Project at Sydney Children's Hospital. Over a six-month period, this has seen a 57 per cent reduction in re-presentations of enrolled children with non-complex asthma. The project is being extended to the Children's Hospital at Westmead.

NSW Health also advised that Sydney Children's Hospital and the University of NSW are collaborating on a project to identify children at risk of life-threatening asthma to bring them under early surveillance and follow-up.

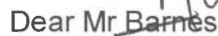
We acknowledge the significant steps taken by NSW Health to improve the follow-up of children who present to hospital with acute asthma symptoms. We note the positive outcomes of the *Aiming for Asthma Improvement in Children* program, and consider that the recommendation has been met.

Appendix:
Agency responses to recommendations from the Child death review report 2015

NSW GOVERNMENT | Health

Your ref ADM/2018/203
Our ref 017/2-21

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



Dear Mr Barnes

NSW Child Death Review Team Annual Report Recommendations Update

Thank you for your letter of 20 April 2018 seeking a formal response from NSW Health regarding the four recommendations that the Child Death Review Team is currently monitoring. Two of the records are from the Child Death Review Report 2015 and the remaining two from the earlier reports.

Attached is NSW Health's status update on Recommendations 1 and 6 from the NSW Child Death Review Report 2015, Recommendation 4 from the NSW Child Death Annual Report 2014 and Recommendation 3 from the NSW Child Death Review Team Annual Report 2013.

If you have any further queries, please contact

Yours sincerely

Elizabeth Koff
Secretary, NSW Health
29/6/18

NSW Ministry of Health
ABN 92 697 899 630
73 Miller St North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Tel. (02) 9391 9000 Fax. (02) 9391 9101
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TAB A

NSW CHILD DEATH REVIEW REPORT 2015

Rec No.	Recommendations from 2015 Report	Requested information for reporting progress to NSW Parliament
1	NSW Health should consider the observations and recommendations made in the report, *Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005-2014* and advise the CDRT of existing or planned strategies to address these.	Health Protection NSW (HPNSW) supports the recommendations in Section 5.12 (*Child deaths from infectious diseases in NSW: 2005-2014*) of the NSW CDRT Annual Report 2015 relating to vaccine-preventable deaths in children. Information on activities undertaken by HPNSW to promote vaccinations, and additional comments are provided under each recommendation: **1. Immunisation of children at high risk is recommended and provided free under the NIP:** • To assist GPs and specialists who care for children with medical conditions or compromised immune systems, HPNSW has funded the National Centre for Immunisation Research and Surveillance (NCIRS) to run the NSW Immunisation Specialist Service (NSWISS) at The Children's Hospital Westmead (CHW) from 2015-19. In addition to providing specialist clinical advice and support for GPs and specialists and parents of children with complex medical needs, NSWISS works with clinics at CHW seeing high risk children to improve vaccine uptake. Currently NSWISS is developing systems to monitor seasonal influenza uptake by specialty clinic risk group. • NSWISS clinicians are supporting the other two tertiary paediatric hospitals (Sydney Children's and John Hunter) to implement similar programs by sharing their protocols and promotional materials so that vaccination uptake in high risk groups can also be facilitated in those hospitals. • HPNSW is currently a partner in an NHMRC grant using data linkage to better understand the uptake of additional vaccines targeting high risk children, and factors that may predict coverage in this group.

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		• In relation to the use of flags in hospital medical records systems to ensure that additional recommended vaccines are received by these children, HPNSW will consult with the three tertiary paediatric hospitals and NSWISS as to whether this would add to the current initiative, and about its feasibility. 2. **Vaccines against influenza and meningococcal B disease are recommended for all Australian children although not provided free of charge in 2016:** • HPNSW routinely reminds general practitioners and the public of the NHMRC recommendations for these vaccines, for example in media releases regarding these conditions, faxes directly to GPs and specialists during the influenza season, or when reporting on cases in the Communicable Diseases Weekly Report. • The Australian Immunisation Handbook recommends annual influenza vaccination for any person 6 months of age or older who wishes to reduce the likelihood of becoming ill with influenza. Influenza vaccine is provided free under the NIP for Aboriginal persons 6 months to 5 years and 15 years and older, and persons 6 months or older with a range of medical conditions placing them at increased risk of complications from influenza infection. HPNSW promotes the vaccination of high risk children through direct fax to GPs and specialists as well as other resources. • HPNSW notes that of the 8 deaths due to meningococcal B disease during the 10 year period, 6 of the children were under one year of age. Given the schedule for meningococcal B vaccine in infancy (3 primary doses and a booster at 12 months), these six deaths may not be preventable, even with increased uptake of meningococcal B vaccine. Furthermore, four of the infant deaths were in infants under 4 months of age. • The Pharmaceutical Benefits Advisory Committee (PBAC) rejected the inclusion of the meningococcal B vaccine, Bexsero, on the NIP Schedule

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<td>due largely to concerns about the cost effectiveness of the vaccine. However, the Australian Government Health Minister, Hon Greg Hunt MP, has requested a review by the Commonwealth Chief Medical Officer of whether the vaccine should be placed on the NIP schedule, after it was added to the United Kingdom's immunisation program. The cost to parents currently is $120-$140 per dose of the vaccine.

3. Immunisation of contacts is recommended for children at high risk of influenza, pertussis and varicella:
• HPNSW regularly reminds general practitioners and parents of the NHMRC recommendations around vaccinating close contacts of infants against pertussis, and writes to every new parent to reiterate this message.
• Other comments from Recommendation 1 regarding the NSWISS initiatives at CHW are also relevant here for influenza and varicella.

4. Immunisation against pertussis and influenza is recommended during pregnancy and provided free in NSW:
• HPNSW continues to facilitate and promote routine antenatal vaccination of all pregnant women including through mass media campaigns, education to general practitioners, and training of midwives. Podcasts to up skill general practitioners on antenatal pertussis and influenza vaccination have been developed in collaboration with the NSW branch of the Royal Australian College of General Practitioners (RACGP) and broadcast in 2016 and 2017.
• In 2017 NSW Health has developed new resources to promote influenza vaccination in pregnancy, and these resources have been adopted by the Australian Government to support the National Immunisation Program.
• Mechanisms to collect coverage data to better focus promotional activities are underway.</td>
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5. Children should receive vaccines for which they are eligible under immunisation catch up programs:
• HPNSW routinely provides advice to providers regarding any catch-up funded vaccines.
• A better understanding of gaps in uptake of catch-up vaccination programs will be one of the outputs from the NHMRC partnership grant mentioned in the response to Recommendation 1, allowing better targeting of promotion of future catch-up programs.

6. Travel immunisation should be provided as recommended:
• HPNSW takes available opportunities to remind general practitioners and the public about recommended pre-travel vaccines. A podcast to up skill general practitioners on travel vaccinations developed in collaboration with RACGP (NSW) is available through the NSW Health and RACGP websites. There are also fact sheets on the NSW Health website with advice to travellers about recommended travel immunisations.
• In establishing the NSWISS, a link was made between this service and the Parramatta Chest Clinic, to facilitate a holistic approach to pre-travel childhood vaccination assessment.
• HPNSW notes that there have been no deaths due to TB in children during or since the period of the report. HPNSW further notes that in NSW, BCG vaccination is only available through chest clinics, however general practitioners have a role to promote BCG vaccination where relevant. NSW Chest Clinics are developing a resource for maternity units in areas where new parents frequently take children to high burden TB countries to increase awareness of BCG vaccination.

7. Data collections on child deaths in NSW should be enhanced and cross-checked between sources:
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- HPNSW notes the value of validating notifiable data with child death register data to improve understanding of child deaths, as evidenced in this report, and welcomes the suggestion that the CDRT will engage in regular communication regarding child deaths from vaccine preventable disease.
- HPNSW is developing a framework to cross-check child death data from available sources (including notifiable data, child death register data and data from the NSW Registry of Births, Deaths and Marriages) and had an initial meeting with the CDRT in April 2017 to progress this.

NSW HEALTH – STATUS UPDATE

1. **Immunisation of children at high risk is recommended and provided free under the NIP**.

- NSW Health continues to fund the National Centre for Immunisation Research and Surveillance (NCIRS) to run the NSW Immunisation Specialist Service (NSWISS).
- Electronic medical record alerts ("flags") have been implemented at The Children's Hospital Westmead (CHW) and John Hunter Children's Hospital (JHCH) to identify high risk children requiring vaccination. Influenza drop-in vaccination clinics have been established at these hospitals and opportunistic influenza vaccination is also being undertaken at Sydney Children's Hospital (SCH).

2. **Vaccines against influenza and meningococcal B disease are recommended for all Australian children although not provided free of charge in 2016.**

- In 2018, the NSW Government is offering free influenza vaccine to all children aged 6 months to less than 5 years of age, in addition to the groups funded under the National Immunisation Program (Aboriginal children and children with medical risk factors). It is anticipated that this universal childhood program will increase uptake in high risk groups, as

		was seen with hepatitis B and pneumococcal vaccination. **3. Immunisation of contacts is recommended for children at high risk of influenza, pertussis and varicella** • NSWISS activities at CHW include influenza vaccination for families of children at high risk. **4. Immunisation against pertussis and influenza is recommended during pregnancy and provided free in NSW.** • An online education module has been developed for maternity staff and midwives to promote pertussis vaccination during pregnancy. • In January 2018 Chief Health Officer requested all public health directors to ensure their maternity services are recommending influenza and pertussis vaccination of pregnant women and highlighting the protection this may afford the newborn infant. • The National Centre for Immunisation Research and Surveillance conducted an evaluation of the 2017 NSW Health antenatal influenza campaign and materials and found a majority of pregnant women were aware of influenza vaccination, and that the NSW promotional materials had high recognition amongst pregnant women, and were effectively supported vaccine uptake. **5. Children should receive vaccines for which they are eligible under immunisation catch up programs** • In 2017, the Australian Government extended the National Immunisation Program to include catch up vaccines for 10-19 year old children, and NSW Health conducted a webinar in partnership with RACGP in November 2017 to inform GPs about the catch-up program.

		6. Travel immunisation should be provided as recommended. • The NSW TB Program has a working group to develop measures to increase appropriate use of BCG that is due to report to the TB Advisory Committee in June 2018. **7. Data collections on child deaths in NSW should be enhanced and cross-checked between sources.** • Health Protection NSW together with the NSW Ombudsman has established an annual database check for child deaths with the NSW Notifiable Conditions Information Management System (all notifications of infectious diseases reported in NSW are entered into this database) and the Ombudsman Deaths Register. All deaths where there is a discrepancy between databases are reviewed and are added or removed depending on the outcome of the review.
6	**NSW Health and Red Nose (formerly SIDS and Kids)** NSW Health, in consultation with Red Nose, should review current advice and educational strategies, with a view to: a) The inclusion of advice and preventive strategies to parents and carers in relation to unintentional bed sharing as part of NSW Health education and advice programs, and the Red Nose 'Safe Sleep My Baby' public health program. b) Strategies targeted to young mothers, including use of alternative avenues of advice	NSW Health supports the recommendation. Preliminary discussions have been held with Red Nose to discuss safe sleeping and it is anticipated that there will be continued deliberations. NSW Health has undertaken the following initiatives to address the issue of safe sleeping, these include: The development of a cot card for use in NSW Health maternity facilities. The card was developed in response to the findings of the 2014 Safer Sleeping Practices for Babies in NSW Public Health Organisations Audit, which identified a need for more information for parents regarding safe sleeping, both in hospital and at home. The purpose of the Safe Sleep Cot Card is to reinforce safe sleep messages for parents. It contains information for parents in relation to safe sleeping practices for babies. NSW Health provided each maternity facility across all local health districts with an initial pack of Safe Sleep Cot Cards and additional

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	through social media and parenting blogs, and targeting grandmothers for safe sleep education.	supplies of the cards are available for facilities to order. The development of a Safe Sleeping eLearning module to increase the awareness of the risk of SUDI and safe sleeping messages for health clinicians, The module is designed for clinicians to increase their knowledge to support and model safe sleep practices and improve their confidence in having conversations about safe sleep practices with parents and families. The revision of the Personal Health Record (Blue Book) contains the six safe sleeping messages aligned with the safe sleep messaging provided by Red Nose Saving Little Lives. A copy of the Blue Book is given to every baby born in NSW. The revised version will be launched in July 2017 and will be translated into 18 languages. The revision of the Aboriginal Maternal and Infant Health Service (AMIHS) and Building Strong Foundations (BSF) *Safe sleeping for your baby* brochure is in line with the six safe sleeping messages supported by Red Nose Saving Little Lives. An extensive consultation process was undertaken in the development of this culturally appropriate resource for Aboriginal families. The brochure was published on 27 July 2017. It is available through the AMIHS and BSF services and can be ordered by other services providing maternity and child and family health care to Aboriginal families. The brochure is also available on the NSW Health website http://www.health.nsw.gov.au/kidsfamilies/MCFhealth/Pages/safe-sleeping-for-your-baby.aspx. The NSW Health Stay Strong and Healthy - It's Worth It campaign aims to raise awareness to Aboriginal women, their partners and families of the risks of drug and alcohol consumption during pregnancy. The Facebook page posts up-to-date health information about pregnancy and having a young baby, including information on safe sleeping. The Facebook page currently has 1087 followers.

		NSW HEALTH - STATUS UPDATE Since that time, the new version of the Child Personal Health Record (Blue Book) has been published which includes safe sleeping information with the support of Red Nose. The translations of the complete resource in 18 community languages are available on the NSW Health website. The Safe Sleeping eLearning module to increase the awareness of the risk of SUDI, and promote delivery of safe sleeping messages by health clinicians, is complete and the module has been launched on the Health Education and Training Institute online learning platform. The module was designed for clinicians to increase their knowledge to support and model safe sleep practices and improve their confidence in having conversations about safe sleep practices with parents and families. It demonstrates delivery of safe sleep messages in a variety of settings, and with Aboriginal and culturally diverse families. It includes modelling of conversations with grandparents. Red Nose was directly involved with the development of the eLearning module, and there is ongoing dialogue about advice and education between the two agencies. NSW Ministry of Health has completed the actions for this recommendation, and suggests that the recommendation may now be closed.

Rec No:	Recommendation	Requested information for reporting progress to NSW Parliament
4.	The Department of Family and Community Services (FACS) and NSW Health should jointly consider initiatives in other jurisdictions that specifically target high risk populations, with a view to considering their applicability to NSW. This should include consideration of the findings emerging from safe sleep pod programs in New Zealand and Cape York.	NSW Health has conducted some analysis of national and international programmes for reducing co-sleeping and improving safe sleeping using Pods or baby boxes. NSW Health is using this analysis and other local data to investigate the possibility of conducting a trial in NSW. Further discussion and consideration of a potential trial is on-going. Discussions are planned between FACS and NSW Health to: (i) Review the Safe sleeping Supporting parents to make safer choices when placing their baby to sleep resource produced by FACS (2014) and ensure the consistency of messages (ii) Consider strategies to target safe sleeping messages to parents/ families who have been identified as at risk (iii) Review information currently available for high risk populations. **NSW HEALTH - STATUS UPDATE** Since last reporting to the Ombudsman, the Ministry of Health has met with FACS and agreed to continue to work collaboratively on review and production of resources, particularly for high risk populations. The Ministry of Health continues to monitor the outcomes of trials that utilise baby boxes and pods such as Pepi Pods. In 2018, the Ministry met with the Red Nose Regional Coordinator for the trial of Pepi Pods in the Kimberly, Western Australia, about the project. The distribution of Pepi-Pods in Western Australia is part of the Reducing the Risk of SUDI in Aboriginal

		Communities (RROSIAC) program run by Red Nose and funded by the Australian Government. The Ministry will continue to monitor the outcomes of this and other trials, and consider the implications for NSW families, and especially those families at higher risk of SUDI.

3	NSW Health should consider the Team's review of asthma deaths 2004-2013 in relation to post-hospitalisation follow-up of children with asthma, and provide detailed advice to the Team on the adequacy of processes within Health for: a. identifying children/families who may require more assertive follow-up and asthma education b. facilitating active follow-up of these children/families, and c. monitoring practice and related outcomes in relation to acute management by health services of asthma in children, including links to follow-up support.	The *Aiming for Asthma Improvement in Children Program* (AAIC) continues to take an active role in the Sydney Children's Hospital's Network Kids GPS Integrated Care Project for children with asthma. The project team has created clear process maps for referrals of children with complex and non-complex asthma. The team is also developing strategies to reduce asthma emergency department re-presentations for non-complex asthma through processes such as care coordinators whose roles include actively engaging in facilitating appropriate referral of these children. AAIC, in collaboration with the Integrated Care Project, is continuing to work on strategies to facilitate assertive follow up and overall improved asthma control. As an example, a webinar targeting evidenced based paediatric asthma management will be available for GP's in the coming month. Further plans include developing a risk score for severe asthma and undertaking a State-wide review of childhood asthma models of care to identify gaps in the community to improve integrated care pathways. **NSW HEALTH - STATUS UPDATE** The Sydney Children's Hospitals Network Integrated Care Asthma Project was piloted at Sydney Children's Hospital (SCH) and has seen a 57 per cent reduction in re-presentations to SCH ED of the enrolled cohort of children with non-complex asthma, over a six month period following enrolment. This project is being extended to The Children's Hospital at Westmead and has the potential to be implemented by Local Health Districts across NSW. Additionally, SCH and UNSW are collaborating on a project to help identify children at risk of developing life threatening asthma and bring them under early surveillance and follow-up.

Premier & Cabinet

NSW GOVERNMENT

Ref: A2515771

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

Dear Mr Barnes

Thank you for your letter of 20 April 2018 regarding recommendations from the *Child Death Review Report 2015.*

The Department of Premier and Cabinet (DPC) and the Deputy State Coroner, Teresa O'Sullivan, are working with agencies to address recommendations from the Child Death Review Team's (CDRT) 2015 report. Work is progressing through a Cross-Agency Working Group (CAWG) with NSW Police, NSW Health (including NSW Ambulance and Forensic Medicine) and the NSW State Coroner's Court. The role of the CAWG is to agree some immediate, practical actions NSW agencies can take to improve responses to Sudden Unexpected Death in Infancy (SUDI).

Recommendation 2
The CAWG has identified key pressure points in the current system. Work is progressing across all agencies to establish a clearer and more coordinated approach to responding to incidents of SUDI.

The CAWG is also progressing practical actions to support:

- An increase in the proportion of explained SUDI in NSW from 25 per cent (2006-2015).
- Ensure all NSW families affected by SUDI receive follow-up support (71 per cent as at 2015).

These actions are being progressed by NSW Police, NSW Ambulance, NSW Health and the NSW State Coroner. Implementation is tracked through interagency meetings. Regular updates are provided to the NSW Ombudsman. To date, DPC has co-chaired two meetings of the CAWG and held three meetings with the NSW Ombudsman. A final report will be provided to the NSW Ombudsman by end 2018.

Recommendation 3
Work progressing through the SUDI CAWG will improve guidance and policy directives for NSW Health, NSW Police and the NSW State Coroner in a SUDI investigation. Actions support the following objectives:

- Establishing clear protocols for information sharing
- Improving guidance for investigators
- Improving the availability and collection of evidence

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Tel: (02) 9228 5555 ■ www.dpc.nsw.gov.au

- Ensuring alignment across policy directives
- Increasing workforce training
- Improving support for families.

This work is currently in the early stages, with key deliverables for practical actions identified for June and September 2018. It is expected that longer-term work will progress beyond this.

I understand your office has redirected the request for an update on Recommendation 11 to the Department of Finance, Services and Innovation for response.

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

Yours sincerely

Tim Reardon
Secretary

3 June 2018

NEW SOUTH WALES STATE CORONER

Office of the State Coroner,
Coroner's Court
Coroner's Investigation Team
Coroner's Advocacy Team

44 - 46 Parramatta Road,
Glebe NSW 2037

Telephone: 8584 7777
Fax: 9518 9156

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

10 May 2018

Dear Mr Barnes,

Thank you for your letter of 20 April regarding recommendations from the Child Death review Report 2015.

NSW Deputy State Coroner, Teresa O'Sullivan and the Department of Premier and Cabinet (DPC) are working with agencies to implement recommendations from the Child Death Review Team's (CDRT) 2015 report. Work is progressing through the Cross-Agency Working Group (CAWG) with NSW Police, NSW Health (including NSW Ambulance and the Department of Forensic Medicine). The role of the CAWG is to agree upon some immediate actions NSW agencies can take to improve responses to Sudden Unexpected Death in Infancy (SUDI).

Recommendation 4
The NSW Coroner's Court and the Department of Forensic Medicine (DOFM) now convene a Multi-disciplinary Paediatric Review Team meeting. This group of specialists reviews all SUDI cases. The State Coroner continues to support the involvement of a paediatric pathologist either in performing, or being consulted, in autopsies for all SUDI cases.

NSW Health Pathology are working with DOFM to obtain support from paediatric pathologists in performing and/or consultation in SUDI cases.

Recommendation 5
The State Coroner continues to work with the Child Death Review Team to provide advice and feedback on the development of a consistent approach to the classification of SUDI cases and a consistent application of the classifications.

Kind regards,

Les Mabbutt
NSW State Coroner

Michael Barnes
Convenor, NSW Child Death Review Team
NSW Ombudsman

"*Red Nose see a future where no child dies suddenly and unexpectedly during pregnancy, infancy or in childhood. One of our key goals is to equip all parents and families with skills and information to keep their babies and children safe*."

Dear Mr Barnes,

Thank you for your correspondence on 20 April seeking our response to Recommendation 6 in the *NSW Child Death Review Report 2015.*

Recommendation 6

NSW Health, in consultation with Red Nose, should review current advice and education strategies, with a view to:

- The inclusion of advice and preventative strategies to parents and carers in relation to unintentional bed sharing as part of NSW Health education and advice programs, and the Red Nose 'Safe Sleep My Baby' public health program.
- Strategies targeted to young mothers, including use of alternative avenues of advice through social media and parenting blogs and targeting grandmothers for safe sleep education.

Currently, Red Nose is continuing to provide:

1. The continuation of the free distribution of Red Nose resources to public health services. This year we distributed over 200,000 brochures to NSW Health Services. Our current suite of educational brochures include: Safe Sleeping, Safe Wrapping, Cot to Bed and Tummy Time.
2. The provision of information to culturally and linguistically diverse groups (CALD) ensuring that they are not disadvantaged. Red Nose has proposed to work closely with NSW Health to translate its current free resource suite to identified languages. Currently, we have only been able to develop a small selection of multi lingual

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

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brochures however our mobile APP is available to download for free and translatable into the following languages:

English, Chinese, Vietnamese, Chinese, Hindi. These are available for both iOS and Android devices. Once we are able to secure further funding we will be able to expand this to include more of our multi-cultural constituents.

3. Culturally appropriate Safe Sleep education and resources to the Indigenous communities of NSW to aid in reducing the disparity between Indigenous and non-Indigenous smoking rates during pregnancy, pre-term births, low birth rates and infant mortality rates with particular target messaging to young mothers. We will touch on this again further into our response letter.

4. Identification of education gaps. Currently, safe sleeping information is provided predominately to parent's post-partum. Red Nose proposes to create a series of projects aimed at providing parents information whilst pregnant and more likely to engage and digest new information. This proposal is still in its development phase and requires additional funding to complete.

4a. A free Red Nose booklet provided to expectant parents at an appropriate juncture of their pregnancy covering four key areas which will support them to reduce modifiable risks;

i. Safe Practice – Safe sleeping/tummy time/wrapping
ii. Safe Environment – Bedding, nursery set up, temperature control
iii. Safe Lifestyle – Smoking/drug use/diet
iv. Safe Products – Purchasing safe products

4b. A free online portal where parents and family members visit to engage in digital content (more in-depth than a booklet) that has an education curriculum design. This includes website redevelopment and access to e-learning products. Again, this is subject to additional funding that Red Nose will re-apply for in the coming months as we see this as a vital component within our education suite.

In addition, the Red Nose Safe Sleep e-learning courses are currently under review and due for release this year. The courses are aimed at Health Professionals, Early Childhood Educators, Community Services, Parents and Carers.

5. Better education, Face to Face (F2F) and online for NSW health professionals to further enhance the educational experience of those receiving the information and solidify the consistent messaging. This will be backed by NHMRC guidelines (due for submission June 2018) and be supported by free parent resources outlined above. We are growing our F2F education catchment with the employment of new education staff who will be

deployed as required to provide ongoing support. The development of a new booking engine will ensure that health professionals and child- care workers can plan for and book training and Red Nose can collect data to ensure the needs of the relevant target audiences are met.

6. The Red Nose RROSIAC program seeks to reduce unacceptably high-risk Aboriginal infants dying of SIDS and fatal sleep accidents. This program has been successfully operating throughout WA since 2005. Red Nose has recently introduced the Pepi-Pod to complement this targeted education program. We proposed that this program be replicated in NSW and discussions have been held in relation to the provision of data outcomes from QLD and WA for review prior to any potential introduction to NSW.

7. Targeted education plan for young mothers. Our marketing department conducted a social media review to see how users interacted with our social media platforms and to find out how young mothers wanted to receive their education and information with regard to safe sleep practices. What we found, was that this group of parents wanted quick, online information that was accurate and easy to understand. Currently, our biggest platform targeting young mothers is Facebook where Red Nose regularly posts video demonstrations, live Q & A's and videos and receives questions late at night for review via our messenger service. Other platforms we cover include: LinkedIn, Twitter and Instagram.

   Further, Red Nose aims to re-shape our websites:

   Red Nose Official Site – Education - https://rednose.com.au/

   Guiding Light – Grief and Loss - https://rednosegriefandloss.com.au/

   In addition, Red Nose has been collaborating with Red Cross and delivered education to caseworkers, young, single and at risk mothers. We also provide ongoing support via phone and email to Red Cross to further assist these families.

   Red Nose hopes to develop and roll out a new e-learning product specifically for this target audience that can be accessed for free across a variety of different channels. Red Nose will require financial assistance to complete this product and are currently looking for funding opportunities.

8. Red Nose has identified a need within the grandparent target group. In recent years, the number of grandparents providing care to pre-school grandchildren has increased. Australian grandparents are the biggest providers of informal child-care for children between birth and 12 months of age. (Australian Bureau of Statistics [ABS], 2006).

   Red Nose proposes to research thoroughly the needs of this specialised group and create safe sleep education covering that can be presented to them in a meaningful way.

Unfortunately, Red Nose was unsuccessful in its application to NSW Health to secure funding to develop a national based literature review and NHMRC guidelines for safe sleeping that would guide both clinical care and parental behaviour.

Red Nose would like to acknowledge the financial support we receive from the NSW Heath Department for our Bereavement support services.

Red Nose also receives funding from other State Governments as well as the Federal Government, however these funds in total represent only a small fraction of the funds required to fully implement the actions described in this letter.

Red Nose would welcome the opportunity when funds are available for reconsideration of financial support for our life-saving programs and resources.

Thank you for taking an interest in Red Nose and this opportunity to update you on our progress.

Yours sincerely,

Theron Vassiliou

CEO Red Nose

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Family & Community Services

2 1 JUN 2018

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

Dear Mr Barnes,

Thank you for your letter of 20 April 2018 about the Department of Family and Community Services (FACS) response to the Child Death Review Team (CDRT) report in 2014.

While overall the number of children known to FACS who die in circumstances of sudden unexpected death in infancy has been decreasing, it remains on average the second highest circumstance of death, and disproportionately affects Aboriginal children, which is worrying.

FACS remains committed to looking at initiatives that can improve its practice, and working with other agencies in seeking out best practice approaches to addressing the underlying factors which place these children at risk of harm.

Please find attached our response to the recommendation which is the focus of reporting in 2018, and which addresses improving FACS response to sudden unexpected death in infancy.

If your officers have any further questions, they are invited to contact

Yours sincerely,

Michael Coutts-Trotter
Secretary

Department of Family and Community Services
Postal address: Locked Bag 10, Strawberry Hills NSW 2012
W www.facs.nsw.gov.au | **E** facsinfo@facs.nsw.gov.au
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Sudden Unexpected Death in Infancy (SUDI)

Recommendation 4 (CDRT Annual Report 2014)

The Department of Family and Community Services (FACS) and NSW Health should jointly consider initiatives in other jurisdictions that specifically target high risk populations, with a view to considering their applicability to NSW. This should include consideration of the findings emerging from the safe sleep pod programs in New Zealand and Cape York.

Requested information from CDRT for reporting progress to NSW Parliament

In correspondence dated 20 April 2018, the Ombudsman wrote that 'In July 2017, you advised us that there had been preliminary discussions between the Serious Case Review Unit and NSW Health about the evaluations of safe sleep pod programs in Queensland and New Zealand. You advised us that there was a commitment to further discussions, and a commitment to the evaluation of trials associated with devices for reducing SUDI. Please provide an update on the progress of this work with NSW Health to implement this recommendation. We would welcome any other information that you consider is relevant.'

FACS June 2018 response

The NSW Government's *Their Futures Matter* reform is a cross government reform delivering whole of system changes to better support vulnerable children and families. It is being implemented by a cross agency implementation unit in the FACS cluster, with involvement from FACS, the Department of Education, the Ministry of Health, and the Department of Justice. Under the reform, this unit uses a cohort approach to identify and understand groups of vulnerable children and families with similar needs, characteristics and experiences, and develop new or improved wrap-around supports that better meet their needs.

The Their Futures Matter Implementation Unit is undertaking work focused on improving wellbeing outcomes for parents and children, including improving perinatal health, in a cohort of vulnerable Aboriginal families. As part of this work, Their Futures Matter will consider evidence referred to in Recommendation 4 'initiatives in other jurisdictions that specifically target high risk populations [and] the findings emerging from the safe sleep pod programs in New Zealand and Cape York, Queensland', along with other evidence based programs and responses that may improve outcomes for these vulnerable families.

NSW GOVERNMENT | Justice

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Mr Michael Barnes
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Dear ~~Mr Barnes~~ Michael

Thank you for letter received on 27 April 2018 requesting an update on quad bike safety initiatives for inclusion in the 2016-17 Child Death Review Team Annual Report.

Specifically, you have requested an update on the NSW Quad Bike Safety Improvement Program, the NSW Quad Bike Safety Industry Action Group and NSW Government efforts in advocating for a national safety rating system for quad bikes. SafeWork NSW is responsible for these initiatives and has provided the following information.

Quad Bike Safety Improvement Program

This program continues to provide practical support to farmers to improve quad bike safety. The program includes strategies to address vehicle design, retrofit safety devices, use of helmets, free training and education. Farmers access rebates for side-by-side vehicles, safety equipment for existing quad bikes and approved helmets; as well as free quad bike safety training which includes a free helmet. As at May 2018, the program has resulted in investments of more than $20.3 million from farmers improving their quad bike safety. More than 840 farmers have been trained in safe quad bike handling and received a free helmet.

The program's comprehensive regional public awareness campaign has appeared in print, radio, digital and television mediums and is supported by the program's industry and community partners. A child safety TV advertisement appeared on all commercial regional TV stations and received an additional 162,000 online views. An independent mid-point evaluation undertaken in August 2017 found that since the program commenced, NSW farmers with a safety-driven attitude towards quad bikes have increased by 12 per cent and those who do not prioritise quad bike safety have decreased by 19 per cent.

Quad Bike Safety Industry Action Group

This group continues to meet regularly to further the objectives of the Quad Bike Safety Improvement Program through collaboration with industry, farming, emergency services, child health and rural community organisations.

National safety rating system for quad bikes

NSW continues to work with the Commonwealth, other jurisdictions and industry to reduce quad bike deaths. NSW is a member of the Interdepartmental Committee on quad bike safety (**IDC**) which is chaired by the Commonwealth Department of Jobs & Small Business.

The Australian Competition and Consumer Commission (**ACCC**), which is a member of the IDC, is undertaking an investigation into quad bike safety to determine recommendations to establish mandatory safety standards for quad bikes and side-by-side vehicles under the Australian Consumer Law. Responses to a Consultation Regulation Impact Statement closed on 4 May 2018 and are being reviewed by the ACCC. Options being investigated include requirements for all quad bikes and side-by-side vehicles sold in Australia to meet basic safety standards and/or undergo testing and rating under a national consumer safety rating system.

As SafeWork NSW has primary responsibility in relation to quad bike safety in NSW, SafeWork NSW would be best placed to provide any further updates on the above initiatives.

Yours sincerely

Andrew Cappie-Wood
Secretary

28 MAY 2018

Cc: Peter Dunphy, Executive Director, SafeWork NSW

Finance, Services & Innovation

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Office of the Secretary

Our ref: FTMIN18/246
Your ref: ADM/2018/203

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

Dear Mr Barnes Michael

Thank you for your letter requesting information from the Department of Finance, Services and Innovation (DFSI) about its progress implementing recommendations arising from the *NSW Child Death Review Report 2015.*

As you may be aware, administration of the *Swimming Pools Act 1992,* the Swimming Pools Regulation 2008 and the Swimming Pool Register transferred from the Office of Local Government to DFSI from 1 January 2018.

I note the Office of Local Government responded to you regarding these recommendations in July 2017 outlining the NSW Government's position that the most effective strategy in improving child safety in and around backyard swimming pools is public education, emphasising the critical importance of responsible adult supervision.

In response to your request for information from DFSI about Recommendation 8b, Recommendation 10 and Recommendation 11, I have attached a table which includes DFSI's response to each recommendation.

Should your staff have any queries, please encourage them to contact

Yours sincerely

Martin Hoffman
Secretary

18 May 2018

DFSI – Progress of implementation of recommendations arising from the *NSW Child Death Review Report 2015*

RECOMMENDATION	SUMMARY OF PREVIOUS OLG RESPONSE	CURRENT REQUEST FROM CHILD DEATH REVIEW TEAM	DFSI RESPONSE
Recommendation 8 In the context of the CDRT's previous recommendations, the Office of Local Government (OLG) should: (a) Include within the prescribed information that pool owners must supply on registration of a pool, details about whether children under five years of age reside at or regularly visit the property. (b) Work with local councils to prioritise inspections of pools at locations where children reside or regularly visit and rental properties with pools	(a) OLG previously advised that this recommendation is not supported. (b) OLG previously indicated that Councils already have access to demographic information that assists them to prioritise inspections to areas of risk.	(a) Nil (b) Department of Finance, Services and Innovation (DFSI) has been asked to provide further information about the availability of the demographic information and how it enables Councils to target swimming pools.	(b) Under section 22B of the *Swimming Pools Act 1992*, local councils must develop a mandatory inspection program for the inspection of swimming pools in their area. Councils have access to: • general local demographic information from the Australian Bureau of Statistics, including areas with a high population of young children • information from the NSW Registry of Births Deaths and Marriages about annual births on a local government area basis • development applications for residences with multiple bedrooms, as well as extensions involving extra bedrooms, and swimming pool construction • information about residences close to local schools and child care facilities • information about rental properties via rates notices (difference between property address and property owner's address). This information would assist in targeting properties which have a higher likelihood of having children residing, visiting, as well as assisting with identifying rental properties. In addition, clause 16 of the Swimming Pools Regulation 2008 requires councils to establish and implement a strategy for engagement with the local community when developing a program for the inspection of swimming pools in its area. Councils would be able to consult with their community to obtain additional information to prioritise pool inspections.

DFSI – Progress of implementation of recommendations arising from the *NSW Child Death Review Report 2015*

RECOMMENDATION	SUMMARY OF PREVIOUS OLG RESPONSE	CURRENT REQUEST FROM CHILD DEATH REVIEW TEAM	DFSI RESPONSE
Recommendation 10 The OLG should publish annual data from its analysis of the swimming pool register, including but not limited to: (a) The number of pools registered (b) The number of pools that have been inspected (c) The proportion of inspected pools that were non-compliant with the Act at the time of inspection (d) The main defects identified at the time of inspection (e) whether or not owners have rectified defects within a reasonable period of time.	OLG's Annual Report has previously reported information on the number of swimming pools registered in NSW and the number of certificates of compliance issued. OLG was exploring options to enhance the register to report on a wider range of statistics. Local councils already have a statutory obligation to include in their annual reports the number of mandatory inspections carried out, along with the number of certificates of compliance and non-compliance issued.	DFSI has been asked to provide advice regarding any enhancements or changes to the Swimming Pool Register, and any improvements to the public reporting of data from this register.	The responsibility for the administration of the Swimming Pool Register transferred from the OLG to DFSI from 1 January 2018. Since then, DFSI has been reviewing the IT infrastructure supporting the Swimming Pool Register. DFSI is considering several priority performance enhancements to the Swimming Pool Register. These include matters identified in the Independent Review of Swimming Pool Regulation, such as: - updating the Swimming Pool Register to include recording of the occupation certificate - identifying the Australian Standard used in assessing the pool. Other Swimming Pool Register enhancements DFSI is considering include the ability to report on defects identified at the time of inspection, and amalgamated data reporting across councils.

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DFSI – Progress of implementation of recommendations arising from the *NSW Child Death Review Report 2015*

RECOMMENDATION	SUMMARY OF PREVIOUS OLG RESPONSE	CURRENT REQUEST FROM CHILD DEATH REVIEW TEAM	DFSI RESPONSE
Recommendation 11 In the context of proposals contained in the independent review of swimming pool barrier requirements for backyard swimming pools in NSW (discussion paper), the NSW Government should amendment the *Swimming Pools Act 1992* to: • include a single standard for NSW for child resistant swimming pool safety barriers, aligned to national standards, in order to enable the relevant state agency or agencies to interpret and provide guidance on required standards to pool owners and the general public. • Remove automatic exemptions from swimming pool safety barrier requirements. • Require persons purchasing a portable swimming pool that is subject to the requirements of the Act to register the pool at the point of sale	OLG previously advised that this recommendation was not supported. The NSW Government has indicated that the most effective strategy for improving child safety in and around swimming pools is public education emphasising the importance of responsible adult supervision.	DFSI has been asked to provide advice about work being undertaken or planned in regard to the following areas referenced by OLG: (a) Pool safety education campaigns on the importance of responsible adult supervision. (b) The development of easy-to-understand user guidance for swimming pool owners that will assist them in meeting their obligation to make their pool compliant, and the provision of private and council certifiers on their legislative and regulatory responsibilities.	(a) The Office of Emergency Management, Department of Justice, delivered the NSW Government's "Be Water Safe, Not Sorry" campaign across Summer 2017/18. One of the key messages of the campaign was to *"Always supervise small children in or near water - don't get distracted by your phone, people at your door, or attending to other children".* The campaign was based on the findings of a report commissioned by the NSW Government from Royal Life Saving NSW, which found that during Summer 2016/17, beaches and swimming pools were the leading locations for drowning, accounting for nearly 25 per cent of fatalities each. The campaign was communicated through print, radio, social media and Spotify, focusing on the most common locations and behaviours that lead to drowning. (b) Extensive resources are already available online to pool owners, councils and certifiers regarding their obligations via a range of websites including: • www.swimmingpoolregister.nsw.gov.au • www.fairtrading.nsw.gov.au/ftw/Consumers/Product_and_service_safety/Pool_safety/Swimming_pools.page • www.fairtrading.nsw.gov.au/ftw/About_us/News_and_events/Whats_new/Swimming_pools.page The Swimming Pool Register website includes detailed self-assessment checklists for pool owners at www.swimmingpoolregister.nsw.gov.au/checklists As part of its Response to the Independent Review of Swimming Pool Regulation, the NSW Government indicated it would further explore ways to provide guidance to pool owners, councils and private certifiers. DFSI is considering additional guidance material for pool owners, councils and private certifiers with a view to releasing it in 2018/2019.

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