

NSW Child Death Review Team Annual Report 2016-17



October 2017

NSW Child Death Review Team Annual Report 2016-17

NSW Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

Phone 02 9286 1000

Toll free: 1800 451 524 (outside Sydney Metro Area)

Facsimile: 02 9283 2911

Website: www.ombo.nsw.gov.au

Email nswombo@ombo.nsw.gov.au

ISBN 978-1-925569-49-0

ISSN 1329-640X

© State of New South Wales, October 2017

This publication is released under a Creative Commons license CC BY 4.0.

Contents

About this report.....	d
Chapter 1. The NSW Child Death Review Team.....	1
Who we are	1
Team members in 2016–17	2
Expert advisers.....	3
Our functions	3
Chapter 2. Reporting of child deaths.....	4
Causes of death	4
Overall decline in rates of death.....	5
Chapter 3. Research to help reduce child deaths	6
Our research in 2016/17.....	6
Other projects.....	8
Chapter 4. Our plans.....	11
Chapter 5. Disclosure of information.....	12
Chapter 6. Recommendations.....	13
Vaccine preventable infectious diseases	13
Sudden Unexpected Death in Infancy	15
Transport: quad bikes and side-by-side vehicles.....	19
Drowning: private swimming pools.....	21
Deaths from suicide.....	26
Deaths from asthma.....	28
Deaths in house fires.....	29
Appendix:	
Agency responses to recommendations from the Child death review report 2015	31
NSW Health.....	32
Department of Family and Community Services	52
Office of Local Government.....	55
Fire and Rescue NSW.....	59
NSW State Coroner	60
Red Nose.....	61
Department of Justice.....	64

About this report

This annual report describes the operations of the NSW Child Death Review Team (CDRT) during 2016 – 17.

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
- 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.

Prior to 2016 the CDRT annual report was included in the Team's annual *Child death review report*. Amendments passed in the NSW Parliament in November 2015 changed the frequency of these reports to biennial. In that context, the annual report to Parliament will be prepared and tabled as a separate document.

The report is arranged in the following sections:

- Section 1: The NSW Child Death Review Team – an overview of the CDRT, its members and the functions of the Team
- Section 2: Reporting of child deaths – our annual Child death review report 2015
- Section 3: Research to help reduce child deaths – details of our research and projects to meet our purpose and functions
- Section 4: Our plans – our future priorities
- Section 5: Disclosure of information – details of the disclosure of information for the purpose of research.
- Section 6: Our recommendations – details the acceptance by agencies of the CDRT's recommendations, and progress towards implementation. Appendix 1 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 Team
- 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 Team

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 Team 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.

Team members in 2016–17

Statutory members

Professor John McMillan AO

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

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

Professor Les White (to July 2016)

NSW Chief Paediatrician
NSW Health

Detective Superintendent Michael Willing

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 Luciano Dalla-Pozza

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

Dr Jonathan Gillis

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 Team 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
- Dr Isabel Brouwer, Statewide Clinical Director Department of Forensic Medicine
- Associate Professor Rebecca Mitchell, Australian Institute of Health Innovation, Macquarie University

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

Our functions

Under the Act, our functions are to:

- maintain a register of child deaths occurring in NSW
- classify deaths in the register 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.

The Team reports directly to the NSW Parliament, with oversight by the Parliamentary Committee on the Ombudsman, the law Enforcement Conduct Commission and the Crime Commission.

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. 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>

Between July 2016 and June 2017, we registered the deaths of 481 children that occurred in NSW.

We record information about the death of a child on the NSW Child Death Register. 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.

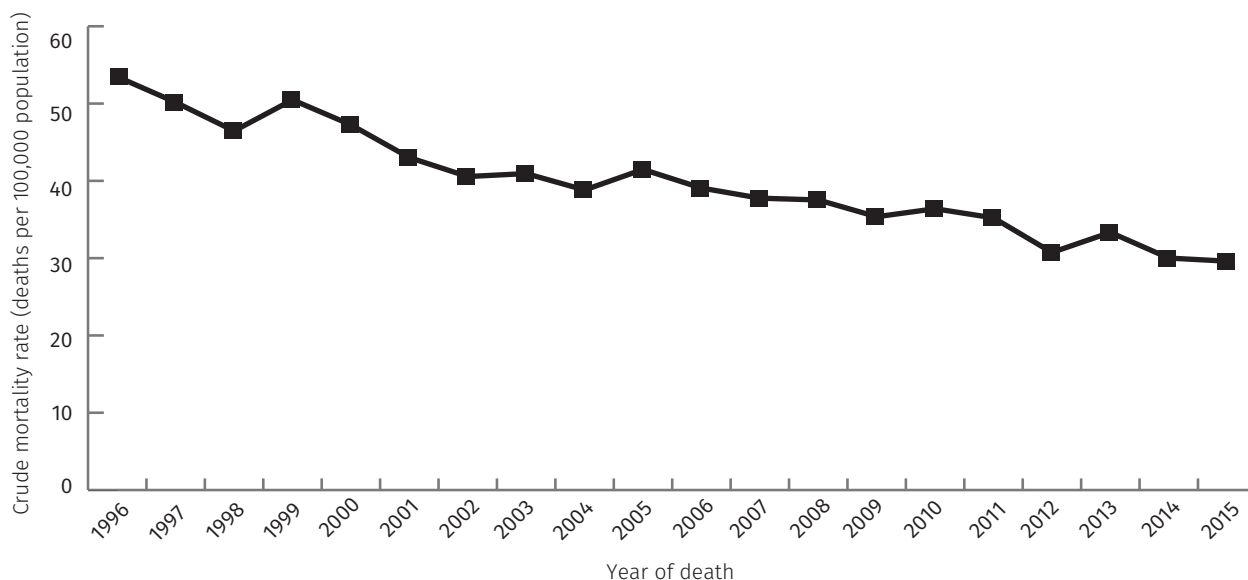
Our reporting of child deaths is based on our analysis of information contained in the Register. The biennial report includes data collected and analysed in relation to child deaths that occurred during the two previous calendar years.

Chapter 2. Reporting of child deaths

In October 2016, we tabled our *Child Death Review Report 2015*.

In 2015, 504 children aged from birth to 17 years died in NSW - a mortality rate¹ of 29.61 deaths per 100,000 children. As shown in the figure below, this is the lowest annual rate recorded since the Team was established in 1996.

Figure 1: Deaths due to all causes: children 0-17 years, 1996-2015



Of the 504 children who died, 282 were male and 222 were female.

The majority of the children who died (294, 58%) were infants aged less than 12 months. Almost three quarters of these infants (208, 71%) died in the neonatal period, which is within 28 days of their birth.

Causes of death

A cause of death was known for 458 of the 504 children who died.

The majority of the children (370; 81%²) died as a result of natural causes. Most of these children were infants. Conditions arising in the perinatal period and congenital and chromosomal conditions accounted for half of the deaths of children in NSW in 2015.

There has been a significant decline in the rate of death of children in NSW from natural causes over the past 15 years, and the mortality rate of 21.74 in 2015 was the lowest annual rate in 15 years. The decrease mostly reflects a decline in infant mortality.

Almost one in five children (88, 19%) died as a result of injury. The deaths of 54 children resulted from unintentional injury. The deaths of 34 children were intentional; 26 were due to suicide, and eight children died in circumstances of abuse.

1. Crude mortality rate - deaths per 100,000 people under 18 years of age. For children aged less than 12 months, this report uses the Infant Mortality Rate, which is deaths of infants under 12 months per 1,000 live births.
2. Based on a known cause of death (458 children)

Overall decline in rates of death

The overall decline in the mortality rate for children aged less than 18 years has been significant and continual. However, the decline in the rate has not been uniform. For example:

- the significant decline in the injury-related mortality rate over the 15 years to 2015 relates to males rather than females, and while the rate for males is still higher than for females, the gap has narrowed since 2001.
- fifty-nine children (12%) who died in 2015 were identified as being of Aboriginal or Torres Strait Islander background; a mortality rate 2.3 times the rate for non-Aboriginal or Torres Strait Islander children (64.08 to 27.64). Injury-related causes for Aboriginal and Torres Strait Islander children occurred at a rate almost five times higher than that of non-Indigenous children.
- suicide was the leading cause of death for 15-17 year olds in 2015, and the suicide mortality rate for this age group in that year was the second highest since 1997.
- the infant mortality rate³ for Sudden Unexpected Death in Infancy (SUDI) has, overall, declined since 2001, however the rate has not changed significantly since 2008.

Our *Child Death Review Report 2015* made 12 recommendations, relating to Sudden Unexpected Death in Infancy, quad bikes and side-by-side vehicles, swimming pool safety and suicide prevention. The recommendations, and agencies' responses to them, are detailed in section 6.

3. Infant mortality rate is deaths per 1,000 live births.

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 issues 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 Team – 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 (eg 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 Team?
- 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 in a reasonable timeframe?

Our research in 2016/17

In 2016/17, four commissioned research projects were underway or completed. The projects are described below.

Vaccine preventable infectious diseases

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 report authors were Anastasia Phillips, Frank Beard, Kristine Macartney and Peter McIntyre. Gemma Savaranos and Jocelyn Chan also contributed to the project.

The research analysed data held in the NSW Child Death Register in relation to the deaths of children resulting from infectious diseases in NSW over the 10-year period, with the aim of:

- describing child deaths in NSW from diseases for which a vaccine is currently available in Australia, and
- providing recommendations to improve prevention of child deaths due to vaccine-preventable diseases.

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.

The report noted that immunisation has been successful in dramatically reducing the number of childhood deaths from infectious diseases in Australia. However, as the report shows, deaths in children from potentially preventable infectious diseases continue to occur in NSW, particularly in young infants. The work underscores the importance of maintaining a high rate of vaccination.

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 December 2016, the Centre for Health Service Development (CHSD) at the Australian Health Services Research Institute, University of Wollongong, finalised research we commissioned to examine best practice in coordinating childhood injury prevention, and lessons for NSW. The research was conducted by Kathleen Clapham, Cristina Thompson and Darcy Morris.

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.

The second phase of research included a rapid review of the literature and a series of expert stakeholder interviews. The literature review considered coordination mechanisms used within Australia and in several other countries where examples of advances in childhood injury prevention efforts were evident. The project also involved a focused consultation with stakeholders predominantly located across Australia and including several representatives from other countries perceived as leaders in the coordination of childhood injury prevention.

As a first step, and prior to tabling the report, we have provided a copy to the NSW Ministry of Health for consideration and comment. Our intention is to release the report in the second half of 2017.

Analysing geospatial variation in 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. This information is valuable in relation to targeting prevention efforts. The project has four main aims:

- to provide a set of maps of the residential locations of children who died in NSW (by particular characteristics or causes of death)
- to create area-based measures of child deaths and use them to conduct a descriptive analysis of variation between areas and whether there have been changes over time, and to identify particular geographic areas with high numbers and rates of child deaths
- to examine how the risk of death varies by area level characteristics, and
- to test whether adding area-level characteristics to individual level deaths data affects the cause of death distribution, above and beyond the individual area level characteristics of the child.

In July 2017, the AIHW provided us with a draft copy of a report detailing the findings of the geospatial analyses. Our intention is to table the report in Parliament later in 2017.

Review of seatbelts and child restraints in car crashes

In May 2017, we commissioned Dr Julie Brown from Neuroscience Australia to review child deaths resulting from motor vehicle crashes, and the possible contribution of inadequate or inappropriate restraints in these deaths. The review will examine 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.

Our *Child Death Review Report 2015* notes that inappropriate use, or lack of a restraint, was a factor in the deaths of six children who died in transport fatalities in 2015. In the previous year (2014) we found that for eight of the children who died in transport fatalities, restraint problems were either identified or considered to be possible contributory factors.

10 year reviews: drowning and quad bike fatalities

In 2016, we reported the results of two ten-year reviews conducted in 2016. The reviews were included in our *Child Death Review Report 2015*.

The first review considered swimming pool drowning deaths of 70 children over the ten years from 2006 to 2015. The majority (61) of the children were under five years of age, and most of these children (53) were aged two years or less. Arising from our findings, and drawing on the *Independent swimming pool barrier review*⁴, we made recommendations to the NSW Government and Office of Local Government.

The second review examined the deaths of 10 children in quad bike or side-by-side vehicle incidents in NSW over a 10 year period from 2006 to 2015. The 10 children who died were aged between seven and 16 years, with the majority (7) aged less than 12 years. The causes of death were predominantly crush injuries or major head trauma. In eight of the 10 incidents the crash occurred while off-road driving on private property. Arising from our review, we made a recommendation to the Attorney-General.

Agency responses to the recommendations are detailed in section 6.

Other projects

A particular focus throughout 2016/17 has been Sudden Unexpected Deaths in Infancy (SUDI). In section 6, we describe the key findings and recommendations arising from our reviews of SUDI in 2015, and agency responses to them.

In addition to our review and reporting processes, members of the CDRT – Professor Heather Jeffery, Dr Susan Arbuckle, Dr Bronwyn Gould and Ms Jane Gladman – worked closely with staff to progress initiatives to improve responses to SUDI.

SUDI Classification

In NSW, there is no consistent classification of SUDI where a cause of death remains unexplained after investigation. Consistent classification can help to identify factors that may contribute to infant deaths, which is a key first step toward preventing future infant 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 2004.⁵

Since that time, there has been significant shifts in the epidemiology of SUDI and significant advances in our understanding and identification of 'modifiable risk factors'.⁶

In 2017, we developed an alternative classification – drawing on the earlier framework - that takes into account key modifiable and non-modifiable SUDI risk factors. Figure 2 below summarises the approach, which will be subject to further consultation over 2017. The aim is to provide for a consistent approach to SUDI by Coroners, pathologists and the NSW Child Death Review Team.

Staff and CDRT members have discussed our proposal with key agencies, including the State Coroner's office, Forensic Services and our state CDRT counterparts. Forensic Services (NSW Health) have agreed to trial the classification in 2017. Members of the Australian and New Zealand Child Death Review and Prevention Group, a national group that brings together all state child death review teams and similar mechanisms, are also testing the classification. We have also submitted our work to the World Health Organisation for consideration in its revision of the International Classification of Diseases.

4. Office of Local Government NSW <https://www.olg.nsw.gov.au/content/swimming-pool-barrier-review-2015>

5. <http://www.sidsandkids.org/research/sids-and-kids-2004-pathology-workshop/>

6. Mitchell, E and Krous, H 2015, 'Sudden unexpected death in infancy: a historical perspective', *Journal of paediatrics and Child Health*, 51, 108 – 112.

Figure 2: Proposed classification for Sudden Unexpected death in Infancy

Unexplained SUDI⁷

Classification	Definition
SUDI 0	<p>Post-death investigation is not sufficient, and a cause of death cannot be determined or excluded with certainty <u>because of lack of information</u>:</p> <ul style="list-style-type: none"> • Death scene examination is undocumented or insufficient • No or incomplete review of medical history of the child / family, including family interview (protocol) and review of clinical records • Autopsy not in compliance with the SIDS protocol, or missing tests or screens necessary to confirm or exclude a cause
SUDI 1	<p>The infant was found in a <u>safe</u> sleeping environment with no evidence of accidental death, unexplained trauma, or abnormal presentation¹ prior to death. Following thorough investigation, all other possible causes have been excluded.</p> <p>Safe sleep environment means:</p> <ul style="list-style-type: none"> – The infant was placed to sleep and found on their back (not prone, not on side) – The infant was placed to sleep in their own infant-specific bedding (not in adult bedding or on a surface not designed for sleep) – The infant was not exposed to tobacco smoke – The infant was not overdressed for the conditions or covered with heavy/adult/overly warm bedding – No soft pillows or other objects in sleep environment – Face not covered – Not exposed to smoking <p>Thorough investigation includes a minimum of:</p> <ul style="list-style-type: none"> – Full and documented death scene examination – Review of medical history of the child / family, including family interview with protocol and review of clinical records – Autopsy in compliance with the SIDS protocol
SUDI 2	<p>As above, with the exception that <u>non-modifiable</u> (intrinsic) risk factors are identified:</p> <ul style="list-style-type: none"> – Low birth weight (less than 2500g) – Pre-term birth (less than 37 weeks) – Small for gestational age (less than 10th percentile weight for age on relevant WHO charts or Intergrowth newborn charts for term and preterm infants) – Preceding infectious illness (within the last two weeks) – Prenatal smoking

...continued over page

7. Abnormal presentation includes sudden acute illness or unusual symptoms (for example, seizures) observed in the 24 hours prior to death

Classification	Definition
SUDI 3	<p>The infant was found in an <u>unsafe</u> sleeping environment with <u>modifiable</u> (extrinsic) risk factors present, and following thorough investigation, mechanical asphyxia or suffocation cannot be determined or excluded with certainty</p> <p>Unsafe sleeping environment:</p> <ul style="list-style-type: none"> - Infant placed to sleep prone or on their side (and for infants less than 6 months, <u>located</u> prone or on their side) - Infant placed on a sleep surface with heavy or excess bedding - Infant placed with soft pillows or other objects in sleep environment - Infant in bedding not specifically designed for infant sleep (eg pram, sofa) - Infant <u>under 6 months</u> of age sharing a sleep surface with others (any circumstances), or infants <u>over 6 months</u> sharing a sleep surface with others, where evidence suggests the other person/s were likely impaired by drugs or alcohol - Exposed to smoking
Undetermined	<p>A finding of undetermined should only be applied in a SUDI context where the above classifications are insufficient.</p> <p>This would include:</p> <ul style="list-style-type: none"> - Sudden unexpected death of an infant not in a sleep environment and no cause found - where there was abnormal acute presentation prior to death (for example fitting, sudden onset illness) but this is not sufficient to explain a cause of death

Explained SUDI

SUDI Explained	The infant dies suddenly and unexpectedly and following investigation, a cause of death can be determined with certainty.	ICD 10 classification
----------------	---	-----------------------

Multidisciplinary review

A further notable and pleasing development arising from discussion between the CDRT, the State Coroner's office and Forensic Services has been Forensic Services establishment of a multidisciplinary review group of experts, including relevant CDRT members, as a reference group for pathologists in investigating SUDI.

Chapter 4. Our plans

In July 2016, we held a planning meeting to consider our strategic priorities. We agreed to four key focus areas, and goals within those areas that we will aim to achieve by the end of 2019. In summary, these are:

- ***To deliver a number of substantial and well-targeted projects and reports that go to our core aim of preventing the deaths of children.*** The projects described above represent a major component of this work, along with our first biennial child death review report, to be tabled in 2018.
- ***To enhance our infrastructure, including our data capture and analytical and reporting capability.*** In 2017, we commenced a design review of the Child Death Register. The Register was transferred from a legacy system in 2014, and the review is focused on identifying further enhancements that could be made to improve our capture of information and reporting capacity. We are also keen to explore opportunities for data linkage.
- ***To identify and pursue opportunities to engage with key stakeholders and to communicate our key findings and recommendations.*** We have continued our involvement in the Paediatric Injury Research and Management Forum, and the Australia and New Zealand Child Death Review and Prevention Group. In 2016, we prepared and published fact sheets from our report as a key initiative to communicate key findings from our Child death review report.
- ***To explore opportunities to extend our analysis and reporting to areas directly relevant to our purpose of preventing the likelihood of child deaths.*** Injury prevention is a key area in this regard, and we will explore with stakeholders how we can best contribute in this area.

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 section 34L(1)(b) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. This 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'.

In 2016/17, we did not release information under this provision.

As described in section 3, the Team 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, section 34D (3) allows the Convenor to enter into an arrangement for the exchange of information between the Team and a person or body having similar functions in another State or Territory, relevant to the exercise of the Team'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 July 2016, 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 Sudden and Unexpected Death in Infancy). This was reported in the *Annual Report: Deaths of children and young people, Queensland, 2015-16*⁸
- The ACT Children and Young People Death Review Committee. The ACT child death register includes children who normally live in the ACT, but whose death occurs outside of the ACT. In February 2017, we provided the Committee with information about the deaths of ACT resident children who died in NSW.

8. <https://www.qfcc.qld.gov.au/sites/default/files/child-deaths-annual-report2015-16/supplementary-chapter-australian-and-new-zealand-child-death-statistics-2014.pdf>

Chapter 6. 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.

Under our legislation, we must include 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; to continue monitoring the recommendation; or to amend the recommendation to take account of progress to date, or other developments that change the need for the recommendation.

At present, we have 16 open recommendations, relating to vaccine preventable infectious disease, Sudden Unexpected Death in Infancy, quad bikes and side-by-side vehicles, private swimming pools, suicide prevention, 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

As described above, the National Centre for Immunisation Research and Surveillance (NCIRS) completed a review of child deaths from vaccine-preventable diseases over a 10 year period. We tabled the report, *Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005-2014*, in 2016.

The report noted that immunisation has been successful in dramatically reducing the number of childhood deaths from infectious diseases in Australia. It also highlights:

- the importance of ensuring that children at high risk (such as those with compromised immune systems) have full access to immunisation, and
- promoting immunisation for those in contact with children at high risk, including infants.

Our recommendation to NSW Health

We recommended that:

NSW Health should consider the observations and recommendations made in the report, *Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005-2014* and advise us of existing or planned strategies to address these.

(Recommendation 1, Child Death Review Report 2015)

NSW Health's response

In July 2017, NSW Health advised us that it supports 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 amongst children.⁹ Key strategies include:

- Health Protection NSW has funded the NCIRS to run the NSW Immunisation Specialist Service at Westmead Children's Hospital to 2019. The service provides clinical advice and support to General Practitioners, specialists and parents of children with complex medical needs. Clinicians at the NSW Immunisation Specialist Service are also working with the other tertiary paediatric hospitals (Sydney Children's and John Hunter) to implement a similar program aimed at improving vaccine uptake amongst children at high risk.

9. Letter to A/NSW Ombudsman from Secretary, NSW Health, dated 14 July 2017.

- Health Protection NSW is a partner in a National Health and Medical Research Grant using data linkage to better understand the uptake of vaccines amongst children at high risk, and to identify factors that may affect coverage amongst this group. Analysis of this data could also facilitate better targeting of vaccination catch-up programs.
- Health Protection NSW routinely disseminates reminder alerts to General Practitioners and other immunisation providers, and engages in mass media campaigns to promote the importance of vaccination including during peak seasons for outbreaks.
- Health Protection NSW promotes routine antenatal vaccination for pregnant women through mass media campaigns, education of General Practitioners and training of midwives. In collaboration with the NSW branch of the Royal Australian College of General Practitioners, Health Protection NSW have developed podcasts to up-skill General Practitioners on antenatal pertussis and influenza vaccination, and writes to parents of newborns to reinforce messages about the importance of vaccination for people in close contact with their infant.

NSW Health further advised that in 2017, following rejection by the Pharmaceutical Benefits Advisory Committee of a proposal to include the meningococcal B vaccine on the National Immunisation Program schedule, the Federal Minister for Health has requested a review by the Commonwealth Chief Medical Officer as to whether the vaccine should be placed on the schedule.

Our comments

We welcome the actions undertaken by NSW Health to increase vaccination rates among children. We will continue to monitor the outcomes of the various initiatives, including the work of the NSW Immunisation Specialist Service in partnership with the tertiary paediatric hospitals to develop and implement strategies aimed at increasing vaccination uptake amongst high risk groups.

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 that:

- The Child Death Review Team should implement measures to improve identification and coding in the Child Death Register of specific pathogens and isolation sites associated with vaccine preventable diseases to facilitate review of child deaths from infectious diseases in NSW.
- The Child Death Review Team and Health Protection NSW should engage in regular communication and cross-checking regarding child deaths from vaccine preventable diseases.
- The Child Death Review Team and Health Protection NSW should work with NSW Health Pathology in regard to standard protocols for testing and notification of infectious diseases identified following a child's death.

In relation to measures to improve data collection in the Child Death Register, we note that the identification of pathogen and isolation sites associated with vaccine preventable diseases is largely reliant on the information we receive from NSW Health and the Coroner. In addition, as noted above we have had a new Child Death Register in place since 2014. The new register has greater capacity for recording, linking and retrieving information about specific causes of death and will help to better facilitate data sharing with Health Protection NSW and other key stakeholders.

This year, we have engaged with Health Protection NSW to identify strategies that could improve the identification and classification of deaths due to infectious disease. To support this work, Health Protection NSW is currently developing a framework for cross-checking data from all available sources, including notifiable data, the Child Death Register and the NSW Registry of Births, Deaths and Marriages. In 2017, we will start a process of information exchange with Health Protection NSW to ensure that all vaccine preventable deaths of children in NSW are identified.

Sudden Unexpected Death in Infancy

In 2015, we reviewed the deaths of 42 infants that were sudden and unexpected. Our recommendations below reflect our observations from reviews in 2015, and take account of trends over 15 years:

- Almost all of the infants who died in 2015 were exposed to one or more modifiable risk factors – such as being placed prone for sleep, bed sharing with an adult, and being exposed to tobacco smoke. This has been consistent over time.
- On average, a cause of death is able to be determined in only one-quarter of SUDI. This is much lower than best practice.¹⁰ Identifying a cause of death following a sudden and unexpected 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.
- SUDI in 2015 – and in previous years – disproportionately affected families residing in areas of low socio-economic advantage; families with a child protection history and Aboriginal and Torres Strait Islander families.
- In 2015, six infants died in circumstances where adults unintentionally fell asleep while feeding or caring for the child. Over a five year period, 18 infants died in these circumstances.

In relation to SUDI, we directed recommendations to the NSW Government, the State Coroner, NSW Health and Red Nose.

Our recommendations to the NSW Government

Identifying a cause of death following a sudden and unexpected death requires a thorough investigation, involving police, NSW Health (emergency departments and forensic services) and the Coroner's office. However, as noted, there is no whole-of-government policy in NSW to direct the cross-agency coordination of responses to SUDI.

For this reason, we recommended:

In the context of previous CDRT recommendations and the work of Garstang et al¹¹, the NSW government should:

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:

- (a) 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)**
- (b) Specialised training and development of resources for police in SUDI investigation.**
- (c) Identified specialists to take the SUDI medical history, and review of the SUDI medical history form and the immediate post mortem findings to enable further specific history taking where necessary.**
- (d) Application and monitoring of standardised protocols for SUDI pathology, with specific requirements for standard screens in sudden unexpected infant death.**
- (e) The conduct of SUDI post mortems by specialist paediatric pathologists. Minimally, where post mortems are not conducted by paediatric pathologists, there should be consultation with paediatric specialists.**

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

11. Garstang J., Ellis C., & Sidebotham, (2015), op cit, is derived from work completed for NSW Kids and Families, through the Sax Institute.

- (f) **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.
- (g) **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)

The NSW Government's response

In July 2017, the NSW Government advised us that it supports improving the interagency approach to SUDI investigation in NSW. The Government is currently consulting with agencies on options to improve the whole-of-government response to SUDI.

In addition, each of the involved agencies with a role in responding to SUDI has expressed support for the recommendation, and more broadly, for a change in the approach to SUDI investigation.

Our comments

We welcome the NSW Government's support for a whole-of-government approach to SUDI response and investigation.

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

Our recommendations to the NSW State Coroner

We made the following recommendations to the NSW State Coroner:

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.

The State Coroner, with the Child Death Review Team, should establish a consistent approach to classifying SUDI.

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

The NSW State Coroner's response

In May 2017, the Coroner advised us that both recommendations are supported.¹²

In relation to recommendation 4 above, the Coroner also indicated support for:

- a paediatrically-trained pathologist either performing, or being consulted, in autopsies for all SUDI cases, and
- a multi-agency case discussion taking place within days of the death and a multi-agency case review once all investigations are complete.

12. Letter to A/NSW Ombudsman from NSW State Coroner dated 11 May 2017.

In relation to recommendation 5 above, we have developed in consultation with the Coroner and Forensic Services, a proposed new SUDI classification for use in matters where a cause of death is unable to be determined following investigation. As noted above, the proposal draws on an earlier framework and clearly distinguishes between key modifiable and non-modifiable SUDI risk factors. The aim is to provide for a consistent approach to classification of SUDI in NSW.

Our comments

We welcome the Coroner's full support and active involvement in developing and implementing a simplified and consistent approach to SUDI classification in NSW.

As noted above, we have discussed our proposed SUDI classification with key agencies, including the Coroner's office, Forensic Services (NSW Health) and our state CDRT counterparts. We also acknowledge the important role of Forensic Services in this work and are pleased that they have been involved in discussions to date.

Members of the Australian and New Zealand Child Death Review and Prevention Group, a national group that brings together all state child death review teams and similar mechanisms, are also testing the classification.

We will continue to work with our agency partners to develop a consistent SUDI classification, and will report on progress in our next annual report.

Our recommendation to NSW Health and Red Nose (formerly SIDS and Kids)

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:

- (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 through social media and parenting blogs, and targeting grandmothers for safe sleep education.**

(Recommendation 6, Child Death Review Report 2015)

NSW Health's response

In July 2017, NSW Health advised us that they support this recommendation. Health has held preliminary discussions with Red Nose to discuss safe sleeping and anticipates there will be continued deliberations. Health advises that it has undertaken the following initiatives:

- development of a "Safe Sleep Cot" card for use in NSW Health maternity facilities to reinforce messages to parents about safe sleeping practices
- development of a Safe Sleeping eLearning module to increase awareness amongst health clinicians about SUDI risks and to promote safe sleeping practices
- revision of the Personal Health Records (Blue Book) to align with the key safe sleeping messages promoted by Red Nose, and
- revision of the *Safe Sleeping for Your Baby Brochure* developed by the Aboriginal Maternal and Infant Health Service and Building Strong Foundations, which targets culturally sensitive safe sleeping messages to Aboriginal and Torres Strait Islander families.¹³

13. Letter to A/NSW Ombudsman from Secretary, NSW Health, dated 14 July 2017.

Red Nose's response

In July 2017, Red Nose also stated their support for the above recommendation and advised that the organisation is 'well positioned to develop and deliver strategies in partnership with NSW Health across two other [of our SUDI] recommendations'.¹⁴ Red Nose provided information about the strategies it is currently working on to meet the intent of our SUDI recommendations.

In May 2017, Red Nose submitted a funding proposal to undertake a literature review and develop national guidelines on infant safe sleeping. Red Nose also plans to submit a further proposal to develop a range of programs and resource, potentially in partnership with NSW Health:

- Continued free distribution of Red Nose resources to public health services in NSW, and translation of these resources into a range of different languages.
- The development of safe sleeping resources specifically targeted at expectant parents with a focus on setting up an infant-safe environment.
- The development of a free online portal where parents and carers can access more in-depth information and interactive content about modifiable risk factors for SUDI.
- The development and roll out of training aimed at building the capacity of NSW health professionals and child protection caseworkers in supporting parents implement strategies to reduce modifiable SUDI risks.
- The replication in NSW of a program that Red Nose has been running in Western Australia for over 10 years called 'Reducing the Risks of SUDI in Aboriginal Communities'. In 2017-18, Red Nose plans to introduce safe sleep pods in Western Australia as part of this program. Red Nose's proposal for NSW includes safe sleep pods as a component.

Our comments

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.

We will monitor and report progress on the outcome of Red Nose's proposals to develop targeted resources and roll out a safe sleep program including sleep pods in NSW.

Previous recommendations relating to SUDI

In addition to the new recommendations above, we have continued to monitor a joint recommendation to NSW Health and Family and Community Services. 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)

NSW Health's response

In 2014, NSW Health advised us that they accepted this recommendation.

NSW Health provided its most recent advice on progress towards meeting the recommendation in July 2017.¹⁵ NSW Health told us that the agency had conducted some analysis of national and international programs 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 a trial in NSW. NSW Health further advised that discussions with FACS are planned to:

- review the *Safe sleeping supporting parents to make safe choices when placing their baby to sleep* resource produced by FACS in 2014 in order to ensure consistency of messages between the agencies

14. Letter to A/NSW Ombudsman from Chief Executive Officer, Red Nose, dated 14 July 2017.

15. Letter to A/NSW Ombudsman from Secretary, NSW Health, dated 14 July 2017.

- consider strategies to target safe sleeping messages to parents/families who have been identified as being at risk, and
- review the information currently available to high risk populations.

As noted above, Red Nose also support a trial of safe sleep pods in NSW.

FACS' response

In 2014, FACS advised us that they accepted this recommendation.

FACS provided its most recent advice on progress towards meeting the recommendation in July 2017. FACS told us that their Serious Case Review Unit has had preliminary discussions with NSW Health in relation to the evaluations of safe sleep pod programs in Queensland and New Zealand. FACS noted that *'while there is still no scientific advice on the safety of the [safe sleep pods], there is a commitment to meet again with NSW Health and to include other business units later in 2017 to jointly identify communities that may benefit from more in-depth support and educational messages about safe sleeping highlighted in the published findings'*.¹⁶

FACS further advised that *'there is also a commitment to continue to evaluate the longer term outcomes of the trials associated with the devices for reducing sudden unexpected deaths in infancy'*.

Our comments

In our *Child Death Review Report 2015*, we referred to research and evaluation reports that provided growing evidence in support of the effectiveness of safe sleep pods at reducing SUDI risk, based on trials in New Zealand and Queensland.¹⁷ In March 2017, we note that the Queensland Government made a commitment to pilot a safe sleep pod program in Indigenous communities throughout Queensland, given the promising findings from an evaluation of the research trial.¹⁸

Against the background of work that is individually being taken by NSW Health and Red Nose to examine the feasibility of such a trial, we would encourage FACS to work closely with NSW Health and Red Nose to implement measures that have been demonstrated to have a positive impact in reducing SUDI amongst populations at increased risk.

We will continue to monitor and report on progress in the implementation of this recommendation.

Transport: quad bikes and side-by-side vehicles

As described in section 3, our *Child Death Review Report 2015* included an examination of quad bike fatalities involving children, over the 10 years to 2015.

NSW legislation governing the use of quad bikes and side-by-side vehicles (SSV) differs, depending on whether they are being driven on-road, in recreational vehicle areas, or on private property.

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 8 years of age can ride an appropriately registered motor vehicle, including a quad bike or side-by-side vehicle, in a recreation vehicle area. It is broadly accepted that children under the age of 16 years should not ride adult-size quad bikes or SSVs. Manufacturer warning labels and information issued with adult-size quad bikes routinely state that the vehicles should not be operated unless the rider is at least 16 years old with a valid driver's licence.

We believe that adult quad bikes and SSVs are inherently dangerous for children and should not be operated by a child under 16 years. Recent Coronial inquests in NSW, Queensland and Victoria have highlighted the need for education, cultural change and regulation to prevent child death and injury.

16. Letter to A/NSW Ombudsman from Secretary, Family & Community Services, dated 7 July 2017.

17. Young, J., Watson, K., Craigie, L., Cowan, S., & Learney, L (2015), *Reducing Risk for Aboriginal and Torres Strait Islander babies: trial of a safe sleep enabler to reduce the risk of sudden unexpected deaths in infancy in high risk environments*, Final Report; Mitchell, E.A., Cowan, S., & Tipene-Leach, D (2016), 'The recent fall in post-perinatal mortality in New Zealand and the Safe Sleep Programme', article accepted for publication in *Acta Paediatrica*.

18. The Hon. Anastacia Palaszczuk, Queensland Premier and Minister for the Arts, and The Hon Shannon Fentiman, Minister for Child Safety and Minister for the Prevention of Domestic and Family Violence, *Safe Sleeping Program to be rolled out to help babies sleep*, Joint Media Release, accessed from <http://statements.qld.gov.au/Statement/2017/3/1/safe-sleeping-program-to-be-rolled-out-to-help-babies-sleep-tight> on 2 August 2017.

Our recommendation to the NSW Attorney General

In this context, we recommended that:

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

The Department of Justice's response

The Department of Justice advised that our recommendation is not supported. In explaining this position, the Department of Justice noted:

[The] Deputy State Coroner ... released findings from the Inquest into the deaths of nine people who died as a result of quad bike accidents in 2015. These findings included a recommendation that consideration be given by the Attorney General and NSW Law Reform Commission to the introduction of legislation prohibiting any child under 16 years from using an adult sized quad bike, side-by-side or related vehicle ...

The former Attorney General referred this recommendation to the former Minister for Roads, Maritime and Freight. The response, which included input from the former Minister for Innovation and Better Regulation, did not support legislative amendment to ban the use of quad bikes by children. This remains the case. This response was the NSW Government response to the Coronial recommendations and may be found on the NSW Department of Justice website at:

<http://www.justice.nsw.gov.au/lrb/Pages/coronial-recommendations.aspx>

The Government's response to the 2015 Coronial recommendation gave the following explanation for not supporting that recommendation:

The Minister for Roads and Maritime and Freight advised the Attorney General on 27 April 2016 as follow: Road transport law does not have jurisdiction over private property. However, a Class C Driver Licence (car) is required to conditionally register a side by side vehicle or quad bike for use on a road or road related area. A driver licence is not available to children under the age of 16 years.

Transport for NSW is committed to strengthening conditional registration arrangements for the use of quad bikes and side by side vehicles on roads and road related areas. The aim of this is to encourage a flow on effect to their use on private land.

Regulating the operation of quad bikes and side by side vehicles for commercial purposes on private land falls within the responsibility of agencies established to ensure work health and safety such as SafeWork NSW, which has responded to the recommendation.

The CDRT recommendation supported the Deputy State Coroner's recommendation that the NSW Attorney General refer the issue to the NSW Law Reform Commission for review.

The Department of Justice response to the CDRT recommendation¹⁹ referred to steps the NSW Government was taking to reduce the levels of quad bike deaths, including those of children. The main response to date has been the introduction in June 2016 of a \$2 million *Quad Bike Safety Improvement Program*. The program includes strategies to address vehicle design, retrofit safety devices, use of helmets, free training and education, including a regional education campaign commenced in 2017. Under the program, farmers can access rebates to purchase a SSV, retrofit safety equipment to an existing quad bike or purchase an approved helmet. Under the program, the Government has also launched training initiatives and a regional education campaign.

The Department of Justice response also noted the Government's commitment to working with the Commonwealth, other jurisdictions and the agricultural industry to reduce quad bike deaths. One such initiative has been the formation of a NSW Quad Bike Safety Industry Action Group.

19. Letter to A/NSW Ombudsman from Secretary, Department of Justice, dated 7 September 2017.

Our comments

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. Research findings and evidence from coronial inquires has also reinforced the significant risk of serious injury and death that quad bikes and SSVs pose to children:

- Findings from the 2015 inquest into seven quad bike deaths – including the deaths of three children – referred to the ‘false sense of security’ that can arise from common perceptions that quad bikes are safe, given their four wheels and stability when stationary. The Deputy Coroner’s findings note that quad bikes and SSVs are ‘*not stable vehicles, and are susceptible to rollover...[including] in circumstances that may not be easily foreseen, even on flat ground.*’²⁰
- The *Quad Bike Performance Test* for the Workcover Authority of NSW (Transport and Road Safety – TARS) concluded that ‘*The fatal incidents involving children operating adult Quad bikes and the inability of children to properly handle adult Quad bikes, identifies that children under 16 should not operate adult-sized Quad bikes.*’ TARS also recommended that there be a separate study of safety performance and requirements in relation to quad bikes marketed for use by children under 16.²¹
- The Royal College of Surgeons (RACS) wrote to the then Attorney General in December 2015 urging the Government to act swiftly on recommendations handed down by the Coroner which ‘*methodically and sensibly set out a roadmap to implement legislation that will save lives and prevent serious injury from quad bikes.*’ The RACS strongly endorsed the implementation of strategies to prohibit children under 16 from riding adult quad bikes.²²

We note that eight of the 10 children who died between 2006 and 2015 from injuries sustained in quad bike or SSVs crashes were on private property when the incident occurred. In the other two cases, the crashes occurred when the quad bikes crossed into a public area from private property. We also note that commercial operators in recreational areas such as Stockton Beach advertise the availability of quad bike tours for families, including children over eight years of age.

In our view, there is a 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 respectfully disagree with the rationale for not accepting this recommendation.

Drowning: private swimming pools

As noted in section 3, our *Child Death Review Report 2015* included details of a review of the drowning deaths of 70 children in private swimming pools over the 10 years to 2015.

We reported that the drowning mortality rate for children declined overall between 2001 and 2015. However, the drowning mortality rate in private swimming pools in 2015 (0.41) was the highest since 2009. Key observations from our review were:

- Children under five are most at risk of drowning in backyard pools. We have previously recommended that priority for inspections should be pools at properties where young children reside.
- All children under five years who drowned did so in the absence of adult supervision. This ranged from clearly inadequate supervision, to carer distraction or misunderstanding of the whereabouts of the child. There is a clear nexus between lack of direct supervision, even for very short periods of time, and faulty child resistant barriers.
- Almost all of the swimming pools eligible for exemption from pool barrier requirements were fenced. Although fenced, the barriers were mostly non-compliant with the *Swimming Pools Act 1992*.
- Faulty gate latch mechanisms were the most common barrier defect through which young children accessed the pool. Gate latches are common weak points in pool barriers as they comprise moveable parts which must align for effective operation.

20. Deputy State Coroner Sharon Freund (2015), Inquest findings, NSW State Coroner’s Court, pp 39-40

21. Grzebieta, Raphael et al (2015), *Final project summary report: Quad bike performance project test results, conclusions and recommendations, report 4*, Transport and Road Safety, University of NSW for the Workcover Authority of NSW.

22. Department of Justice, *Coroners’ Recommendations and Government Responses 2015*, accessed from <http://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx>

- Access to Standards Australia standards for child resistant safety barriers is limited. Child-resistant pool safety barriers must comply with specific standards established by Standards Australia, which are available for purchase, and cannot be published.
- One in five swimming pools in which children drowned in the ten year period were portable. Ten of the 13 portable pools in which children drowned required a child-resistant safety barrier under the *Swimming Pools Act 1992*, however most were unfenced.
- There is little publicly available data on the number of inspections carried out and the level of compliance with legislative requirements. We consider it in the public interest that there be public reporting on the effectiveness of the swimming pool registration and inspection regime.

In this context, we made a number of recommendations to the NSW Government and the Office of Local Government.

In May 2017, the Department of Premier and Cabinet advised us that they had referred the recommendations we directed to the NSW Government to the Office of Local Government.²³ In July 2017, the Office of Local Government responded to our recommendations and indicated that the response reflected the Government's position.

The Government did not accept the majority of our recommendations. The Office of Local Government advised us in July 2017 that:

The NSW Government's position is 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...The Government is seeking to strike a balance between regulation and changing pool owner behaviour.²⁴

The Office of Local Government further advised that the Government's position is based on the findings of an independent cost-benefit analysis and better regulation statement commissioned by the Office in October 2016, in response to recommendations from the Independent Review of Swimming Pool Barrier Requirements (the Lambert review).²⁵

Our comments

Whilst we are supportive of the Government's commitment to increase resourcing for education initiatives that reinforce the importance of compliant pool safety barriers, and the need for vigilant and responsible adult supervision of young children in and around pools, we are disappointed that the Government has decided against implementing the regulatory measures we have recommended.

The individual recommendations, the Government's response and our comments are detailed below.

Amendments to the Swimming Pools Act

We recommended that:

In the context of proposals contained in the Independent Review of Swimming Pool Barrier Requirements for Backyard Swimming Pools in NSW²⁶ (discussion paper), the NSW Government should amend 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.**

(Recommendation 11, Child Death Review Report 2015)

23. Letter to A/NSW Ombudsman from Deputy Secretary, Social Policy, Premier & Cabinet, dated 26 May 2017.

24. Letter to A/NSW Ombudsman from A/Chief Executive, Office of Local Government, dated 4 July 2017.

25. The Centre for International Economics (2016), *Review of Swimming Pool Fence Requirements – Cost-benefit analysis*, prepared for the Office of Local Government, August 2016; The Centre for International Economics (2016), *Regulation of Private Swimming Pool Barriers – Better Regulation Statement*, prepared for the Office of Local Government, August 2016.

26. Lambert, M (2015), *Independent Review of Swimming Pool Regulation Final Report*, accessed from <https://www.olg.nsw.gov.au/sites/default/files/OLG%20-%20Lambert%20Swimming%20Pool%20Review%202015%20-%20Final%20Report.pdf> on 29 July 2017.

The Office of Local Government's response

The Office of Local Government advised that this recommendation is not supported on the basis that:

- In November 2016, the NSW Government released its response to the Independent Review of Swimming Pool Barrier Requirements for Backyard Swimming Pools in NSW (the Lambert review) and *'careful analysis of this suite of recommendations revealed that increased public education will be most effective in improving child safety in and around private swimming pools, including portable pools'*.
- An independent cost benefit analysis prepared for the Office of Local Government in response to the Lambert review *'clearly 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. Retrospectively applying the latest standard for pool barriers is therefore not an effective or proportionate means of improving child safety'*.
- 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 requiring upgrade to the latest standard.
- Portable pools that meet the definition of a pool under the *Swimming Pools Act* are already subject to registration and safety barrier requirements.

Our comments

The Government's view was informed by a cost benefit analysis which indicated that any safety benefits expected to accrue from the introduction of a simplified, single standard together with the phased removal of automatic exemptions were not proportionate to the costs associated with implementation.²⁷

However, we note that the accompanying better regulation statement identified that, despite the significant regulatory framework already in place in relation to swimming pools, the cost to the community resulting from near-drowning and drowning deaths of young children is substantial, and therefore supports an *'in-principle case for additional regulation'*.²⁸

Against this background, we are disappointed that the Government has decided against legislating to introduce a single standard for pool barriers, to remove all remaining automatic exemptions and to impose additional regulations on portable pools.

Prioritisation of swimming pool inspections

In relation to prioritising swimming pool inspections, we recommended:

In the context of the CDRT's previous recommendations, 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)

The Office of Local Government's response

The Office of Local Government advised that this recommendation is not supported 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.
- The Swimming Pool Register is a register of pools rather than owners and if information regarding children were to be captured on the register, it would quickly become out of date.

27. The Centre for International Economics (2016), *Regulation of Private Swimming Pool Barriers – Better Regulation Statement*, prepared for the Office of Local Government, August 2016, pg 23.

28. The Centre for International Economics (2016), *Regulation of Private Swimming Pool Barriers – Better Regulation Statement*, prepared for the Office of Local Government, August 2016, pg 15.

- Councils already have access to demographic information that assists them prioritise compliance inspections to areas of risk.
- It is the responsibility of each individual council to determine its resource priorities, including in relation to non-mandatory swimming pool inspection regimes.

Our comments

Given that young children are at highest risk of drowning in backyard swimming pools, our work has demonstrated the critical need for councils to be able to clearly identify and target inspections to swimming pools at properties where young children reside or regularly visit. In that context, we are disappointed that our recommendation has not been accepted.

The Office of Local Government has indicated that the decision not to implement this recommendation is in part due to concerns about pool owners' sensitivity to revealing how many children reside at, or regularly visit, a particular address. However, the basis for the view that such information is sensitive, and that to require it could adversely impact pool registrations, is unclear. Whilst we acknowledge that there will always be some owners who choose not to register their pool (for any number of reasons, including avoidance of inspections) we note that the Lambert review estimated this proportion to be relatively small.²⁹

In addition, the Office of Local Government indicates that it encourages councils to target resources towards swimming pools used by young children. However, we were not advised as to what information is used to assist targeting, or whether council inspection programs are effective in this regard.

Given the importance of this issue, we will continue to focus on Council inspection programs and outcomes from these.

Variation of standards

Our review of drowning deaths of children in private swimming pools (2006 – 2015) found that that the majority of private swimming pools in which children drowned had compliance issues. Of the non-compliant pools, almost all had an issue relating to the pool gate or latch mechanism that affected the gate self-closing. In this context, we recommended:

The Office of Local Government should consider an application to Standards Australia to vary the standard AS 1926.1-2012 to include requirements for tolerance and movement of self-closing gate latch mechanisms.

(Recommendation 8, Child Death Review Report 2015)

The Office of Local Government's response

The Office of Local Government advised that this recommendation is 'not applicable', as the Australian Standard AS1926.1-2012 is currently undergoing review by Standards Australia. Standards Australia expect to finalise the review by April 2018 and the office understands that issues relating to tolerance and movement of self-closing gate latch mechanisms have been referred to the relevant Technical Committee for consideration.

Our comments

In light of the review that is underway by Standards Australia, we will not continue to monitor this recommendation. We will await the outcome of the review and consider any resulting revisions to the standard in the context of our ongoing work.

29. Lambert, M (2015), *Independent Review of Swimming Pool Barrier Requirements for Backyard Swimming Pools in NSW*, Discussion Paper: September 2015, accessed from <https://www.olg.nsw.gov.au/sites/default/files/Independent-Review-of-NSW-Swimming-Pool-Barrier-Requirements-Discussion-Paper-2015.pdf> on 8 August 2017.

Monitoring outcomes of the inspection regime

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 demonstrating outcomes, we recommended:

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)

The Office of Local Government's response

The Office of Local Government advised that this recommendation is supported in-principle. The office also advised that:

- their Annual Report for 2015-16 included for the first time information on the number of swimming pools currently registered in NSW and the number that had been issued with a compliance certificate as at 30 June 2016
- individual 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, and
- the office is '*is continuing to examine options for enhancing the Swimming Pool Register where possible to allow for reporting on a wider range of statistics*'.³⁰

Our comments

We note that the requirement for councils to provide information in annual reports on the outcome of swimming pool inspections commenced in April 2016.³¹ We will monitor compliance by councils over the next reporting period.

We also note that while the swimming pool register currently includes capacity for authorised officers/ accredited certifiers to record the date/time of inspection, whether the pool is compliant or non-compliant, the reasons for non-compliance (gate, fence, window, door, sign, other) and comments/explanation for non-compliance³², the Office of Local Government has previously advised that the register has extremely limited reporting capacity. It is not currently possible to extract and report on information about the number of pools inspected within a defined period, or details about the proportion of pools deemed non-complaint, the nature of the defects identified and subsequent rectification work.

30. Letter to A/NSW Ombudsman from A/Chief Executive, Office of Local Government, dated 4 July 2017.

31. Swimming Pools Regulation 2008, cl 18BC.

32. Division of Local Government, Department of Premier and Cabinet (2013), *Swimming Pool Register User Guide*, accessed from <http://www.olg.nsw.gov.au/sites/default/files/Swimming-Pool-Register-User-Guide.pdf> on 31 July 2017.

The Lambert review recommended substantial upgrades to the register in order to facilitate meaningful reporting on compliance activities and inspection outcomes. The NSW Government's response to the Lambert review states that '*the NSW Government will look at ways to improve the Swimming Pools Register's data capture to assist with informing future policy decisions*'.³³

We consider that a swimming pool register which contains, and is able to report on, relevant information about a pool's compliance history is a necessary pre-condition to the effective targeting of inspection programs.

We will continue to monitor and report on work by the Office of Local Government to enhance the functionality of the register to support this critical function.

Deaths from suicide

Suicide was the leading cause of death for 15-17 year olds in 2015, and the suicide mortality rate for this age group in that year was the second highest since 1997. Our *Child Death Review Report 2015* identified that:

- coordination of care and treatment for young people in contact with health services was not always optimal
- some young people who died by suicide did not present with suicidal behaviours or signs of intent
- young people often told their friends about their thoughts of self-harm or intent to suicide, and
- there is no focused suicide prevention plan for young people in NSW.

Our recommendation

We recommended that:

In the context of suicide being a leading cause of death for young people aged between 10 and 17 years in NSW, NSW Health should consider the observations in our report and advise us about existing or planned strategies to address these.

(Recommendation 12, Child Death Review Report 2015)

NSW Health's response

In response to this recommendation, NSW Health provided advice about a range of strategies and initiatives currently being implemented across NSW, including:

- **Life Span:** NSW Health is collaborating with the Black Dog Institute in trialling Life Span, which is a 'systems approach' to suicide prevention. Key strategies under LifeSpan are: increased access to mental health services; quality education programs targeting frontline workers (e.g. hospital emergency staff, school teachers, General Practitioners); minimising access to lethal means; and encouraging safe conversations about suicide in schools, workplaces and communities. LifeSpan also involves lead agencies working with service providers that support to groups within the community known to have rates of suicide, including young people.
- **Suicide prevention fund:** The NSW Government has invested \$8 million over four years to fund non-government and community based organisations to deliver local suicide prevention services and activities. Pilot sites in the Murrumbidgee, Central Coast, Illawarra Shoalhaven and Newcastle will commence operations in 2017.
- **Guidelines to support transitions for young people:** NSW Health is developing evidence-informed guidelines to support the transition of young people from community-based or inpatient specialist Child and Adolescent Mental Health Service care to adult mental health service. The guidelines will have a focus on clarifying roles and responsibilities to ensure that continuity of care and safety are maintained throughout the period of transition. NSW Health expects to finalise the guidelines in 2017.
- **Youth Mental Health First Aid:** This course is delivered to adults working or living with young people and aims to increase knowledge about when and how to assess for suicide risk, seek appropriate professional help and encourage self-help strategies with young people exhibiting psychological distress. As part of the NSW Government's response to *Living Well*, over 800 NSW youth and other workers received the training in 2015-16, mainly in rural and regional areas.

33. NSW Government Response to the Independent Review of Swimming Pool Regulation, November 2016, pg 6.

- **Youth Community Living Support Services:** As part of the NSW Government's response to *Living Well*, funding was provided to expand community-based psychosocial support services to young people aged 16 to 24 years who have severe mental illness and at risk of developing a functional disability. Currently, five pilot sites are providing services to young people and their families in partnership with local mental health services.
- **Conversations Matter:** Funded by the NSW Ministry of Health, the Hunter Institute of Mental Health has developed resources to support community conversations about suicide. The Conversations Matter website provides advice on bereavement support and includes resources for teachers and parents on how to have conversations with children and young people about suicide.
- **Capacity building for NSW Health Staff**, including:
 - the issue of a new policy directive – *Clinical Care of People who May be Suicidal* – to assist the mental health workforce provide care across emergency, inpatient and community settings and in collaboration with other health professionals. Associated training will also be rolled out to the health workforce in 2016-17, with a focus on identifying and responding to individuals who may be at risk of suicide.
 - the launch of the Essential Youth Healthcare Skills Training Workshop in 2016 to build capacity amongst health staff in engaging with young people, and assessing and responding to psychosocial and suicide risks.
 - the development of a standardised youth health and wellbeing assessment tool and guidelines to facilitate the early identification of concerns across hospital and community settings.

In addition, NSW Health advised that they fund and deliver a number of suicide prevention programs in partnership with the Department of Education. These include:

- **School-Link:** This program operates in all Local Health Districts and Speciality Networks and provides consultation, clinical care and a range of mental health services in schools and TAFES.
- **Project Air for Schools:** This program assists school staff to identify, and support students with complex mental health concerns, including managing challenging behaviours such as self-harm.
- **Postvention Guidelines:** NSW Health partnered with the Department of Education to develop the *Responding to Student Suicide – Support Guidelines for Schools* to support schools in responding to a student's death by suicide.
- **Getting on Track in Time – Got It!:** This is a school-based clinical early intervention service for conduct disorder delivered by Child and Adolescent Mental Health Service teams in partnership with Department of Education staff.

Our comments

We note NSW Health's advice about the range of programs and initiatives that aim to prevent deaths by suicide in NSW. As we have previously reported, strategies and programs to tackle suicide risk amongst young people need to be effectively targeted and co-ordinated across a range of different government and non-government agencies, and it is not always evident whether, and how well, activities are coordinated.

In this regard, we appreciate that LifeSpan is intended to provide a co-ordinated whole-of-government approach to suicide prevention. Given this, it is critical that there are robust systems in place to measure and evaluate the impact and effectiveness of LifeSpan, including any associated activities and interventions occurring in local communities.

Through our review work, we will continue to monitor the implementation and outcome of suicide prevention strategies targeted to young people.

Deaths from asthma

Our *Child Death Review Report 2013* included a review of the asthma deaths of 20 children over the 10-year period 2004 to 2013. We found that most (17) of the 20 children had factors that may have increased their risk of death, including:

- sub-optimal level of asthma control
- presentation/admission to hospital for asthma in the year before death
- insufficient follow-up after a hospital presentation/admission for asthma
- lack of a written asthma plan or poor adherence to recommended asthma medication/asthma action plans, and
- exposure to tobacco smoke.

The majority of the children had more than one risk factor. Our review identified opportunities for strengthening policy and practice in two key areas:

- the clinical follow-up of children who present to hospital with asthma, and
- the planning and support provided to students with asthma by schools

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.

Post-hospitalisation follow-up

We recommended that:

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).

NSW Health's response

In 2014, NSW Health advised us that they support this recommendation. Since this time, we have been monitoring progress by NSW Health to improve practice in this area.

In their most recent update to us, NSW Health advised that the *Aiming for Asthma Improvement in Children Program* continues to take an active role on behalf of NSW Health in the Sydney Children Hospital's Networks' 'Kids GPS Integrated Care Project' for children with asthma. Since we last reported on the progress of implementation, the project team has created referral pathways for children with complex and non-complex asthma. The team is currently working on strategies to:

- reduce asthma emergency department representations for non-complex asthma, for example, through greater use of care coordinators
- increase assertive follow up and asthma control following emergency department presentation, for example, through webinars on paediatric asthma management for general practitioners, and
- develop a risk score for severe asthma and a state-wide review of childhood asthma models of care to identify gaps in the community and improve integrated care pathways.³⁴

34. Letter to A/NSW Ombudsman from Secretary, NSW Health, dated 14 July 2017.

Our comments

We acknowledge the actions taken to date by NSW Health to improve clinical practice in relation to the follow-up of children who present to hospital with acute asthma symptoms. We will continue to monitor and report progress by NSW Health to implement this recommendation. In particular, we are keen to see the outcome of projects and initiatives being rolled out as part of the Integrated Care Pilot.

School-based support for children with asthma

We recommended that, as auspice agency of a cross-sectoral working party established to identify strategies for improving school-based support to children with asthma and their families, NSW Health should provide detailed advice on the outcomes of the working party, including any action taken to develop a standard asthma action plan for use in schools.

(Recommendation 1, Child Death Review Report 2014)

NSW Health's response

In 2014, NSW Health advised us that they supported our original recommendation, which detailed the need for school policy review.

In their most recent progress report to us in July 2017, NSW Health advised that following extensive consultation with key stakeholders, the working party has finalised the *Schools and Child Services Action Plan for Asthma Flare-up*. Consultation regarding the rollout of the action plan is underway and with support from NSW Health, the Department of Education and Local Primary Health Networks. The action plan together with the *Asthma First Aid Management in Schools iBook* will be formally launched in the second half of the year.

In addition, *Asthma and Your Child – A Resource Pack for Parents and Carers* has been revised. This educational resource includes checklists and prompts for parents/carers to seek regular medical review and up-to-date asthma action plans in order to achieve good asthma control for their child.

Our comments

We acknowledge the work undertaken by NSW Health, government and non-government education authorities and other key stakeholders to develop a standardised asthma action plan and guidance for schools in managing asthma risks. We welcome the launch and roll out of the new resource and are satisfied that the intent of this recommendation has been met. We will no longer seek progress reports from NSW Health in relation to this recommendation.

Deaths in house fires

Our *Child Death Review Report 2013* included a review of the deaths of 35 children who died in 27 house fires over the 10-year period 2004 to 2013. Our review highlighted the risks associated with:

- children having access to, and playing with, matches and lighters
- heaters and candles being placed too close to flammable materials and/or being left unattended while in use
- young children being unsupervised or left in the supervision of young teenagers
- smoke alarms not being installed or being disconnected, and
- household members not having adequate means of escaping the premises.

Targeting prevention resources and activities: Fire and Rescue and Family and Community Services

We recommended:

Against the background of the high proportion of children with a child protection history who were among those who died in house fires over the 10 year period; the high proportion of these fires having been started by children playing with matches/lighters; and the previous recommendations of the NSW Coroner, we recommended that FACS and Fire & Rescue NSW should:

- **meet to discuss the issues raised in our report and opportunities for collaborative work to reduce the fire risks of children known to the Department, and**
- **provide advice on any action they intend to take to reduce these risks, such as through targeted prevention resources and activities.**

(Recommendation 16, Child Death Review Report 2013)

FACS' response

In 2014, FACS advised us that they supported this recommendation and we have been monitoring implementation since that time.

In their most recent update in July 2017, FACS told us that the agency had undertaken the following actions to progress implementation:

- Met with Fire & Rescue on three occasions between August 2016 and February 2017 to discuss preventative resources and activities provided by Fire & Rescue, and identify those households with children known to FACS who may benefit from fire awareness intervention and/or a home fire and safety check from a local fire and rescue team.
- Fire & Rescue provided FACS with a copy of its child protection policy in June 2017 to inform further discussion between the agencies in relation to referral pathways.
- FACS expects to release its new practice resource on neglect later in 2017. Fire & Rescue has provided FACS with information that will be referenced in the neglect practice resource to assist child protection practitioners identify fire safety hazards when conducting safety and risk assessments.³⁵

Fire & Rescue's response

In 2014, Fire & Rescue advised us that they support this recommendation.

In their most recent progress report to us in May 2017, Fire & Rescue advised that the agencies established a working group in August 2016 that meets regularly to share information and review serious fire related incidents involving children. Fire & Rescue has made a commitment to *'provide fire safety information for FACS to distribute amongst their client base, and additionally FRNSW will conduct Home Fire Safety visits at the request of FACS to residences identified as having a potential risk of a residential fire'*.³⁶

Our comments

We welcome FACS and Fire & Rescue's advice about the establishment of a working group to share information and learnings between the agencies, accompanied by an arrangement whereby Fire & Rescue will conduct home visits for families referred by FACS. We consider the agencies have met the intent of this recommendation and will not continue to seek progress reports.

35. Letter to A/NSW Ombudsman from Secretary, Family & Community Services, dated 7 July 2017.

36. Letter to A/NSW Ombudsman from Commissioner, Fire & Rescue, dated 17 May 2017.

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

Professor John McMillan
Convenor, NSW Child Death Review Team
Acting NSW Ombudsman
Level 24, 580 George Street
SYDNEY NSW 2000

Your ref ADM/2017/155
Our ref 017/2

Response to NSW Ombudsman on Implementation of Recommendations to NSW Health in the Child Death Review Report 2015

Dear Prof McMillan

Thank you for your letter of 13 April 2017 seeking NSW Health's progress report in the implementation of the recommendations directed at NSW Health in the Ombudsman's CDRT report *Child Death Reviews Report 2015*. Please find attached our comments on the progress made against the recommendations.

Also included in the attached documentation are the views of NSW Health on recommendations 2 and 3 of the report, which focus on the development of a whole of government framework to address the Sudden Unexpected Death in Infancy (SUDI) matters. NSW Health supports the proposal that an interagency framework be developed in response to SUDI and I understand that further engagement will be sought with the relevant agencies in order to progress work in this area.

If you have any further queries, please contact Paul Giunta, Director, Corporate Governance and Risk Management on 9391 9654 or via e-mail to Paul.Giunta@moh.health.nsw.gov.au

Yours sincerely



Elizabeth Koff
Secretary, NSW Health

14/7/17

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
 TAB A

Reference	Recommendations from 2015 Report	Requested information for reporting progress to NSW Parliament
<p>Rec 1</p>	<p>NSW Health should consider the observations and recommendations made in the report, <i>Child Deaths from Vaccine Preventable Infectious Diseases, NSW 2005-2014</i> and advise the CDRT of existing or planned strategies to address these.</p>	<p>Health Protection NSW (HPNSW) supports the recommendations in Section 5.12 (<i>Child deaths from infectious diseases in NSW: 2005-2014</i>) 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:</p> <p>1. Immunisation of children at high risk is recommended and provided free under the NIP:</p> <ul style="list-style-type: none"> • 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 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 speciality 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. • 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.

		<p>2. Vaccines against influenza and meningococcal B disease are recommended for all Australian children although not provided free of charge in 2016:</p> <ul style="list-style-type: none"> • 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, six 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 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. <p>3. Immunisation of contacts is recommended for children at high risk of influenza, pertussis and varicella:</p> <ul style="list-style-type: none"> • HPNSW regularly reminds general practitioners and parents of the NHMRC
--	--	---

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>recommendations around vaccinating close contacts of infants against pertussis, and writes to every new parent to reiterate this message.</p> <ul style="list-style-type: none"> • Other comments from Recommendation 1 regarding the NSWISS initiatives at CHW are also relevant here for influenza and varicella. <p>4. Immunisation against pertussis and influenza is recommended during pregnancy and provided free in NSW:</p> <ul style="list-style-type: none"> • 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 upskill 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. <p>5. Children should receive vaccines for which they are eligible under immunisation catch up programs:</p> <ul style="list-style-type: none"> • 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. <p>6. Travel immunisation should be provided as recommended:</p> <ul style="list-style-type: none"> • HPNSW takes available opportunities to remind general practitioners and the public about recommended pre-travel vaccines. A podcast to upskill general
--	--	--

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>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.</p> <ul style="list-style-type: none"> • 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. <p>7. Data collections on child deaths in NSW should be enhanced and cross-checked between sources:</p> <ul style="list-style-type: none"> • 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 Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

Rec 6	<p>NSW Health and Red Nose (formerly SIDS and Kids)</p> <p>NSW Health, in consultation with Red Nose, should review current advice and educational strategies, with a view to:</p> <ul style="list-style-type: none"> 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 through social media and parenting blogs, and targeting grandmothers for safe sleep education. 	<p>NSW Health supports the recommendation.</p> <p>Preliminary discussions have been held with Red Nose to discuss safe sleeping and it is anticipated that there will be continued deliberations.</p> <p>NSW Health has undertaken the following initiatives to address the issue of safe sleeping, these include:</p> <p>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 supplies of the cards are available for facilities to order.</p> <p>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.</p> <p>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.</p> <p>The revision of the Aboriginal Maternal and Infant Health Service (AMIHS) and Building Strong Foundations (BSF) <i>Safe sleeping for your baby</i> brochure. It is in</p>
--------------	---	---

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>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 will be available from July 2017, 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 will also be available on the NSW Health website. The AMIHS/BSF brochure will be provided to young mothers and families (this can include grandmothers) through AMIHS and BSF services.</p> <p>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.</p>
<p>Rec 12</p>	<p>Suicide NSW Health</p> <p>In the context of suicide being a leading cause of death for young people for young people aged between 10 and 17 years in NSW, NSW health should consider the observations made above and advise the CDRT of existing or planned strategies to address these.</p>	<p>The NSW Government invested \$1.8 billion for mental health services in 2016-17. Enhancements to NSW suicide prevention initiatives are a critical area for the Government's investment.</p> <p>Activities and Initiatives NSW Health is undertaking to address the CDRT's observations:</p> <p>The Proposed Suicide Prevention Framework for NSW was released in 2015. The Mental Health Commission, National Health and Medical Research Council and the Black Dog Institute developed the framework, which identifies nine strategies that could be applied in parallel at a local or regional level to reduce the number of completed suicides and forms the basis for LifeSpan.</p> <p>LifeSpan</p> <p>NSW Health is collaborating with the Black Dog Institute in trialing LifeSpan – a systems approach to suicide prevention. LifeSpan is being piloted in four areas of NSW with the aim of improving the response to suicide at a local level and</p>

	<p>reducing the rate of suicide and suicide attempts. The four pilot sites are: Murrumbidgee, Central Coast, Illawarra /Shoalhaven and Hunter New England Local Health Districts (LHDs).</p> <p>The key strategies of the LifeSpan approach include improved access to mental health care, quality education programs for people at the front line (emergency staff, teachers, GPs), minimising access to lethal means and encouraging safe conversations about suicide in schools, workplaces and communities. A key focus will be working with services and communities who support and are in contact with groups known to have elevated rates of suicide.</p> <p>The Ministry of Health provides Black Dog \$1.469 million per year (over three years) for suicide prevention, including school and community education initiatives.</p> <p>Suicide prevention fund</p> <p>The NSW Government has invested \$8 million over four years from 2016-17 to establish a new suicide prevention fund to support people at risk of suicide across NSW.</p> <p>International research indicates that a 'systems approach' to suicide prevention shows the most promise for improving responses to suicide, where multiple interventions are implemented simultaneously at a local level.</p> <p>The NSW Suicide Prevention Fund provides opportunities for non-government organisations and community based services to deliver local suicide prevention services and activities. Following an expression of interest process, successful applicants were announced in August 2016.</p> <p>The four successful pilot sites are:</p> <ul style="list-style-type: none"> • Murrumbidgee (lead agency Murrumbidgee PHN), which will commence in September 2017.
--	--

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014 , CDRT Annual Reports 2013 and 2014 **TAB A**

	<ul style="list-style-type: none"> • Central Coast (lead agency Central Coast LHD), which commenced in May 2017. • Illawarra Shoalhaven (lead agency South East NSW PHN), commenced February 2017. • Newcastle LGA (lead agency Hunter New England LHD), planning commenced in October 2016. <p>Services supported for funding will address identified gaps in local service delivery, providing local, and targeted suicide prevention activities to reach at risk population groups, including young people.</p> <p>Clinical care of people who may be suicidal including follow-up after emergency department presentations and inpatient admissions</p> <p>The recently issued NSW Health Policy Directive PD2016_007 <i>Clinical Care of People Who May Be Suicidal</i> (www0.health.nsw.gov.au/policies/pd/2016/pdf/PD2016_007.pdf) assists the specialist mental health workforce to provide care across community, inpatient and emergency settings in collaboration with other health professionals. It supports the provision of timely evidence-based clinical care of people at risk of suicide, outlines the roles and responsibilities of mental health services and clinicians and supports a consistent and coordinated evidence-informed approach to support application of clinical guidelines and training. Associated suicide prevention training will be rolled out to support increased skills in identifying and responding to individuals who may be at risk of suicide. \$365,000 has been committed for this training in 2016-17</p> <p>This Policy Directive cross-references PD2012_060 <i>Transfer of Care from Inpatient Mental Health Services</i>, which includes the requirement that, prior to approval by the treating psychiatrist, leave decisions are to be considered by a multidisciplinary team, with regard to improved assessment and management of</p>
--	--

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>the risk of harm to self or others by the patient (www0.health.nsw.gov.au/policies/pd/2016/pdf/PD2016_054.pdf).</p> <p>Follow-up within 7 days of discharge from a mental health inpatient unit is a National Mental Health Key Performance Indicator and included in NSW Health performance agreements. This indicator receives ongoing prioritised focus at both acute CAMHS inpatient unit and community CAMHS benchmarking/quality improvement forums and in site visits with acute CAMHS inpatient units.</p> <p>Supporting Transitions For Young People</p> <p>NSW Health is developing an evidence-informed guideline to support the optimal transition of young people from community-based or inpatient specialist Child and Adolescent Mental Health Service (CAMHS) care or Youth Mental Health Service (YMHS) care to Adult Mental Health Service (AMHS) care. The Guideline focuses on the ongoing health care needs of young people in the context of their evolving and changing developmental needs. It sets out responsibilities to ensure continuity of care and safety are maintained during the period of transition. The Guideline is expected to be finalised in 2017 and will assist Local Health Districts and Speciality Networks in developing local policies.</p> <p>Suicide prevention training</p> <p>In 2016-17, \$500,000 was been allocated for specialist suicide prevention training for NSW health clinicians who are not working in mental health services.</p> <p>Youth Mental Health First Aid</p> <p>The Youth Mental Health First Aid course is for adults working or living with young people. This course is particularly suitable for parents, teachers, sports coaches, and youth workers. Mental Health First Aid (MHFA) training has been well evaluated and found to increase participants' knowledge regarding mental health, decrease their negative attitudes, and increase supportive behavior toward</p>
--	--	--

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>individuals with mental health problems.</p> <p>The 2016 Youth MHFA evaluation suggests that individuals participating in Youth MHFA training are better informed regarding when to assess for risk of suicide, listen non-judgmentally, encourage appropriate professional help, and encourage self-help strategies with young people in psychological distress.</p> <p>As part of the NSW Government response to <i>Living Well</i>, \$350,000 was provided to Wesley Mission to deliver MHFA training. Across 2015 and 2016, over 800 NSW youth and other workers, mainly in rural and regional areas received the training.</p> <p>NSW Health funds a number of programs conducted in partnership with Department of Education including:</p> <ul style="list-style-type: none"> • School-Link: A longstanding collaboration between NSW Health and the Department of Education, the School-Link program operates in all local health districts and speciality networks. Specialist health services are provided through the program, including consultation, liaison, clinical care planning for recovery, and the delivery of specialist mental health individual and group initiatives in schools and TAFEs. • Project Air for Schools: A new program developed by the University of Wollongong, jointly funded by NSW Health and Department of Education. The program assists school staff to identify, respond, support and refer school students with severe and complex mental health concerns, particularly personality disorder. The program also assists school staff in managing challenging behaviour, including self-harm. • Postvention Guidelines: NSW Health partnered with the Department of Education to develop the Responding to Student Suicide – Support Guidelines for Schools to support schools in responding after a student's
--	--	--

		<p>death by suicide. The Guidelines assist schools in providing a consistent and appropriate response immediately after a death, over the next 24-72 hours and in the longer term.</p> <p>Getting on Track in Time – Got It! is a specialist school-based clinical early intervention service for conduct disorder delivered by Child and Adolescent Mental Health Services (CAMHS) teams in partnership with NSW Department of Education staff. The delivery of the program in a school environment provides the opportunity for Education and mental health staff to work closely together to help children and families in a setting familiar to them.</p> <p>Exchange of Information</p> <p>In response to a recent Coronial recommendation, NSW Ministry of Health, Illawarra Shoalhaven LHD and DoE developed a fact sheet for Health and Education staff that explains the legal basis for exchanging information about children and young people in NSW under Chapter 16A of the <i>Children and Young Persons (Care and Protection) Act 1998</i>.</p> <p>Peer Support Australia (PSA)</p> <p>PSA has been funded by NSW Health since 1990. PSA provides school communities with an evidence-based, peer led approach to enhance the mental, social and emotional wellbeing of young people. PSA is integrated into curricula and sustained through all year groups in participating schools. It supports positive cultural change within schools by incorporating a range of strategies developed through collaboration with members of the whole school community for the specific needs of the school.</p> <p>Youth Community Living Support Services (YCLSS)</p> <p>As part of the NSW Government response to <i>Living Well</i>, funding was provided to expand community-based psychosocial support services to young people aged 16 to 24 years who have severe mental illness and who have, or are at risk of</p>
--	--	---

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

	<p>developing significant functional disability.</p> <p>Based on the successful Young People's Outreach Program (Y-POP) pilot, five YCLSS sites are providing services to young people and their families, in partnership with local mental health services. The total funding commitment for YCLSS to June 2017 under the NSW Mental Health Reform is \$4,862,000. RichmondPRA was contracted to provide YCLSS in Western Sydney LHD, Nepean Blue Mountains LHD and Hunter New England LHDs, with MI Fellowship contracted for South Western Sydney LHD and Northern NSW LHDs. Both organisations have undergone a name change and rebranding since the signing of the YCLSS Agreement. RichmondPRA is now known as Flourish and MI Fellowship is rebranded as Wellways.</p> <p>Conversations Matter</p> <p>The Hunter Institute of Mental Health (HIMH) has developed resources to support community conversations about suicide, funded by the NSW Ministry of Health. The Conversations Matter website provides advice on responding to persons following bereavement by suicide and includes resources for teachers and parents on how to have conversations with children and young people. The resources are the first of their kind internationally and have been developed with the support of academics, service providers, people with lived experience of suicide and community members in New South Wales and across Australia (www.conversationsmatter.com.au).</p> <p>Capacity building for NSW Health staff</p> <p>Under Policy Directive PD2010_073 <i>NSW Youth Health Policy</i>, the <i>Essential Youth Healthcare Skills training workshop</i> was launched in 2016 to build capacity among NSW Health staff to engage with young people and to assess and respond to psychosocial risk and protective factors, including suicidality among young people. A standardised youth health and wellbeing assessment tool and guideline to enable early identification of concerns are in development for hospital and</p>
--	---

	<p>community settings.</p> <p>Supporting young people’s access to timely and appropriate primary care</p> <p>Training resources for General Practitioners have been developed to assist them to engage with and provide effective healthcare for young people aged 12-24. These resources feature psychosocial assessment which can identify suicide risk.</p> <p>Information and education is being provided to specific private health professionals who were included as prescribed bodies for the purposes of Chapter 16A of the <i>Child and Young Persons (Care and Protection Act 1998)</i> in 2016. This provision in the legislation enables health professionals to proactively share relevant information with other prescribed bodies and respond to concerns about the safety, welfare and wellbeing of children and young people, including where there is identified suicide risk.</p> <p>Funding (\$50,000) has been provided to support a research project through the University of Technology Sydney on <i>The Primary Care Response to Adolescent Self Harm</i>. The project will provide information on General Practitioner experiences of identifying and responding to self-harm in young people. This research will inform how GP healthcare for young people who self-harm can be improved. The final report of this project is due in June 2017.</p> <p>NSW Mental Health Commission resources</p> <p>To support improved quality in the use of medication as one component in multimodal treatment for mental health problems and more informed conversations between prescribers and consumers and their carers/families, the Mental Health Commission of NSW has produced a resource <i>Medication and Mental Illness: perspectives</i>. The document is available at: nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Medication%20and%20mental%20illness%20perspectives%20-</p>
--	---

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>%2012%20Feb%202016.pdf.</p> <p>Improved engagement with medication</p> <p>The Medications postcard project was rolled out in February 2017. The postcard is a discussion guide designed to empower people taking mental health medication to discuss the various implications with their health care professionals. Distribution of postcards is through every pharmacy and Neighbourhood Centre across NSW with promotion in the Pharmacy Guild Bulletin.</p> <p>“Right from the Start” Resources</p> <p>NSW Health in collaboration with the Keeping the Body in Mind (KBIM) team at Bondi Community Health Centre, produced a wallet size card and pamphlet for young people experiencing psychosis for the first time. These resources foster conversations between young consumers and their health care providers, supporting them to work together to improve the young person’s physical health. Six thousand printed copies of the ‘Right from the Start, Keeping Your Body in Mind’ resources were distributed in early 2017 to all LHDs/SNs and NGOs such as BEING.</p>
<p>Recs 2 and 3 Ombudsman has sought NSW Health views on Rec 2 and 3 in their letter to Secretary,</p>	<p>Sudden Unexpected Death in Infancy (SUDI) The NSW Government (Recommendations 2 and 3)</p> <p>In the context of previous CDRT recommendations and the work of Garstang et al, the NSW Government should :</p> <p>2. 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</p>	<p>In response to these recommendations, NSW Health supports the development of a joint agency policy and procedure for governing the individual and coordinated roles and responsibilities of NSW Health, the NSW Police Force and the NSW Coroner in SUDI investigation.</p>

<p>NSW Health Reference ADM/2017/155</p>	<p>consistently to SUDI.</p> <p>3. 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:</p> <ul style="list-style-type: none"> a. 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). b. Specialised training and development of resources for police in SUDI investigation. c. Identified specialists to take the SUDI medical history, and review of the SUDI medical history form and the immediate post mortem findings to enable further specific history taking where necessary. d. Application and monitoring of standardised protocols for SUDI pathology, with specific requirements for standard screens in sudden unexpected infant death. e. The conduct of SUDI post mortems by specialist paediatric pathologists. Minimally, where post mortems are not conducted by paediatric pathologists, there should be consultation with paediatric specialists. g. 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 	
---	---	--

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

	<p>surviving children and parents, and prevention strategies for the family in the context of identified risks.</p> <p>h. The introduction of clear procedures to ensure families are provided with:</p> <ul style="list-style-type: none"> i. appropriate advice and referral, particularly where genetic causes are indicated or suspected, and ii. ongoing contact, including for provision of grief counselling. 	
--	--	--

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014 **TAB A**

Ref	Recommendations from previous Annual Reports 2013 and 2014	Requested information for reporting progress to NSW Parliament
Page 107	<p>Recommendation 1 (CDRT Annual Report 2013)</p> <p>As auspice agency of the cross-sectoral working party that has been established to identify strategies for improving school-based support to children with asthma and their families, NSW Health should provide detailed advice to the Team on the outcomes of the working party, including any action taken to develop a standard asthma action plan for use in schools.</p>	<p>The formal consultation period with key stakeholders has been completed and the <i>Schools and Child Services Action Plan for Asthma Flare Up</i> is finalised ready for dissemination. Consultation regarding the strategic implementation of the document, planned for Term 2, is currently underway with support from NSW Health, NSW Department of Education and Care services, and Local Primary Health Networks.</p> <p>The <i>Schools and Child Services Action Plan for Asthma Flare Up</i> and <i>The Asthma First Aid Management in Schools</i> iBook will be launched collectively, involving key stakeholders such as Asthma Australia, NSW Health, Sydney Children's Hospitals Network, and the Education and Care Sectors. The formal launch by the NSW Health and Education Ministers is currently being scheduled.</p> <p>Revision of the <i>Asthma and Your Child - A Resource Pack for Parents and Carers</i> content has been completed and is being graphically designed. This educational resource includes highlighted points of reminders to encourage parents/carers to work towards achieving good asthma control for their child and regular general practitioner (GP) follow up. In addition, a discharge checklist prompting provision of an asthma action plan, asthma education, and details for medical follow-up have been included. The pack will be translated into the following languages: Bengali, Mandarin, Vietnamese, Arabic, Nepalese, and Korean.</p> <p>The <i>Parent Asthma iBook</i> development is under development using the revised content from the <i>Asthma and Your Child - A Resource Pack for Parents and Carers</i>.</p> <p>Following completion of a research study evaluating the effectiveness of the <i>Asthma First Aid Management in Schools iBook</i>, the self-directed training resource for school staff, Sydney Children's Hospitals Network is coordinating publishing the resource through the Apple iTunes store.</p>

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>Culturally linguistic videos of the asthma first aid plan and steps for using a spacer device in the following languages; Bengali, Mandarin, Vietnamese, Arabic, Nepalese and Korean have been completed and final edit is underway. The NSW Multicultural Health Unit will translate these videos with language voice overs and English subtitles in June 2017.</p>
<p>Page 109</p>	<p>Recommendation 2 (CDRT Annual Report 2013)</p> <p>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:</p> <ul style="list-style-type: none"> 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. 	<p>The <i>Aiming for Asthma Improvement in Children Program (AAIC)</i> 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 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.</p>
<p>Page 109</p>	<p>Recommendation 4 (CDRT Annual Report 2014)</p> <p>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.</p>	<p>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.</p> <p>Discussions are planned between FACS and NSW Health to:</p> <ul style="list-style-type: none"> (i) review the <i>Safe sleeping Supporting parents to make safer choices when placing their baby to sleep</i> resource produced by FACS (2014) and

NSW Response to NSW Ombudsman – Child Death Review Report 2015, Child Deaths from Vaccine Preventable Infectious Disease, NSW 2005-2014, CDRT Annual Reports 2013 and 2014
TAB A

		<p>ensure the consistency of messages;</p> <ul style="list-style-type: none"> (ii) to consider strategies to target safe sleeping messages to parents/ families who have been identified as at risk; and (iii) review information currently available for high risk populations
--	--	---

Professor John McMillan AO
Acting Ombudsman
Convenor Child Death Review Team
Level 24 580 George Street
SYDNEY NSW 2000

Dear Professor McMillan,

Thank you for your letter of 23 April 2017 about the Department of Family and Community Services (FACS) response to the Child Death Review Team (CDRT) report in 2015.

We remain committed to preventing and reducing child deaths and to seek out best practice approaches to addressing the underlying factors which place children at risk of harm.

Please find attached our response to the recommendations which are the focus of reporting in 2017 and which address improving FACS response to SUDI and children at risk of house fires.

If your officers have any further questions, they are invited to contact Donna Mapledoram, Director, Serious Case Review on 9716 2942 or by email at donna.mapledoram@facs.nsw.gov.au.

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
T (02) 9377 6000 | **TTY** (02) 8270 2167

House Fires

Recommendation 9 CDRT Annual Report 2014

Against the background of the high proportion of children with a child protection history who were among those who have died in house fires in the last 10 years; the high proportion of these fires having been started by children playing with matches/lighters; and the previous recommendations of the NSW coroner, FACS and Fire and Rescue NSW should provide advice to the Team on actions taken, or planned, to reduce fire risks to children with a child protection history.

Requested information from CDRT for reporting progress to NSW Parliament

In 2016, FACS advised that it had one meeting with Fire and Rescue in 2014 and were planning to meet again to progress actions to address the recommendations.

In addition FACS advised that it is developing a practice resource on neglect to support child protection practitioners achieve a more holistic and comprehensive response to cumulative risk of harm. FACS advised that the resource is due for completion in 2017 and that it will include a focus on the key safety issues that have been identified in FACS serious case reviews including fire safety.

In this context, the CDRT would appreciate advice in relation to:

- The outcome of the meetings with Fire and Rescue including details about the current status of and any outcomes achieved by strategies to address recommendation 9.
- A progress update in relation to the neglect resource including whether it will specifically identify fire safety risks for consideration by caseworkers when conducting safety and risk assessments in the homes of children and their families.

FACS July 2017 response

FACS and NSW Fire and Rescue have met three times between August 2016 and February 2017. The focus of meetings has been on identifying the broad preventative resources and activities provided by NSW Fire and Rescue and identifying those households with children known to FACS who may benefit from intervention fire awareness and/or a home fire and safety check from a local fire and rescue team. In June 2017, NSW Fire and Rescue provided FACS with a copy of its child protection policy for review before further meetings are held in August 2017 to discuss the detail of the different referral pathways between FACS and NSW Fire and Rescue.

An update on the progress of FACS neglect practice resource has been published in the *Report of Reviewable Deaths in 2014-2015*. The resource is due for release later in 2017. NSW Fire and Rescue has provided FACS with a number of resources that will be referenced in the neglect practice resource to assist practitioners to identify fire safety risks in the context of holistic safety and risk assessment.

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

As noted in our Child Death Review Report 2015 (p110), since making this recommendation, a number of larger studies have evaluated the safe sleep pod programs in New Zealand and Queensland. We would appreciate advice about the outcomes of work with NSW Health, particularly in relation to SUDI, and any further consideration of safe sleep pod programs for high risk populations.

FACS July 2017 response

FACS Serious Case Review unit has had preliminary discussions with NSW Health Maternity Services and Child and Family Health in May 2017 to discuss the findings of the safe sleep pod programs in Queensland and New Zealand. While there is still no scientific advice on the safety of the pepi-pods, there is a commitment to meet again with NSW Health and to include other FACS business units later in 2017 to jointly identify communities that may benefit from more in-depth support and educational messages about safe sleeping highlighted in the published findings. There is also a commitment to continue to evaluate the longer term outcomes of the trials associated with the devices for reducing sudden unexpected deaths in infancy.



Office of Local Government

5 O'Keefe Avenue NOWRA NSW 2541
Locked Bag 3015 NOWRA NSW 2541

Our Reference:
Your Reference:
Contact:
Phone:

Professor John McMillan
Acting NSW Ombudsman
Convenor, NSW Child Death Review Team
Level 24, 580 George Street
SYDNEY NSW 2000

Dear Professor McMillan

Thank you for your letter of 13 April 2017 seeking information from the Office of Local Government (the Office) about progress against previous recommendations to be included in the Child Death Review Team (CDRT) 2017 Annual Report.

The NSW Government's position is 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. This position is underpinned by evidence from the Royal Life Saving Society's report, 'Drowning Deaths of Children Under Five in Private Swimming Pools in NSW: A 13 Year Review', which states that for the 13-year period to 30 June 2015, supervision was completely absent in 59% of cases.

The Government is seeking to strike a balance between regulation and changing pool owner behaviour. It is worth noting that the benefits of regulatory reforms legislated in 2012, and fully implemented in April 2016, are still being realised and are occurring in tandem with increased public awareness campaigns such as the recent 'Get Water Safe not Sorry' and 'World's Most Costly' campaigns.

In relation to the recommendations specifically referred to the Office for advice, please refer to Appendix 1.

I trust this information will be of assistance.

Yours sincerely

Melissa Gibbs, 4/7/17

Melissa Gibbs
Acting Chief Executive
Office of Local Government

T 02 4428 4100 F 02 4428 4199 TTY 02 4428 4209
E olg@olg.nsw.gov.au W www.olg.nsw.gov.au ABN 44 913 630 046



Appendix 1: OLG response to CDRT Recommendations

Recommendation	OLG response on behalf of NSW Government
<p><u>Recommendation 8 – not supported.</u> In relation to prioritising swimming pool inspections, the Office of Local Government should:</p> <ol style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> • The Government seeks to strike a balance between individual responsibility and State and local government responsibility to increase child safety around private swimming pools. • Making it compulsory to supply sensitive information may have a detrimental effect on the willingness of pool owners to register their pools. • The Swimming Pool Register is, as the name suggests, a register of swimming pools rather than pool owners. There is a risk that even if information regarding children was captured, it could quickly become out of date. • Councils already have access to demographic information that will assist them in assessing this risk factor and prioritising inspections in their community. • It is up to each council to determine, in consultation with its community, its resource priorities, including in relation to swimming pool compliance activities beyond their mandatory requirements.
<p><u>Recommendation 9 – not applicable</u> The Office of Local Government should consider an application to Standards Australia to vary the standard AS1926.1-2012 to include requirements for tolerance and movement of self-closing gate latch mechanisms.</p>	<ul style="list-style-type: none"> • The Office does not maintain expert knowledge regarding technical standards. • Australian Standard AS1926.1-2012 is currently undergoing a review by the relevant Technical Committee of Standards Australia, with an expected completion date of 27 April 2018. The Office understands that this issue has been raised as part of the review, and it is therefore appropriate to be guided by independent experts on this matter.
<p><u>Recommendation 10 – supported in principle</u> The Office of Local Government should publish annual data from its analysis of the swimming pool register, including but not limited to:</p> <ol style="list-style-type: none"> a. the number of pools registered b. the number of pools that have been 	<ul style="list-style-type: none"> • The Office's 2015-16 Annual Report included information on the number of swimming pools registered in NSW as well as the number of certificates of compliance issued as at 30 June 2016. • The Office is continuing to examine options for enhancing the Swimming Pool Register where possible to allow for reporting on a wider range of statistics.

<p>inspected</p> <ol style="list-style-type: none"> c. the proportion of inspected swimming pools that were 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. 	<ul style="list-style-type: none"> • Individual 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.
<p><u>Recommendation 11 – not supported</u></p> <p>In the context of proposals contained in the <i>independent review of swimming pool barrier requirements for backyard swimming pools in NSW</i> (discussion paper), the NSW Government should amend the <i>Swimming Pools Act 1992</i> to:</p> <ol style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> • On 24 November 2016, the NSW Government released its response to the <i>Independent Review of Swimming Pool Regulation</i>, supporting 46 of the 62 recommendations made. The Government Response can be viewed on the Office of Local Government's website at: www.olg.nsw.gov.au/content/swimming-pool-barrier-review-2015 • Careful analysis of this suite of recommendations revealed that increased public education will be most effective in improving child safety in and around private swimming pools, including portable pools. • The independent cost benefit analysis of the Review's recommendations clearly 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. Retrospectively applying the latest standard for pool barriers is therefore not an effective or proportionate means of improving child safety. • The NSW Government recognises that the number of pools with automatic exemptions will decrease over time as pools deteriorate and are removed, or undergo major renovations, triggering an upgrade to the latest standard. • Portable pools that are captured under the <i>Swimming Pools Act 1992</i> are already subject to the same requirements for a compliant pool barrier and registration on the NSW Swimming Pool Register. The obligation to register a pool and install and maintain a compliant barrier rests with the pool owner.

	<ul style="list-style-type: none">• The Government's focus at this time is on increased pool safety education campaigns centred on the importance of responsible adult supervision.• The Government is committed to developing easy-to-understand user guidance for swimming pool owners that will assist them in meeting their obligation to make their pool compliant, and to provide guidance material for private and council certifiers on their legislative and regulatory responsibilities.
--	---



File Ref. No: NFB/09168
TRIM Ref. No: D17/30574

17 May 2017

Professor John McMillan
Convenor, NSW Child Death Review Team
Acting NSW Ombudsman
Level 24
580 George Street
SYDNEY NSW 2000

Dear Professor McMillan

Thank you for your recent letter regarding the NSW Child Death Team Annual Report 2017. Fire & Rescue NSW (FRNSW) acknowledges the 2015 report into the review of Child fatalities, particularly its reference to child fatalities from fire.

I can confirm that FRNSW and Family and Community Services (FACS) met in August 2016 with the aim to establish a working group between the two agencies.

Since that time, Superintendent Michael Ollerenshaw and members of the FRNSW Community Engagement Team met with FACS Serious Case Review Team and have committed to meeting regularly to share information and review serious fire incident cases.

FRNSW has committed to provide Fire Safety information for FACS to distribute amongst their client base, and additionally FRNSW will conduct Home Fire Safety visits at the request of FACS to residences identified as having a potential risk of a residential fire.

Yours sincerely

A handwritten signature in black ink, appearing to read "P Baxter".

Paul Baxter
Commissioner





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

Child Death Review Team
Ombudsman Office NSW
Att: Professor John McMillan
Level 24, 580 George Street
SYDNEY NSW 2000

11 May 2017

Dear Professor McMillan,

Thank you for the opportunity to comment on recommendations 4 and 5 in the *NSW Child Death Review Report 2015*.

Both recommendations are supported.

In relation to *Recommendation 4*, I would also support a paediatrically-trained pathologist performing or being consulted in all SUDI cases, a multi-agency case discussion taking place within days of the death and a multi-agency case review once all investigations are complete.

Kind regards

Michael Barnes
NSW State Coroner

Acting NSW Ombudsman
Child Death Review Team
Level 24, 580 George St,
Sydney, NSW 2000

Dear Professor McMillan,

I refer to your letter reference number ADM/2015/2015 dated the 23rd of April 2017 whereby you request Red Nose to advise you on one recommendation outlined in the Child Death Review Report 2015, recommendation 6. Red Nose fully supports the recommendations set out within the report;

- a) The inclusion of advice and preventative strategies to parents and carers in relation to unintentional bed sharing as part of the NSW Health education and advice programs, and the Red Nose 'Sleep Safe My Baby' public health program.
- b) 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.

Red Nose has a good relationship with NSW Health which I am pleased to report is developing further due to a number of current opportunities outlined below. Red Nose currently holds a contract to deliver state wide bereavement support services and outlined in this contract is a commitment by both parties to represent on any forum that relates to Red Nose core business, saving little lives or grief and loss.

In addition to the above Red Nose through the General Manager of National Services has been holding quarterly meetings with representatives from NSW Health and across this year discussions have taken place that have resulted in two current proposals to meet recommendations set out in the Child Death Review Report.

Firstly Red Nose was encouraged to submit a proposal/application for funding to develop a national based literature review and NHMRC guideline for safe infant sleeping that will guide both clinical care and parental behaviour. This was submitted in May 2017 and Red Nose is currently awaiting feedback on this.

Secondly, Red Nose is shortly to submit a comprehensive proposal to develop a systemic range of programs and resources to meet not only recommendation 6 outlined above but two further recommendations outlined in the Child Death Review 2015, recommendation 4 (p. 109) and 8 (p. 116). Red Nose has proposed seven areas that they and NSW Health could potentially partner on, these are as follows;

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

Suite 17/75 Lorimer Street, Docklands VIC 3008
T 1300 998 698
E info@rednose.com.au
W rednose.com.au

ABN 81462345159

1. The continuation of the free distribution of Red Nose resources to public health services in NSW. In 2016/17 Red Nose delivered over 200,000 free brochures to NSW Health Services.
2. To ensure CALD communities are not disadvantaged Red Nose has proposed to work in partnership with NSW Health to translate its current free resource suite to identified languages.
3. Current safe sleeping information is provided predominately to parent's post-partum. Red Nose has proposed a series of projects aimed at providing parents information whilst pregnant and more likely to engage and digest new information. These are;
 - a. A free Red Nose booklet provided to expectant parents at an appropriate juncture of their pregnancy covering four keys areas which will support them to reduce modifiable risks;
 - i. Safe practice – Safe sleeping/tummy time/wrapping etc.
 - ii. Safe environment – Bedding, nursery set up, temperature control etc.
 - iii. Safe lifestyle – Smoking/drug use/diet etc.
 - iv. Safe products – Purchasing safe products
 - b. A free online portal where parents and family members visit to engage in digital content (more in-depth than a booklet) that has an educational curriculum design framework where they can immerse themselves in the four topics outlined above to further understand modifiable risks.
4. The development of capacity building education, either face to face or online, for NSW health professionals to further enhance consistent messaging and approaches. This can be backed by NHMRC guidelines and be supported by free parent resources outlined above.
5. Red Nose has been running a very successful Aboriginal safe sleeping program in WA for over 10 years called 'Reducing the Risks of SUDI in Aboriginal Communities' (RROSAC). In 2017/18 Red Nose will introduce the Pepi-Pod to complement its targeted education program. Red Nose has proposed that this program be replicated in NSW and support recommendation 4 in the Child Death Review Report, 2015.
6. The final area was in support of recommendation 8 in the Child Death Review Report, 2015. Red Nose has proposed to work in partnership with NSW Health to deliver either face to face or online training aimed at child protection staff to build capacity in supporting them to in turn support high risk parents to implement strategies to reduce modifiable risks.

So as you can see Red Nose not only supports recommendation 6 made in the Child Death Review Report, 2015, it is well positioned to develop and deliver strategies in partnership with NSW Health across 2 other recommendations.

Red Nose has a scheduled meeting with representatives of NSW Health in late July where it is hoped that these ideas will be further developed with a view to identifying the appetite to partner on these projects.

If you would like any additional information or clarity on the above please do not hesitate in contacting me to clarify.

Kind regards,

A handwritten signature in black ink, appearing to read 'Theron Vassiliou', with a long horizontal flourish extending to the right.

Theron Vassiliou
Chief Executive Officer
Red Nose

CC April Deering
Dr Nigel Lyons



Justice

Office of the Secretary
Justice Precinct Offices
Locked Bag 5111
PARRAMATTA NSW 2124
Tel 02 8688 7777 | Fax 02 8688 7980
www.lawlink.nsw.gov.au

Professor John McMillan
Acting NSW Ombudsman
Level 24
580 George Street
SYDNEY NSW 2000
nswombo@ombo.nsw.gov.au



Dear Professor McMillan

Recommendation 7 - Child Death Review Report 2015

Thank you for your letter received 21 April 2017 seeking advice about whether the Attorney General supports Recommendation 7 of the NSW Child Death Review Team report *Child death review report 2015*.

The NSW Government is committed to working with the Commonwealth, other jurisdictions and the agricultural industry to reduce the levels of quad bike deaths in our communities, including those of children.

What the NSW Government is doing

The NSW Government is providing incentives to encourage farmers to improve the safety of their quad bikes and education programs to support safer usage. In June 2016, the NSW Government implemented the \$2 million NSW Quad Bike Safety Improvement Program, which formed part of the NSW Government's response to the Coronial recommendations. The program incorporates recommendations of the NSW and Queensland Coronial Inquiries into quad bike deaths, as well as the findings of independent research.

The program consists of Australia's broadest range of harm prevention strategies. These strategies address issues around vehicle design, retrofitting of safety devices such as an operator protective device, training, helmets, safe use and education. As a key component of the program, farmers can access rebates of up to \$1,000 for the purchase of a side-by-side vehicle, \$500 for the retrofitting of safety equipment (operator protective devices) to an existing quad bike, and \$90 for the purchase of an approved helmet.

Over the last two months the NSW Government has moved to further strengthen the program, including by announcing free training and launching a regional campaign to deliver strong, confronting safety messages related to farmers, farm workers and child safety. The NSW Government is also calling for the Commonwealth Government to introduce a national five-star safety rating system for quad bikes. A rating system would build on the NSW Government's Quad Bike Safety Improvement Program.

The NSW Government has also established the NSW Quad Bike Safety Industry Action Group, which is a collaborative forum that develops and implements communication and engagement activities for quad bike safety. Members include the Royal Flying Doctor Service, the Westpac Rescue Helicopter Service, the NSW Farmers Association, the Country Woman's Association of NSW, the NSW Department of Primary Industries, Local Land Services and the Australian Quad Bike Distributors' Association. The group is chaired by SafeWork NSW.

Your recommendation

The Minister for Roads, Maritime and Freight has portfolio responsibility for regulating quad bike and side-by-side use on roads. Regulating the operation of quad bikes and side-by-side vehicles in a workplace falls within the responsibility of agencies established to ensure work health and safety, such as SafeWork NSW and SafeWork Australia.

As noted in Recommendation 7 of the *Child death review report 2015*, Deputy State Coroner Sharon Freund released findings from the Inquest into the deaths of nine people who died as a result of quad bike accidents in 2015. These findings included a recommendation that consideration be given by the Attorney General and NSW Law Reform Commission to the introduction of legislation prohibiting any child under 16 years from using an adult sized quad bike, side-by-side or related vehicle (recommendation 7(b)).

The former Attorney General referred this recommendation to the former Minister for Roads, Maritime and Freight. The response, which included input from the former Minister for Innovation and Better Regulation, did not support legislative amendment to ban the use of quad bikes by children. This remains the case. This response was the NSW Government response to the Coronial recommendations and may be found on the NSW Department of Justice website at:

<http://www.justice.nsw.gov.au/lrb/Pages/coronial-recommendations.aspx>

Yours sincerely



Andrew Cappie-Wood
Secretary

7 SEP 2017

NSW Child Death Review Team

NSW Ombudsman
Level 24, 580 George Street
Sydney NSW 2000

General enquiries: (02) 9286 1000
Toll free (outside Sydney Metro Area, NSW only): 1800 451 524
Facsimile: (02) 9283 2911

Email: nswombo@ombo.nsw.gov.au

www.ombo.nsw.gov.au