Media release

Ombudsman New South Wales

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More work needed to reduce child deaths in NSW

A new report shows where progress has been made by NSW Government and non-government agencies over the last 12 months in implementing measures aimed to prevent child deaths.

The *NSW Child Death Review Team Annual Report 2019–20* was today tabled in Parliament.

Acting NSW Ombudsman and Convenor of the NSW Child Death Review Team (CDRT), Mr Paul Miller, said:

> "The report identifies the CDRT's recommendations to prevent or reduce the likelihood of child deaths, whether they have been accepted by agencies, and the progress that has been made to implement them".

As at 30 June 2020, the CDRT was monitoring a total of 19 recommendations in relation to Sudden Unexpected Death in Infancy (SUDI), private swimming pools, road safety, and suicide prevention.

The report acknowledges positive progress in a number of areas. However, it also notes that in some cases work to implement recommendations is yet to commence.

In particular, the report notes:

- **More action is needed by NSW Health to ensure comprehensive medical histories are taken by hospital staff following a sudden and unexpected infant death, and that this information is provided quickly to forensic staff to assist them identify a cause of death – and ultimately, to help prevent future deaths.**
- **NSW Health needs to do more to promote safe infant sleep practices to families at greater risk of experiencing SUDI – those known to child protection services, living in remote areas, and/or living in the most disadvantaged areas of the state.**
- **Local councils still do not provide comprehensive public information about the reasons pool barriers fail inspections and whether non-compliances are rectified by pool owners within reasonable timeframes, more than three years after the CDRT recommended open and regular reporting of the regulatory regime.**
- **Transport for NSW needs to do more to ensure young drivers looking to purchase a used vehicle are able to access information to assist them buy the safest vehicle they can afford.**

Previous work of the CDRT has also shown that, unlike other causes and circumstances of death, the suicide rate for young people age 10-17 years has increased over the past decade. School-aged young people have particular vulnerabilities and needs.

CDRT reviews of suicide deaths identified that the majority of school-aged young people who died by suicide were known to mental health or related support services. It noted that NSW generally has good systems for identifying young people who are at risk of suicide or who are dealing with mental health problems, but intervention once a problem is identified can be episodic and fragmented.

The CDRT reported that the identification of suicide risk must be supported by effective strategies to manage and contain risk in order to prevent suicide. It has also observed

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that, in NSW, demand for access to developmentally appropriate specialist mental health services for children and young people regularly outstrips the capacity to supply timely services.

The CDRT has recommended that the NSW Government include in any suicide prevention plan specific measures targeted to school-aged children and young people across the spectrum of need.

The CDRT also recommended that the NSW Government direct more funds to address gaps in the delivery of appropriate specialist mental health services for children and young people in NSW.

The NSW Government supported both recommendations, and advises that it is considering how best to act on them in the context of the Framework and *Towards Zero Suicides* Premier's Priority (announced in June 2019).

The CDRT will continue to closely monitor all of these recommendations over the coming year.