

Questions for the Commissioner on the 2007 Annual Report of the Child Death Review Team and on Trends in Child Deaths in NSW 1996-2005

Nationally comparable data

1. Did the Australian and New Zealand Child Death Review Teams [ANZCDRT] meet during 2008? If so, what progress has been made on developing a national classification framework for system failures in child deaths and a data dictionary to guide the collection and reporting child deaths? [AR p 2] If not, why did ANZCDRT not meet?

Response: The Australian and New Zealand Child Death Review Teams met in December 2008. At that meeting the New Zealand representative advised they will report on progress on the national classification framework for system failures in child deaths at the next annual meeting. The ANZCDRT has been unsuccessful in securing funding for the data dictionary and consequently this has delayed its development.

Matters arising out of the Committee's review of the CDRT Report on Suicide and risk-taking

2. In November 2004, the Committee examined you on the CDRT Report on *Suicide and risk-taking deaths of children and young people*. At that time it was mentioned that the Government would be reviewing the NSW Suicide Prevention Strategy to reflect the findings of that study.

Did this review take place, and, if so, what changes have occurred to the strategy over the intervening period? Have related strategies, such as drug education and road safety been linked to the revised Strategy?

Response: NSW Health undertook a review of the NSW Suicide Prevention Strategy between 2004 and 2007. NSW Health reported in the *Second Yearly Progress Report on the Interagency Action Plan for Better Mental Health* that this review concluded that the Strategy's strategic directions remain current and appropriate.

One of the priorities for focused action is children and young people and some of the initiatives being developed directly address the findings from the *Suicide and Risk-Taking Deaths of Children and Young People* report including increasing clinical staff capacity to recognise and manage children who are at risk of suicide and developing a youth mental health service model aimed at providing services that are child friendly. Strategies related to drug education and road safety have not been linked to the NSW Suicide Prevention Strategy.

3. It was also noted at that hearing that school-based programs such as School-Link and MindMatters, and programs addressing suicide prevention initiatives for ATSI communities were being evaluated. What was the outcome of these evaluations?

Response: One of the commitments of the *Interagency Action Plan for Better Mental Health* is to “Expand the School-Link initiative to increase the knowledge of teaching staff and health workers about how to respond to the mental health of students”.

The Department of Education and Training have advised that School-Link has several phases and each phase is evaluated as it's implemented. In its *Second Yearly Progress Report on the Interagency Action Plan for Better Mental Health NSW Health* (2008), they report a positive outcome for the last phase (phase 4) which focused on training around co-existing mental disorder and problematic substance use in adolescents.

Another commitment of the *Interagency Action Plan for Better Mental Health* is to “Implement evidence based whole of school approaches in all schools which aim to prevent mental health problems developing, and support students with mental health problems”.

The continuation of MindMatters is part of this commitment. The evaluation of MindMatters is managed by the MindMatters Evaluation Committee and results are available in a series of reports http://www.mindmatters.edu.au/about/evaluation/evaluation_-_landing.html.

The evaluation shows that 87 per cent of secondary schools had taken part in the professional development activities, that students felt more confident about their ability to deal with mental health issues and were more comfortable talking about them and that teachers were more confidence to support and understand the needs of students, and to identify those who may need additional support.

The Commission is unaware of any evaluations that have been conducted on programs addressing suicide prevention in ATSI communities.

4. Has there been a formal evaluation of the guidelines for media professionals in relation to enhancing local community capacity to prevent and respond to increases in suicide?

Response: The guidelines for Australian media professional have been reviewed twice since 1999 to reflect new statistics and research. The most recent version was published in 2007. The effectiveness of the guidelines has not been formally evaluated.

5. In terms of the impact of family dysfunction, it was noted in the Commission's written response to questions on notice for the 2004 meeting that the Department of Community Services was undertaking a major reform program for improving identification of and responses to children that were at high risk of potential suicide due to family dysfunction. Has this reform program concluded, and what changes have occurred to the service system? [Committee's Report, pp 15-16]

Response: I am advised by the Department of Community Services that last year they completed a review of their work with 14 young people who died by suicide and 13 young people who died in the context of risk taking during the period 2004 to

2006. This review made a number of recommendations that aim to support and promote more effective and targeted work with vulnerable young people, and improve staff understanding of factors contributing to suicide and risk-taking behaviours of young people.

The Department advise that the recommendations are in the process of being implemented.

Sudden Unexpected Death in Infancy (SUDI)

6. The CDRT Annual Report 2007 notes that the Standardised Autopsy Protocol for Sudden Unexpected Death of an Infant (NSW) or the Australasian SIDS protocol was noted in 41 of the 58 autopsies that were available at the time of reporting [p xiv]. What do you consider has been the results of the use of these protocols?

Response: In 2006, a trial *Standardised Autopsy Protocol for Sudden Unexpected Death of an Infant (NSW)* was implemented for use. In the 2007 Annual Report the CDRT reported on the use of this protocol.

The final protocol was adopted for use in June 2008. It is too early to know the outcome of the use of the protocol but we anticipate that fewer cases will be incorrectly labelled as SIDS and homicides and perpetrators will be better identified.

7. The CDRT Annual Report 2007 notes that the number of infants that died suddenly and unexpectedly in 2007 was the highest in seven years and substantially higher than for 2006 [p xiv]. Do you consider that this was due to the broader definition of SUDI, or were there other factors contributing to this increase?

Response: In order to know if the broader definition was solely responsible for the increase in the number of deaths the Team would need to review all infant deaths in the years prior to 2007 to see how many infants died suddenly and unexpectedly that were not place for sleep. Other factors could have contributed to the increase including placing an infant for sleep on their side or stomach, a risk factor where we have noticed a proportional increase.

Swimming pool deaths

8. The Trends Report recommended that local authorities be required to inspect all swimming pools notified within their area and monitor compliance with the relevant legislation.

Has any progress been made on this recommendation?

Response: The Commission wrote to the Department of Local Government in September 2008 about the recommendation and was advised that it is being considered as part of the review of the *Swimming Pools Act 1992*. This Act has been under review since July 2005 and no date has been set for the review to be finalised.

The Commission phoned the Department of Local Government in December 2008 and again in early March 2009 to seek further information on progress of the review. The Department advised in March 2009 that the review is ongoing, with no final date set and that it is considering the CDRT's recommendation in its review.

The Commissioner has written to the Director-General of the Department of Local Government seeking a meeting about implementing this recommendation.

9. The CDRT Annual Report notes that twelve children and young people drowned in private swimming pools, the highest directly standardised mortality seen since the CDRT began reporting [p x]. Kidsafe Australia is currently running a water safety campaign which includes references to "fence the pool, shut the gate", and the Department of Local Government's website contains a brochure which sets out the swimming pool laws, particularly as they apply to home owners and tenants.

Do you consider it might be appropriate for a stronger publicity campaign - along the lines of those used in road safety campaigns - targeted at parents and carers?

Response: Research from VicHealth (1998) have identified the biggest barriers to getting people to comply with pool fencing legislation is lack of owner knowledge or confusion over requirements; pool owner attitude; and the cost of fencing. Based on this research, a strong and broad ranging publicity campaign like those used in road safety campaigns is unlikely to be the most effective way of reaching pool owners and changing these issues.

10. The *Swimming Pools Act 1992* places the responsibility for promoting awareness of the requirements under the Act in relation to swimming pools onto local authorities.

To your knowledge, is there any mechanism to monitor local authority compliance with the Act in terms of promoting awareness? Given the large number of local authorities, do you consider that a more coordinated, Statewide approach to promoting awareness by the Department of Local Government might be more effective?

Response: The Commission is not aware of any mechanism to monitor local authorities' efforts to promote awareness. We are not aware of any evidence that a state-wide coordinated approach would be any more effective than actions taken by individual local authorities.

Toddlers in residential driveways

11. According to the Trends Report, 46.4% of pedestrian deaths occurred in residential driveways, but no trend analysis was undertaken for the deaths of children that occurred in the context of inadequate supervision [pp 113-4].

Given that inadequate supervision would seem to be the major cause of these accidents, why did the CDRT decide not to undertake a trend analysis?

Response: The information in the *Trends in Child Deaths in NSW 1996-2005*, on deaths that occurred in the context of inadequate supervision was exploratory and so did not provide any analysis of trends. The Team did analyse trends in supervision deaths and reported in the *2007 Annual Report* that there was no difference in the likelihood of death related to supervision between the periods 1996-2001 and 2002-2007. The Team will continue to analyse trends in deaths that occur in the context of inadequate supervision.

Monitoring

12. The Trends report contains a number of recommendations requiring action by other agencies. What was the response of those agencies to the recommendations?

Response: In relation to swimming pools, the Department of Local Government is currently reviewing the *Swimming Pool Act 1992* and considering the recommendation as part of that review. This Act has been under review since July 2005 and no date has been set for the review to be finalised. The Commissioner has written to the Director-General of the Department of Local Government seeking a meeting about implementing this recommendation (Rec 3).

The Motor Accidents Authority Board has identified the reduction of driver deaths of under 16 year olds as a priority for its next few years and has incorporated it into the MAA's Road Safety Plan (Rec 4). Officers from the Commission and the MAA's Injury Prevention Policy Officer meet bi-monthly to discuss this and other issues.

The Commissioner has written to the Registrar, Births, Deaths and Marriages and the Attorney-General to follow up on actions the Registry is taking to monitor the identification of Aboriginal children (Rec 7).

Preliminary advice from NSW Health indicates they support the recommendation to convey in all education messages concerning children with epilepsy the importance of safe swimming (Rec 5). They also support developing a plan to improve the quality of the medical certificates of cause of death for children and young people (Rec 8).

Discussions are underway with NSW Health about developing prevention strategies that eliminate current inequities relating to meningococcal infection (Rec 1) and pneumonia (Rec 2), and developing a definition of chronic conditions (Rec 9) as alternative approaches may deliver a better outcome.

13. What arrangements does the CDRT or the Commission have in place generally to monitor the acceptance and implementation, or the reasons for non-acceptance of recommendations made by the CDRT?

Response: The Convenor writes to the CEO of relevant agencies following the tabling of an Annual Report or a Special Report, to highlight relevant recommendations and the information that underpins those recommendations. The Convenor writes again the following year, seeking comment on their progress in

implementing them. This progress and the Team's view on this is then reported in the next Annual Report.

In addition to this formal monitoring and reporting, the Commission internally monitors progress on a quarterly basis, and where appropriate, takes action to support the implementation.

The Commission actively responds to and creates opportunities for implementation. This might include strategies such as:

- building support for the recommendations through writing or meeting with government departments, Ministers, relevant community groups or professional associations to advocate, support or advise on implementation. This includes speeches, conference presentations and media comment.
- commenting on drafts of guidelines and policy directions for example, the Commission is assisting Attorney Generals Department develop the questions for trialling the P79a form as recommended in the *2007 Annual Report*.
- educating professional groups regarding the findings and recommendations of specific reports to assist in cultural and practice changes for example, the Commissioner presented on the *Sudden Unexpected Death in Infancy: the NSW Experience* to the RPA Hospital Grand Rounds
- participating in committees that are overseeing the implementation of the recommendations for example, the Commission supported the implementation of the recommendations regarding driveway reversal deaths by sitting on the MAA committee that implemented that recommendation from the *1998-1999 Annual Report*.
- promoting the recommendations and issues through general committees where the Commission is represented for example, a range of issues identified in the *Suicide & risk-taking deaths of children and young people* are promoted through the Commission's membership on the Mental Health Seniors Officers Group
- using its general advocacy work to create opportunities to include and promote the Team's findings and recommendations on other agendas for example, advocating for sustained nurse home visiting through its joint submission to Justice Wood's Special Commission of Inquiry into Child Protection.

Limitation of current analysis options

14. The Trends Report notes that there are fundamental problems for the analysis of mortality data where deaths are rare, or the numbers of deaths are small because commonly used statistical approaches are largely inadequate. As a result of this, the Commission, on behalf of the team, will lead an investigation

of currently available methods that may be more sensitive in the determination of differences between time periods or subpopulations.

Can you elaborate on this planned investigation for the Committee? Has it commenced?

Response: The Commission has tested alternative ways of analysing mortality data with promising results. This confirms there are other statistical methods that could for example, analyse the data at smaller geographical areas. These methods are not widely used in Australia although they are used internationally. The Commission is currently exploring partnerships with institutions and groups who have sufficient authority to support this approach before it is recommend to the Team for adoption.

Socio-economic background

15. The Trends Report notes that the typical pattern is that mortality rates decline as relative socioeconomic advantage increases, except for deaths by suicide and deaths related to asthma, epilepsy and cerebral palsy. ¹Is the CDRT aware of any explanation as to why there is an increase in deaths from asthma in relatively high socio-economic areas but a decrease in low and middle areas?

Response: The finding of an increase in deaths from asthma in high socio-economic areas but a decrease in low and middle areas is similar to that reported in 2007 by Shankardass and colleagues in their study looking at the increase in asthma prevalence in high socio-economic areas.

The finding of most relevance to the CDRT in understanding this finding is that children in lower socio-economic areas may have higher protective exposures to endotoxin in early life (the hygiene hypothesis) and other bacterial compounds.

16. A report by Canadian and American Researchers at the University of British Columbia has found that socially disadvantaged children suffered more severe symptoms of asthma than affluent ones and suggested that disadvantaged children felt more threatened by stresses in their lives, which had an effect on their body chemistry. ²

Has the CDRT concluded that stress is one of the contributing factors to asthma, and if so, what kind of effect does it have? Are you are of any other studies on the different causes of stress suffered by children in low, middle or high socio-economic areas?

Response: The Team has not looked at stress as a contributing factor in asthma deaths - it is difficult, if not impossible to identify this once the child is deceased. The

¹ In relatively low socioeconomic areas there was a 94% decline in the likelihood of an asthma-related death, in middle socioeconomic areas there was a 70% decline, while in relatively high socioeconomic areas there was a 12 % increase: Trends Report Trends Vol 1, xxvii & Vol 2, p 224.

² See *Sydney Morning Herald*, 11 November 2008, "Poverty and poor health in gene link".

study reported in the Sydney Morning Herald would need to be confirmed in larger studies before any real conclusions can be drawn.

There is not a lot of research about the specific causes of stress in children from different socioeconomic backgrounds. There is evidence however that the relationship between stress levels and socioeconomic background may not be a simple one. For example a Canadian study reported in 2000 found that cortisol (a stress hormone) is significantly higher in children with lower socioeconomic status compared with higher socioeconomic status and it was also significantly correlated with his or her mother's extent of depressive symptoms.

17. The Trends Report notes that there appears to be continuing - and in some cases, growing - inequities in health outcomes with reference to Aboriginal identity, socioeconomic disadvantage and geographic remoteness [Vol 1 p xxxi]. Does the CDRT have any plans to undertake more in-depth research on the manner in which these inequities contributed to the deaths of children and young people, and the implications for the provision of health and other services?

Response: The *Trends in Child Deaths in NSW 1996-2005* was analysed at a state-wide level therefore it can't demonstrate that Aboriginal identity, socioeconomic disadvantage or geographic remoteness causes inequity in death. It does show there is an association between Aboriginality and death.

In order to determine whether and how the inequities contributed to children's death would require a critical path analysis of the life of every Aboriginal child who died, and possibly the mothers for infants which was then aggregated and analysed. This is a large research project over a number of years which the Team is not at this stage planning to undertake. In the meantime there is a large body of existing knowledge on health inequities that can and does inform the development of health and other services.