QUESTIONS ON NOTICE

REVIEW OF THE 2006 ANNUAL REPORT OF THE CHILD DEATH REVIEW TEAM

Standardised Autopsy Protocol for Sudden Unexpected Death [SUDI]

1. **What is the view of the CDRT on the possible benefits of the adoption of the *Standardised Autopsy Protocol for Sudden Unexpected Death of an Infant* by the Forensic Pathology units which undertake infant post-mortems [p 27]?**

Response: The protocol supports Forensic Pathologists in their work by guiding them on how to review the clinical and family history of the child, on carefully examining the death scene and on conducting the autopsy according to established criteria.

The Team expects that the protocol will result in

- better identification of the manner and cause of death with fewer cases being incorrectly labelled as SIDS
- reduced family distress because they can have confidence that none of the significant steps in the investigation of their infants' death have been missed in the autopsy
- better identification of homicides with the result that other children or future children in the family are not in danger.
- better identification of manner and cause of death so that parents are not wrongly accused or perpetrators escape punishment.

2. **The CDRT has identified a number of risk factors with regards to SUDI (including women falling asleep while breastfeeding) [p 33]. Does the CDRT believe there is a need to increase awareness in the community of the risk factors to assist in the further prevention of such deaths?**

Response: Yes. In its 2005 special report on SUDI in NSW, the Child Death Review Team made four recommendations aimed at increasing community awareness of risk factors. These included the use of prevention strategies that were effective with

high risk groups, and that placed more emphasis on the risk of the side sleeping position for infants.

The Child Death Review Team also recommended that these efforts should be informed by an investigation by NSW Health of what the most effective methods are for disseminating the information and monitoring of the success of the chosen methods.

NSW Health advise that they have:

- targeted Government initiatives such as Families First, the Aboriginal Maternal and Infant Health Strategy, and the DoCS Early Intervention program to deliver prevention strategies effective with high-risk groups
- included messages encouraging parents to quit smoking to reduce the risk of SIDS in the Personal Health Record
- listed SIDS risk factors among topics for discussion at key health checks.

Transport

3. **Inappropriate use of restraints has also been identified as a contributing factor in a number of deaths for 2006. Does the CDRT have any views as to the cause of this increase, and any means of reducing the number of deaths [p 38]?**

Response: There were more passenger deaths involving inappropriate restraint use in 2006, but it is not possible to say whether this represents a statistically significant increase. The Child Death Review Team needs to monitor this for a longer period before such a claim can be made.

The increase might be due to the increase in both the number of passenger fatalities and multiple incidents in 2006. These incidents most commonly involved teenage males who are more likely to be risk-takers.

Another explanation is that police are better at recording restraint use in their reports.

To reduce fatalities associated with inappropriate restraint use, we need to address two distinct groups:

- male passengers and drivers aged 15-17 years, who do not wear seatbelts when riding in vehicles with friends
- younger children not wearing seatbelts in vehicles, and less commonly baby capsules incorrectly installed.

We welcome the Government's work on restraint use, like the Roads and Traffic Authority's "No Belt, No Brains" billboards aimed at young people and the "Buckle Up" messages aimed at parents.

A campaign targeted specifically at young males may be a useful way forward. It will be important to involve this target group in designing an effective campaign.

Drowning

4. **The Report notes that the *Swimming Pools Act 1992* (NSW) is inadequately monitored or enforced, thereby contributing to a number of drowning deaths [p 48]. Does the CDRT have any suggestions to assist in avoiding further deaths from drowning due to, e.g., inadequate supervision?**

Response: Children need supervision appropriate to the hazards in their environment and their developing capacities. The factors most common in swimming pool drowning of young children are:

- inadequate pool fencing
- lack of direct adult supervision, often because parents don't know their child is in the water
- curious and mobile young toddlers wandering into pools.

While not a replacement for active adult supervision, properly designed and maintained pool fencing provides an effective barrier between young children and swimming pools.

Most swimming pool drowning occurs when parents and carers do not expect children to be in or near swimming pools. This is why pool fencing is an important safety feature of pools.

Parents and carers often assume children are relatively safe, indoors or out. They underestimate the hazards in their child's environment and their exploratory and developing capacities, like wandering off to explore and their ability to open doors and climb.

The Child Death Review Team's current special study will examine trends in drowning deaths over the period 1996 to 2005 including drowning deaths of young children. The findings of this is study will assist the Team in recommending ways to prevent or reduce these deaths.

Suicide

5. **The Annual Report suggests that the fact that a number of young people who committed suicide had accessed some form of counselling prior to their deaths demonstrates the need for the effective engagement of young people in their treatment [pp 56-57]. Does the CDRT have any proposals as to how mental health providers might achieve this?**

Response: In its 2003 report on suicide and risk taking deaths the Child Death Review Team noted that mental health services need to be innovative if they are to engage young people in their treatment.

From our 2005/06 consultations with children about health and what health means to them, we know that services need to:

- be close to where they live
- be affordable
- respect their privacy
- not stigmatise them - they would prefer to get to services through everyday activities like recreation or entertainment

- be available when they need help - young people want to get help quickly long waiting period just don't work. Also because young people are often at school they need service outside normal working hours.

Kids are also looking for health care providers who can talk to them – directly, clearly and without condescension.

We also know that issues young people have don't fit neatly within government agency portfolios. They don't like having to ring lots of different numbers and go to different places to get the help they need. Our findings are consistent with the views of the Adolescent Health Association.

The work undertaken by the Inspire Foundation demonstrates that online support can be very successful. For example, Inspire's Reach Out Central website provides an interactive role-playing game in which young people face dilemmas and are guided though a decision making process that helps clarify their priorities and directs them to formal and informal sources of help.

We support the expansion of Inspire and their willingness to explore new ways to assist young people.

Geographic location and disadvantage

6. **Could you please advise the rationale behind recording deaths in NSW by statistical subdivision, as opposed to Local Government Area [LGA]? What measures are being taken to enable comparative analysis of data collected by statistical subdivision, with data previously collected and reported by LGA?**

Response: The Child Death Review Team collects and records the usual residence for all child deaths. This allows the Team to report at any level of location including Local Government Areas (LGAs).

The Team uses Statistical Divisions as the primary geographic areas, except for the Sydney Statistical Division which is reported at the Statistical Subdivision level. This

is because LGAs are typically smaller than the Statistical Divisions, and this is problematic when the number of deaths is very small. For example the calculation of mortality rates, rate ratios and trends uses actual number of deaths relative to population size. For some small LGAs these calculations cannot give an adequate degree of statistical confidence.

We can still provide information by LGA to others where their research is aimed at reducing or preventing child deaths.

7. **The review of the Nowra/Bombaderry deaths referred to the Chief Health Officer - and released to the CDRT - found that, while the area did have higher death rates compared to the overall rate in NSW, the rate for Nowra/Bombaderry was in fact comparable to other NSW Statistical Subdivisions (SSDs) [p 66]. Were their other commonalities among these SSDs, e.g., socio-economic indicators; and does the CDRT consider that the Nowra/Bombaderry situation requires any further examination, particularly if the rate remains high?**

Response: The Chief Health Officers report did not investigate commonalities in the SSD. This was outside of the scope of their investigation.

The CDRT have not made any recommendations specific to Nowra/Bombaderry. The Team will continue to monitor the geographic distribution of child deaths and will further examine deaths in the Nowra/Bombaderry area if needed.

8. **The review also noted that all risk factors for deaths were not documented, so that under-reporting was possible [p 66]. Does the CDRT consider that incomplete data collection constitutes a widespread or significant problem for the Team?**

Response: Incomplete data, particularly on factors associated with deaths such as restraint use, type of pool fencing, and smoking in the households of infants, is a problem for the completeness of data. The Team often note the extent of missing data in Child Death Review Team Annual Reports.

The national police form funded by the Commonwealth Department of Health and Ageing, should result in the collection of extra information by the police at the initial investigation of a fatality. This will benefit the Team. The resulting national data set will also provide standard information for all of Australia. The extra information that this will provide the Team covers deaths resulting from fires, transport incidents, suicide, poisoning, drowning (including information on supervision of the deceased) and sudden unexpected deaths in infancy.

Missing data is a common problem in all administrative data sets and is not unique to the Child Death Review Team. For example, NSW Health note in their *Mothers and Babies Report 2005* that "due to under-reporting [in the Midwives Data Collection] the true number of Aboriginal babies is about one and one third times higher than shown".

9. **As Convenor of the CDRT, is the Commissioner able to provide any information or comment on the findings of the Chief Health Officer in his report of the investigation of the rate of statistics on child deaths reported in the Nowra/Bomaderry area?**

Response: The report provided by the Chief Health Officer to the Child Death Review Team has helped the Team decide if further action should be taken about the death rate in the Nowra/Bomaderry area.

The Team has changed the way it reports as a result of the Chief Health Officer's report and now provides the confidence intervals around the data it reports by geographic area.

General

10. **The CDRT has identified the lack of adequate or appropriate supervision of children and young people as a contributing factor in a large proportion of deaths. In last year's responses it was noted that, although further research into supervision issues had not yet taken place, the CDRT had "undertaken some initial work on supervision issues as part of**

another project looking at ways to better coordinate strategies for preventing child injury".[1] Can you advise the Committee of the nature and scope of those strategies? Given that the issue of adequate supervision has remained an important issue in a number of deaths, does the CDRT have any current plans to undertake this research?

Response: Following a series of meetings with key stakeholders in 2007 to discuss child injury approaches, the Commission, with NSW Health and other government and non-government agencies has developed an interagency proposal to reduce the rates of accidental injury and death of children and young people.

Two of the three initial priorities concern supervision-related incidents: falling from buildings and off-road use of vehicles. The third involves young people's use of unsafe transport options.

The proposed approach will make existing activities more effective by coordinating activities between agencies. The project involves specific, agreed injury prevention outcomes, with participants proactively identifying and mitigating emerging risks. We are currently discussing the project and its possible implementation with the other agencies.

The Child Death Review Team will consider further research in the light of findings from its current study into trends in child deaths over the period 1996 to 2005.

11. **A greater number of male children and young people than female die each year. Whilst risk-taking behaviour can be seen as a contributing factor in older males, i.e., 15-17 year-olds, it does not explain why younger males die more frequently. As the CDRT has identified inadequate supervision as a contributing factor for many of the deaths, does the CDRT consider that adults tend to provide less rigorous**

[1] Children and Young People Committee Report, *Review of the 2005-2006 Annual Report of the Commission for Children and Young People*, November 2007, p 19.

supervision to boys than they might give to girls? If so, does the CDRT have any strategies to address this?

Response: Improving the quality of supervision can significantly impact on mortality rates for children who die from external causes such as in transport or drowning incidents. However the relationship between supervision and injury or death is complex. For example, some studies show that supervision may be less effective when peers are present.

When thinking about boys in particular, studies have found that boys are "expected to take greater risks, approach physical hazards more quickly and fearlessly and to consider injuries to be bad luck rather than their own behaviour more often then girls"[2] This might result in less rigorous supervision for boys.

It is also likely that some parents expect boys to behave in more risky ways, believe that such behaviour is not possible to change, and so allow and even encourage this behaviour in potentially dangerous environments. It is the differing beliefs about gender evident in every aspect of our society that more than anything else probably leads parents to supervise boys and girls differently.

We need to be careful that adults provide children with opportunities to manage risks competently and to gain experience with resisting peer pressure and distractions. It is not always easy to determine when supervision is "enough but not too much". However, better supervision is unlikely to redress this gender imbalance significantly. Humans are like almost all other mammal species in this regard: more male than female children are born, and they die at a higher rate from infancy to early adulthood.

[2] Schwebel, D. Barton, B. (2005) Contributions of Multiple Risk Factors to Child Injury. *Journal of Pediatric Psychology 30 (7)* pp. 553-561