2023 review of annual and other reports of oversighted bodies – Child Death Review Team (CDRT)

Response to Supplementary Questions

Question

1. **Your fourth strategic outcome for 2022-23 was to 'apply an equity lens' to the CDRT's core work. Can you provide a progress update on this outcome, and outline what benefits you expect it to have?**
    a. **How does the CDRT address potential biases or limitations in its data collections and analysis, ensuring that its findings accurately reflect the experiences of all children?**

Answer

The CDRT's work has consistently sought to identify and report where there may be over-representation of certain demographic characteristics or certain groups of children.

For example, our *Biennial report of the deaths of children in New South Wales: 2020 and 2021*[1] noted that despite the overall decline in mortality rates and positive evidence of improvements in some areas, certain groups of children continue to be over-represented in deaths in NSW, including:

- Aboriginal children
- those living in regional and remote areas of the state, and
- those from the most disadvantaged areas.

Children from families with a child protection history are also consistently over-represented in deaths (1 in 4 children who died from any cause were from families with a child protection history).

The CDRT's research projects have also sought to both draw out where there is over-representation in child deaths of disadvantaged or marginalised groups or particular socio-demographic characteristics, as well as to seek answers to explain this over-representation, including with a view to identifying possible avenues for future research, interventions or other responses that may help to reduce the risk of future deaths. A recent example is the research commissioned from the Australian Institute of Health and Welfare (AIHW), which resulted in the tabling of the report *Effects of perinatal conditions and local area socioeconomic status on early childhood mortality in New South Wales: linked data analysis* in 2022.

A review of our research approach following a strategic planning exercise led to the CDRT to expressly recognise the need to apply this 'equity lens' at all stages of our research process, from planning and design to the sharing of research findings.

Considering equity issues systematically in research supports efforts to target groups at greater risk and where there may be greater opportunities to prevent future deaths.

[1] Child Death Review Team report: Biennial report of the deaths of children in New South Wales: 2020 and 2021 (nsw.gov.au)

a. How does the CDRT address potential biases or limitations in its data collections and analysis, ensuring that its findings accurately reflect the experiences of all children?

The NSW Child Death Register (the dataset for which the CDRT is custodian) collects an extensive range of demographic, social and health information relevant to the circumstances of the child's death.

Under section 34K of *Community Services (Complaints, Reviews and Monitoring) Act 1993* a range of agencies – including any public service agency and medical practitioners providing health services to children – have a duty to provide the CDRT with 'full and unrestricted access' to records that are reasonably required to enable the Team to exercise its functions. This capacity to seek and review a range of records enables a holistic analysis of qualitative and quantitative information.

The potential for bias in data analysis is managed in several ways:

- The data for biennial reports is extracted by an internal data analytics unit within the Ombudsman's office, which is separate from the office's death review team which reports on that data. The data analysis methodology is also reviewed by an external agency (for the most recent biennial report, a review of significance testing methods was conducted by the Australian Bureau of Statistics (ABS)).
- Cause of death coding of child deaths is reviewed on a regular basis by the ABS.
- The Ombudsman also has an internal quality assurance process. Our recent quality assurance processes included an internal review of CDRT records collection processes. An internal audit (conducted by our external independent internal audit provider) was conducted in 2023.
- We draw on the specific expertise of team members, or appoint an expert advisor under section 34E of the Act, in areas where specialist advice is necessary for data analysis.

The AIHW report on the *Effects of perinatal conditions and local area socioeconomic status on early childhood mortality in New South Wales: linked data analysis* demonstrates the rigour and capability of the Child Death Register. That research, for the first time, linked the CDRT Child Death Register with the full set of NSW Health perinatal birth records and the NSW Birth Registration Collection. This data linkage enabled detailed analysis of the risk factors by directly comparing the characteristics of children who have died with the characteristics of all other children born in the same period.

Question

2. What role is the Ngarruwan Ngadju First Peoples Health and Wellbeing Research Centre playing in the development and implementation of suicide prevention initiatives for Aboriginal and Torres Strait Islander Youth? (Transcript, p25)

Answer

The Ngarruwan Ngadju First People Health and Wellbeing Research Centre is conducting research commissioned by the CDRT on preventing, or reducing the risk of, suicide deaths of

Aboriginal and Torres Strait Islander children and young people. Ngarruwan Ngadju First Nations researchers have:

- advised on and conducted case reviews of Aboriginal and Torres Strait Islander children and young people who died by suicide over a ten-year period
- established an Aboriginal Suicide Prevention First Nations Advisory Group to provide strategic expert advice and guidance to Ngarruwan Ngadju and the CDRT Aboriginal Suicide Prevention Project team
- designed and conducted metropolitan and regional consultation forums with Aboriginal community-controlled organisations, frontline workers and community Elders – including individuals who have lived family and kinship experience of suicide – to explore at community-level current services and support, what works well and gaps in available services that can contribute to preventing or reducing the likelihood of suicide deaths.
- literature and policy review and service mapping.

Ngarruwan Ngadju has involved CDRT expert members through a sub-committee, and presents regularly to the CDRT on progress. It is currently finalising a report on its research for the CDRT, which will include suggestions about directions for potential CDRT recommendations. The Ngarruwan Ngadju report to the CDRT is due by 30 June 2024.

After receiving this report, the CDRT will prepare and table a public report on this research project, including any recommendations proposed by the CDRT.

Question

3. How does the CDRT address the challenges of implementing recommendations that may require coordination or collaboration among multiple agencies with varying mandates?

Answer

Most CDRT recommendations are directed toward individual agencies, however some recommendations will require coordination and collaboration across multiple agencies to be implemented. In those cases, the CDRT may explicitly include in its recommendations the need for the relevant agencies to work together to implement the recommendations, and will otherwise seek a coordinated response.

For example, in 2016 the CDRT made two recommendations[2] to the NSW Government in relation to a whole of government response to SUDI (Sudden Unexpected Death in Infancy). The CDRT then engaged with NSW Health and the Department of Premier and Cabinet (DPC), with the Government agreeing to the recommendation.

In relation to the recommendations concern to ensure better cross-agency coordination of SUDI investigation, the CDRT confirmed that DPC would take the lead to establish and coordinate a cross-agency working group to focus on how that would be improved. The group regularly briefed the CDRT on progress. This cross-agency co-ordination has continued, now with both a cross-agency working group (led by NSW Health) and a multidisciplinary group of clinical experts (led by the NSW Coroner). The CDRT continues to monitor these cross-agency SUDI initiatives.

[2] Recommendations 2 and 3 in the NSW Child Death Review Team Child death review report 2015

Question

4. **How does the CDRT evaluate the effectiveness of its death review process, and what measures are taken to continuously improve the quality of its investigations and recommendations?**
    a. **What opportunities are there for stakeholders, including families affected by child deaths, to provide input and feedback on the CDRT's work and recommendations?**

Answer

The CDRT has adopted various mechanisms to evaluate the effectiveness of its review processes, including internal quality assurance measures (also referred to in Q1a) such as auditing, data cleaning, and other checks. Where appropriate, Ombudsman staff obtain expert advice (from relevant CDRT members or expert advisers) for particular reviews. The CDRT's membership includes representatives from a broad range of NSW Government agencies including Health, Police, the Department of Communities and Justice and the NSW Coroner, as well as independent experts.

We are also members of the national child death review group – the Australia and New Zealand Child Death Review and Prevention Group, which holds an annual conference (presentations from various experts, including international speakers) and annual meeting (to discuss and learn about the discipline of death review, to share information about relevant themes and issues and reflect on the effectiveness of our processes). Outside of the annual conference meeting, we often engage with NSW and interstate colleagues to discuss different issues in death review processes. Previously, the CDRT has commissioned expert advice about best practice data capture and reporting.

Measures to improve the quality of reviews and recommendations are part of our continuous improvement initiatives, which include appropriate staff supervision, facilitated reflective practice sessions, and professional development.

The *CDRT Strategic Plan 2022-2025* also identified continuous improvement initiatives, including reviews of:

- CDRT public reporting. This review evaluated various alternative formats for the CDRT's biennial reporting format in terms of their accessibility/effectiveness, efficiency/timeliness and impact on prevention. This will result in an amended format for the biennial report to be tabled in 2025.
- Recommendations made by the CDRT that have not been accepted. This review assessed the impact and outcomes of previous CDRT recommendations and identified key learnings for future recommendations. This resulted in adjustments to the processes for making and consulting with agencies about draft recommendations and updated internal guidance for staff.

    a. **What opportunities are there for stakeholders, including families affected by child deaths, to provide input and feedback on the CDRT's work and recommendations?**

The statutory functions of the CDRT do not contemplate it engaging with families of particular children who have died. Section 34L of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) prevents us from providing any information we obtain in our work to the families of children who have died. However, where families do contact us, we provide families with general information about our review functions and will refer them to the Coronial Information and Support Program. This can be done through a 'warm' referral.

If families have concerns about an agency's conduct in relation to a death they can, however, complain to the Ombudsman about the agency's conduct. Any such complaints would be responded to under the Ombudsman's complaint-handling powers under the *Ombudsman Act 1974* or Part 4 of CS CRAMA.

In relation to stakeholders more broadly, the Ombudsman conducts an annual stakeholder survey, which includes agencies that have interacted with the Ombudsman as part of its work supporting the CDRT, such as in the making and monitoring of recommendations. There are also opportunities for agency stakeholders to provide feedback and input to our work through regular engagement and information sharing, including the provision of comments to our draft reports (annual, biennial, research) prior to tabling.
Depending on the particular issue and research being undertaken, broader stakeholder and if relevant, community consultation will be included when planning research projects. The current CDRT research project concerning the suicide deaths of Aboriginal children has involved, for example, considerable stakeholder and community consultation led by Aboriginal researchers (as also noted in Q2 above).

Question

5. Are there any challenges in implementing recommendations to prevent youth suicide, and what are the next steps that the CDRT will take to address this issue? (Transcript, p27)

Answer

The CDRT has observed that NSW generally has good systems for identifying young people who are at risk of suicide or dealing with mental health issues, but that intervention, once an issue is identified, can be episodic and fragmented. Identification of suicide risk needs to be supported by effective strategies to manage and contain the risk. In addition, demand for specialist services for children and young people has outstripped timely supply of those services and, despite some progress, access to comprehensive mental health care is still an issue given the increasing demands on the system.

In 2019, the CDRT made recommendations[3] regarding suicide prevention in response to these observations. Over the past 5 years, the CDRT has identified challenges in implementing these recommendations include staffing shortages, short-term and pilot programs and initiatives (with limited duration, reach and funding), initiatives that focus on identification of risk rather than management of risk through sustained therapeutic support, programs and initiatives that do not address all age ranges from primary to high school age children, and failure to target young people who are hard to engage and/or who may have complex needs.

[3] Recommendations 10 and 11 in the Biennial report of the deaths of children in New South Wales: 2016 and 2017

The CDRT continues to monitor implementation of a 2019 recommendation relating to the inclusion of specific measures targeted to school-aged children and young people in any NSW suicide prevention plan.

As noted above, the CDRT's current research focus is on the prevention of suicide deaths of Aboriginal and Torres Strait Islander children and young people. The intent of this project is to identify opportunities for identifying both protective factors and risk factors associated with suicide deaths of Aboriginal and Torres Strait Islander children and young people in NSW.