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Ombudsman
New South Wales

17 March 2022

Our reference: ADM/2022/132

Hon Adam Searle MLC
Committee Chair
Select Committee on the Coronial Jurisdiction in New South Wales
By email: coronial.jurisdiction@parliament.nsw.gov.au

Dear Mr Searle

Inquiry into the Coronial Jurisdiction in New South Wales

Thank you for your letter of 1 March 2022 asking whether the NSW Child Death Review Team (CDRT) wishes to make a submission to the Inquiry.

I note that the Committee's terms of reference are focused on the law, practice and operation of the Coroner's Court, its jurisdiction, and related institutional arrangements, including whether it should be a stand-alone court.

The NSW Ombudsman does not oversight the conduct of the Coroner[1] or of any public authority in relation to the carrying on of coronial proceedings.[2]

You have asked whether, given the Ombudsman also has a function of convening the NSW Child Death Review Team (CDRT), we would like to make a submission in that capacity to provide the Committee with any perspective the CDRT can provide of its experience and the experiences of families and community members with the coronial system and in particular the support provided to family and loved ones through the coronial and inquest process, including forensic pathology, counselling support, distribution and explanation of relevant information.

After further considering the Inquiry's Terms of Reference and speaking with the Committee's nominated Senior Council Officer, we confirm that the CDRT will not be making a submission on this matter. As explained below, the CDRT's functions do not focus specifically on the Coroner's activities in supporting families and loved ones and we are therefore not well-positioned to provide assistance to the Committee in respect of that matter.

For your information, I have provided background about my office's role in relation to child deaths in NSW, how this intersects with the NSW Coroner, and our indirect support of families who experience Sudden Unexpected Death in Infancy (SUDI).

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1 As that conduct is excluded by clause 2, Schedule 1 *Ombudsman Act 1974*.

2 Excluded by clauses 7 and 8, Schedule 1 *Ombudsman Act 1974*.

Systemic review of child deaths in NSW

The Ombudsman has two independent statutory functions to review child deaths under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS-CRAMA):

1. The Ombudsman convenes the CDRT under Part 5A of CS-CRAMA. The CDRT registers the deaths of all children in NSW and undertakes specific research and reporting functions to prevent or reduce the likelihood of deaths of children in NSW.
2. Separately, under Part 6 of CS-CRAMA, the Ombudsman monitors and reviews the 'reviewable' deaths of children which includes in circumstances of abuse or neglect, and children in care or detention.

Both death review functions are focused on preventing and reducing the likelihood of child deaths.

Intersection between CDRT/Ombudsman, and NSW Coroner

Each year, approximately 500 children die in NSW.

The majority of these deaths are due to natural causes, and are therefore not reportable to, or considered by, the Coroner. A child's death is reportable to the Coroner only if the child died:

- a violent or unnatural death, or suddenly and the cause is unknown
- under suspicious or unusual circumstances
- in circumstances where the child's death was not the reasonably expected outcome of a health-related procedure, or while a patient of a mental health facility.

The Coroner also has jurisdiction to hold an inquest concerning the death of certain children – such as those in care or detention, those who have been the subject of the child protection report within 3 years immediately preceding their death, and those whose death is or may be due to abuse or neglect.

The NSW Ombudsman is notified of the deaths of all children aged 0-17 years in NSW by the NSW Registry of Births Deaths and Marriages. Relevant information is then sourced from government and non-government agencies and service providers, including where relevant the NSW Coroner. That information is then recorded and held in the Register, which is a comprehensive register of all child deaths in NSW (and not just those that are reportable to, or considered by, the Coroner).

We use this information to classify, analyse, and report on child deaths (under Part 5A of CS-CRAMA),[3] as well as to assist us in conducting detailed reviews of 'reviewable' child deaths (under Part 6 of CS-CRAMA).

As a result, the Ombudsman and the Coroner have overlapping jurisdiction in relation to some child deaths, but a different purpose and focus. Where relevant and appropriate, we provide the Coroner with our reviews of certain deaths, or reports arising out of our research or investigative functions. We also refer information to the Coroner about systemic issues arising out of our child death functions, for example in relation to SUDI, discussed below.

We also rely on the timely provision of information about individual deaths from the Coroner, including P79A reports (police report of a death to the NSW Coroner), briefs of evidence, post-mortem

[3] See e.g. our Biennial report on the deaths of children in NSW: 2018 and 2019.

examination and pathology reports, coronial certificates regarding cause of death, inquest decisions and reasons, and inquest findings and/or transcripts.

Our work in SUDI

Over the past decade, the CDRT has had a particular focus on preventing SUDI, including increasing the number of SUDI cases where the Coroner is able to determine a cause of death. Identifying why an infant died is important for families and communities to understand their loss, to provide information about possible medical or genetic implications for the family, and to learn from untimely deaths and help prevent future deaths.

Our work in this area has also related to the experiences of families, including specialists taking comprehensive family medical histories and our monitoring of the support offered by health professionals to families who experience SUDI.

Further information

While the Ombudsman's responsibilities in relation to child death have not generally involved any direct contact with the families and loved ones of deceased children, and therefore we are not well-positioned to comment on the particular issues raised in your letter, I hope the above information is of some assistance to the Committee to understand our role and that of the CDRT, and its intersection with the role of the Coroner.

While our reviews and other work can, as noted above, be an important input to support the work of the Coroner, so too the proper functioning of the Coroner, including through the timely provision of information and completion of coronial inquests, is an important enabler of the work of my office and the CDRT. Accordingly, we support consideration of any measures to ensure the Coroner has the resources, structure and operational arrangements required to operate most effectively.

If we can assist the Committee further, please contact Helen Wodak, Deputy Ombudsman Monitoring and Review

Yours sincerely

Paul Miller
NSW Ombudsman
Convenor, NSW Child Death Review Team