1999-2000 Report

NSW Child Death Review Team

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NSW Child Death Review Team

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Convenor's Foreword

On behalf of the Child Death Review Team, I extend my sympathies to the families and friends of the 809 children and young people who died in New South Wales over the last year. The Team acknowledges the depth of the bereavement felt by families when they lose a child.

This has been a year of great change for the Child Death Review Team, and I wish to thank my colleagues on the Team for their hard work and for the knowledge and expertise they bring to the Team's deliberations.

The Commission for Children and Young People's research staff have worked tirelessly in undertaking the work necessary to produce this Report, which for the first time includes an analysis of the trends in child deaths since 1996, and a review of the progress made in implementing the recommendations of the Team's previous Annual Reports.

The Team hopes that the information contained in this Report will assist in reducing the number of preventable child deaths in NSW and will increase the commitment from all sectors of our society to enhancing the safety, welfare and well-being of children and young people.

Gillian Calvert
Convenor, Child Death Review Team
Commissioner for Children and Young People

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1999-2000 Child Death Review Team members

Gillian Calvert (June 1999 onwards)
Convenor
Gillian Calvert is New South Wales' first Commissioner for Children and Young People.

Dr Judy Cashmore (April 1996 onwards)
Deputy Convenor
Judy Cashmore is an Honorary Research Associate of the Social Policy Research Centre, University of New South Wales. She has been the Deputy Convenor of the Child Death Review Team since 1996. She was Deputy Chair of the review of the *Children (Care and Protection) Act 1987*, and is currently co-chair of the EnAct Reference Group in relation to the implementation of the *Children and Young Persons (Care and Protection) Act 1998*.

Dr Ian Cameron (December 1999 onwards)
Ian Cameron is a general practitioner, currently Chief Executive Officer of the NSW Rural Doctors Network (RDN), based in Newcastle. RDN works with rural communities in NSW to meet their health needs through having a continuing rural medical workforce, to prioritise health needs and develop strategies to meet them in a sustainable way. Ian comes from Bourke in western NSW and spent eight years there as a general practitioner.

Dr Michael Fairley (December 1998 onwards)
Michael Fairley is a consultant psychiatrist and Head of the Department of Child and Adolescent Mental Health at Prince of Wales Hospital and Sydney Children's Hospital. His particular interests include psychiatric disorders in intellectual disability, the effect of chronic illness, emotional trauma following disasters and the provision of specialist clinical services to rural areas.

Helen Freeland (April 1996 to March 2000)
Department of Community Services representative
Helen Freeland has held senior policy and management positions in community services, juvenile justice, and health. From 1992 until 1995, she was a member of the National Child Protection Council. She is currently an Area Manager in Western Sydney. She holds a Masters Degree in Social Work from the University of Sydney.

Pam Greer (May 1999 onwards)
Pam Greer has been a community worker and consultant since 1988, working in the Northern Territory, Queensland, and New South Wales. She has worked with several government Departments including the Department of Community Services, Police, Health and the Family Court on various projects for the Aboriginal community. Pam has been involved in child protection and domestic violence issues since 1989. She is a member of the Indigenous Women's Committee through the Women's Legal Centre.

Dr Ferry Grunseit (April 1996 onwards)
Ferry Grunseit was Head of the Child Protection Unit at Camperdown Children's Hospital from 1979 until 1987. Dr Grunseit was the NSW Child Advocate until 1996. He chaired the NSW Child Protection Council's Child Death Review Committee, overseeing the research project *Preventing Child Homicide* which laid the foundations for the establishment of the NSW Child Death Review Team.

Commander John Heslop (April 1996 onwards)
Police Service representative
John Heslop is the Commander of the Child Protection Enforcement Agency within the NSW Police Service. He has been a Police officer for some 33 years with involvement in child protection policy and operational policing in child protection investigation since 1987. John is currently the President of the National Association for the Prevention of Child Abuse and Neglect (NSW) and is on the national board.

Associate Professor John Hilton (April 1996 onwards)
John Hilton is Director of the NSW Institute of Forensic Medicine and an Associate Professor in the Department of Pathology at the University of Sydney. He is a Fellow of the Royal College of Pathologists of Australasia, and a member of the Royal Australian College of Medical Administrators. He is a member of the Anaesthetic Mortality Committee NSW, the Surgical Mortality Committee NSW, the Australian Academy of Forensic Sciences, and the NSW SIDS Advisory Council.

James Hirshman (January 1997 – March 2000)
Attorney-General's Department representative
James Hirshman was the Principal Policy Officer with the Legislation and Policy Division of the Attorney General's Department where his responsibilities included aspects of Juvenile Justice. He has previously held positions in the New South Wales Law Reform Commission, the Cabinet Office, and in private legal practice.

Associate Professor Judith Irwin (December 1999 onwards)
Jude Irwin is Associate Professor in the Department of Social Work, Social Policy and Sociology at the University of Sydney. She has researched and written extensively on violence against women, children and young people. Her most recent research undertaken collaboratively with Barnardos, Australia is on domestic violence and child protection.

Melva Kennedy (December 1999 onwards)
Melva Kennedy has been a Senior Aboriginal Educator on domestic violence and child sexual assault at the Education Centre Against Violence since 1992. In 1999, she became Aboriginal Statewide Child Protection Educator. In 1999, Melva received a Winston Churchill Fellowship that enabled her to investigate and learn about child protection and prevention methods within the Indigenous (First Nations Peoples) of Canada.

Helen Kerr-Roubicek (April 1996 onwards)
Department of Education and Training representative
Helen Kerr-Roubicek is the Manager of Student Counselling and Welfare. She has a background in teaching, school counselling, and student welfare program support and policy development. She is a registered psychologist who has a strong commitment to providing effective support to the full range of students in schools, which are themselves well integrated into their communities.

Dr Elisabeth Murphy (December 1999 onwards)
NSW Health representative
Elisabeth Murphy is currently the Clinical Consultant for the Health Services Policy Branch of the Policy Division, NSW Health. Prior to this role she was the Manager of the Maternal and Child Health Unit – NSW Health Department. She is the Chairperson of the Paediatric Policy Committee – Division of Paediatrics, Royal Australasian College of Physicians.

Professor Kim Oates (April 1996 – June 2000)
Kim Oates is the Chief Executive Officer of the New Children's Hospital. He was Convenor of the Child Death Review Team from April 1996 to June 1999. He has been President of the International Society for the Prevention of Child Abuse and Neglect, Chair of the Advisory Board of the National Association for the Prevention of Child Abuse and Neglect, and is Chair of the National Council for the Prevention of Child Abuse.

Graham O'Rourke (April 1996 onwards)
Office of the State Coroner representative
Graham O'Rourke is Manager, Coronial Services NSW and Executive Officer to the State Coroner, Coroner's Court, Glebe. He was appointed as a Coroner for the State of New South Wales in 1970 and was admitted as a Solicitor of the Supreme Court of New South Wales in 1990.

Carol Peltola (April 2000 onwards)
Department of Community Services representative
Carol Peltola is the Executive Director of Child and Family Services in the NSW Department of Community Services. Carol was a member of the Queensland Coordinating Committee on Child Abuse and the NSW Child Protection Council. She is a psychologist with a particular interest in alternative views of childhood and child development.

Toni Single (April 1996 onwards)
Toni Single is the Senior Clinical Psychologist at the Child Protection Unit of the John Hunter Children's Hospital in Newcastle. Her main interest is the forensic assessment of child protection and custody matters, with a special focus on infant mental health.

NSW Commission for Children and Young People

The Child Death Review Team is supported by the Research Unit of the Commission for Children and Young People. The analysis in this report was prepared by the Commission's research officers, Dr Ruth Lawrence Karski, Toby Fattore and Melissa Sankey in consultation with the Team. Richard Thorowgood and Fiona McKerrell were also involved in the process of data collection and records management. Case file reviews were undertaken by John Heins who is an experienced social worker with expertise in child protection and family work. Aboriginal cases were reviewed, as required under the Legislation, by Aboriginal Child Death Review Team members, Pam Greer and Melva Kennedy. Dr Ferry Grunseit with the assistance of Associate Professor John Hilton was responsible for the ICD-10 coding of all deaths in this year's register.

The Team would like to acknowledge the contributions made by the Child Protection Enforcement Agency in the NSW Police Service, NSW Health Department, NSW Registry of Births, Deaths and Marriages, the Office of the State Coroner, and the NSW Department of Community Services in the timely provision of data.

Executive summary: 1999-2000 Annual Report

Child deaths in NSW

- From July 1999 to June 2000, 809 children and young people aged 0 to 17 years died in New South Wales, that is 51.2 fatalities per 100,000 children in the population.

Age at death

- There are large variations in fatality rates according to the age of the child. The highest fatality rates are for infants (under 12 months of age) the majority of whom die from conditions originating in the perinatal period.
- After infancy, the fatality rates drop dramatically and remain relatively low and stable from 1 to 14 years of age.
- For 1 to 4 year olds the leading cause of death is drowning (15 fatalities which is 4.3 fatalities per 100,000 in this age group).
- For 5 to 9 year olds, and 10 to 14 year olds, the leading cause of death is cancer (neoplasms) (respectively 12 fatalities, 2.7 fatalities per 100,000; and 11 fatalities, 2.5 fatalities per 100,000).
- At 15 to 17 years of age there is a sharp increase in fatality rates due to high rates of car passenger fatalities (18 fatalities, 6.8 fatalities per 100,000), intentional self-harm and cancer (both 17 fatalities, 6.5 fatalities per 100,000).

Gender

- There are higher rates of fatalities for male children for both natural (41.5 vs 32.9 fatalities per 100,000 for females) and external causes of death (13.9 vs 7.9 fatalities per 100,000 for females) and this trend is evident since 1996.
- The exception to this established pattern is a higher rate of female suicide in the 1999 (January to December) data.

Indigenous status

- Fifty-two children were identified as indigenous (6.4% of child deaths in this period). Forty-eight children were identified as being Aboriginal (5.9% of child deaths in this period) and 4 were identified as Torres Strait Islanders.
- Based on a low-range population projection, the indigenous child death rate is extremely high, being 100.8 deaths per 100,000 indigenous children 0 to 14 years of age.

Motor transport fatalities

- A large number of children and young people died from a motor transport incident, which was the most common external cause of death (76 deaths, 45.5% of deaths from external causes, 4.8 fatalities per 100,000). This included passenger fatalities (37), pedestrian fatalities (20), motorcycle fatalities (6), car driver fatalities (4), and cyclist fatalities (2).

- Males accounted for 60% of transport fatalities, and a large proportion of transport incidents involved 15 to 17 year olds (34 of the 76 deaths; 44.7%) the majority of whom were passengers in vehicles.
- In 4 out of the 14 passenger fatalities of 15 to 17 year olds, documentation indicated that the driver had consumed alcohol.
- Rural roads were a feature of over half the passenger fatalities.
- There were 4 more fatalities in driveways in this reporting period.
- Pedestrian fatalities mostly involved younger children (between 2 to 9 years, there were 12 fatalities). In contrast to passenger fatalities, pedestrian fatalities largely occurred in residential streets in urban metropolitan environments, especially across South-West and Outer-West Sydney. All pedestrian deaths of 15 to 17 year olds involved risk factors such as alcohol, speed or circumstances implicating intentional self-harm.

Drowning

- Twenty children and young people died as a result of drowning (16 males and 4 females), and it is the leading cause of death of 1 to 4 year olds (15 fatalities).
- Seven children died in private swimming pools, 7 in bodies of natural water such as lakes, creeks, lagoons and rivers, 3 in dams, 2 in bathtubs and in 1 case there is no other information. Over half the drownings occurred in the home environment of the child or a carer of the child.
- Six of the 7 pool drownings were associated with inadequate fencing or improperly used fencing. This finding provides further reinforcement for the recommendations made by the CDRT in the 1998-99 Annual Report.

Suicide and drug overdoses

- Nineteen young people died as a result of suicide in this period and a further 6 young people aged 13 to 17 years (5 males and 1 female) died due to drug overdoses.
- These deaths will be further studied in the research project on suicide and risk-taking behaviour being undertaken by the NSW Commission for Children and Young People, the CDRT, and the Centre for Mental Health.

Sleep incidents

- There is a high rate of infant fatalities from sleep incidents (34 infants, 40.1 fatalities per 100,000) which includes deaths attributed to Sudden Infant Death Syndrome (18 fatalities), accidental suffocation in bed (12 fatalities with 9 involving bed-sharing), and undetermined sleep accidents (4 fatalities).
- Analysis of sleep incidents indicates the continued need for public education regarding the risk factors for SIDS as recommended in prior CDRT reports and the need for further research in this area (see page 53).

Assault

- Fourteen children and young people (10 males and 4 females) died as a result of assault in this period with 10 of the children aged 0 to 5 years. (Note that direct comparison with prior CDRT report categories of non-accidental injury and child homicide should not be made).

Case reviews

- CDRT undertook in-depth reviews of 22 cases in the 1999-2000 reporting period which included cases of SIDS, accidental suffocation in bed, suicide, drowning, assault and drug overdose.
- Review of these deaths show the need for improved performance by the child protection system in case planning, documentation and follow-up of decisions, as well as the need for effective interagency work in recognition, assessment, investigation and referral of child abuse and neglect as recommended in prior CDRT reports (see pages 59-61).

Monitoring recommendations

- As required by legislation, the CDRT has commented in this report on the extent that previous recommendations have been accepted. Many of the recommendations have been accepted and implemented by agencies and government departments. The Team will, in following reports, continue to comment on recommendations that have not yet been fully implemented.

Recommendations: 1999-2000 Annual Report

Recommendation 1

That the Motor Accidents Authority, in consultation with other relevant agencies, investigate fatalities of children and young people involving motor vehicles. This investigation should focus on fatal incidents that occur in regional and remote locations and continue to develop a range of practical measures to reduce the number of fatalities of children and young people involving motor vehicles across NSW.

Recommendation 2

That the NSW Water Safety Taskforce develop targeted strategies as part of the NSW Water Safety Plan to reduce the number of child deaths, particularly of children under 5 years of age, caused by drowning on farms and especially in dams.

Recommendation 3

That the Department of Local Government, in consultation with the NSW Water Safety Taskforce, undertake a review of all exemptions to child proof fencing that exist in the *Swimming Pools Act 1992*. This legislative review should be guided by evaluating the most effective and appropriate amendments to ensure the prevention of drowning and near drowning incidents in swimming pools.

Recommendation 4

That the Government fund CDRT to undertake a research project to investigate the deaths of infants in bed. This project would include the appointment of a researcher to collect information from bereaved families at the time of the infant's death.

Recommendation 5

That the State Coroner give reasons on file for dispensing with inquests, and audit to see if there is variation in the dispensing of inquests and if there is, specify its cause.

Recommendation 6

That the State Coroner audits the process of coronial registration of deaths.

CHAPTER 1

Introduction

1.1 Purpose

As specified in the *Children (Care and Protection) Act 1987* sec.103 the overall purpose of the Child Death Review Team is to prevent or reduce child deaths in New South Wales. The Team's brief includes children and young people who are aged from birth to under 18 years of age (17 years 11 months), and only includes live births.

1.2 Functions

(i) Research and surveillance

The Child Death Review Team legislation recognises that child deaths, in at least some circumstances, are preventable. In order to be able to prevent or reduce child deaths the Team must understand the causes of child death. One of the functions of the Team is to undertake research on the causes of child death *(Children (Care and Protection) Act 1987* sec.103).

Research by the Team is a task that is to be undertaken to reduce or prevent child deaths in NSW. Some of the specific research and surveillance functions of the Team are mandated in the legislation. The Team is to:

a) Maintain a Child Death Register

A register is to be maintained of all child deaths occurring in New South Wales after 1 January 1996. Deaths are to be classified according to cause of death, demographic criteria, and other factors with a view to understanding the causes of child death and preventing these fatalities. The Team is to analyse the data accumulated regarding the causes of the deaths registered and to identify patterns and trends relating to those deaths.

b) Undertake detailed case reviews of deaths due to abuse and neglect

The Team has a unique and specialised function in relation to one category of child deaths, those deaths due to abuse or neglect. The Team is mandated to identify the deaths of children that are due to abuse or neglect. Legislation recognises that it is not always possible to clearly identify all the deaths of children in this category. The Team is, therefore, also mandated to identify the deaths of children that occur in suspicious circumstances. Once these deaths are identified the Team is to undertake a detailed review of the information concerning these deaths, with a view to prevention. Data regarding the causes of death from the reviews is to be analysed, and patterns and trends relating to those deaths are to be identified.

c) Identify areas requiring further research

The Team is also to identify areas requiring further research by the Team or other agencies. This is related to the overall function of the Team, that is areas requiring further research that will assist in preventing and reducing child deaths in NSW.

(ii) Formulation and monitoring of recommendations for prevention of child deaths

The Child Death Review Team legislation recognises that some child deaths are preventable, and that prevention of child deaths is the responsibility of the community, private agencies and the government. The role of the Team is to formulate recommendations for policies and practices to be implemented by government and private agencies and by the community for the prevention or reduction of child deaths.

The Team is also required to comment upon the extent to which its previous recommendations have been accepted, and may comment on the extent to which those recommendations have been implemented in practice.

1.3 History of NSW Child Death Review Team

Impetus for establishing the NSW Child Death Review Team came from the Report, *Preventing Child Homicide* (NSW Child Protection Council, 1995) that was released in 1995. This Report, undertaken by the NSW Child Protection Council, suggested that very little systematic information was available about the deaths of children in NSW. The report recommended that systematic child death reviews be undertaken by a team with a legislative base.

The Child Death Review Team (CDRT) was established by the *Children (Care and Protection) Amendment Act 1995*. For the Team's first three and a half years the Team was administratively supported by the NSW Child Protection Council. In June 1999 when the Commission for Children and Young People came into existence, the Commissioner became the Convenor of the team and the Commission became responsible for providing research and administrative support to the Team.

The NSW Child Death Review Team has nominees from government departments concerned with the safety and well-being of children. This includes nominees from the Department of Community Services, the NSW Police Service, NSW Health, Department of Education and Training, NSW Attorney Generals, and the Office of the State Coroner. The work of the Team is intended to reflect a multi-disciplinary interagency response to protecting children and promoting their well-being, which cuts across traditional portfolios.

Each Child Death Review Team Annual Report has reported on the deaths of children in the reporting year. Each report also includes case reviews of certain categories of deaths. The 1996-97 Annual Report includes a review of 24 cases of children who died during January to December 1996. The 1997-98 Annual Report comments on the deaths of 73 children whose families were involved with the NSW Department of

Community Services before the child's death (these children died between July 1996 and June 1998). The 1998-99 Annual Report included a case review study of coronial cases where parental substance use was identified. This involved 86 coronial cases of children who died between January 1996 and June 1999.

1.4 Other Australian Child Death Review Teams

Victoria is the only other Australian state with a Child Death Review Committee. It was established in Victoria in 1996 and has focused on child abuse deaths. Currently the Committee audits all child abuse deaths and undertakes selected in-depth reviews in order to reveal systemic issues. The Team has recently studied deaths associated with adolescents and substance abuse, early discharge from hospital and SIDS, and defactos and assault.

Although some states operate morbidity and mortality committees, there is not systematic review of child deaths in other states. Western Australia and ACT are currently considering the feasibility of setting up child death review teams and child death registers.

1.5 International Child Death Review Teams

The first child death review team was established in Los Angeles County in 1978 (Durfee, 1994). By 1994 there were teams in 40 states and currently nearly every state in the US has developed some form of child death review team. All teams are interdisciplinary although there is much variation among the states' teams, which are shaped in part by their legislative powers of review and the information available to them. Some teams, such as Missouri Child Fatality Review Program, are county based and aim to give professionals at the local level immediate feedback on individual cases (Thigpen & Bonner, 1994). Other teams, such as those in Oklahoma and Missouri, review child deaths at the state level. Teams such as the LA County Team comment on individual cases and have through the District Attorney changed the outcome of some cases from being classified as accidental and natural death to homicide leading to the prosecution of offenders (Durfee, 1994).

In the US there is now a National Center on Child Fatality Review sponsored by the Interagency Council on Child Abuse and Neglect (ICAN), which provides information and coordination between state child death review teams in the states including the National Directory of Child Fatality Review Teams.

Canada is exploring the possibility of establishing a national child death register. For this purpose the Child Maltreatment Division of Health Canada is conducting a survey of child death data collection practices of other countries. The NSW Child Death Review Team has responded to this survey.

1.6 Report and investigation of child deaths in NSW

By law there are standard procedures and investigations that occur when a child dies in NSW. For the vast majority of child deaths that are due to natural causes (including disease processes) a doctor issues a medical certificate specifying the cause of death. The medical certificate with a Death Registration Form is forwarded to the NSW Registry of Births, Deaths and Marriages.

For cases that are referred to the Coroner and for which a medical certificate cannot be validly issued, a Death Registration Certificate is sent to the Registry with a notation that the death was reported to the Coroner.

Deaths that must be reported to the Coroner are specified in the *Coroner's Act 1980*. Deaths reportable to the Coroner include where there is reason to suspect that:

- the person died a violent or unnatural death
- the person died a sudden death the cause of which is unknown
- the person died under suspicious or unusual circumstances
- a medical practitioner has not given a certificate as to the cause of the death
- the person was not attended by a medical practitioner within the period of three months immediately preceding his or her death
- the person died within 24 hours of the administration of an anaesthetic
- a person has died (within one year and a day) of any accident to which the cause of death may be attributable
- the person died while in or temporarily absent from specified residential care.

An autopsy is conducted to help the Coroner determine the manner and cause of death. Since 1994 all autopsies for under 5 year olds are conducted by specialist forensic pathologists (at Glebe, Westmead and Newcastle Coroner's courts). Deaths of children that are reported to the Coroner include deaths due to motor vehicle accidents, Sudden Infant Death Syndrome, drowning, suicide, homicides, fires, toxicity and poisoning.

The role of the Coroner is to determine the identity of the deceased, and the date, time, place, cause and manner of death in matters referred to him or her. If during the course of an inquest it becomes apparent to the Coroner that a known person or a named person may have committed an indictable offence in relation to the death, the matter is referred to the Director of Public Prosecutions. The Coroner may make recommendations on a case-by-case basis regarding public health and safety and other relevant issues (Coroners Act 1980:22A).

For deaths that are reportable to the Coroner, Police conduct a death scene investigation. This includes a police report of death to the Coroner (a Form P79A), and a Death Scene Investigation Checklist for sudden unexpected deaths of children up to two years of age.

1.7 Research and surveillance

In New South Wales and nationally there are research groups who undertake research and surveillance into specific types of child deaths. Each group has a particular focus, which is determined by the cause of death (for example, drowning or suicide), or the context of the death (farm or occupational for example).

(i) Deaths of children in Australia

The Australian Bureau of Statistics (ABS) publishes data on child deaths using coronial and death certificate data (ABS 1998a). The Bureau uses the International Classification of Disease (ICD) codes for cause of death and in 2000 will release data coded according to ICD-10 (the latest version of the international coding method). ABS data runs calendar years (January to December) and is based on the year that the death was registered. The data is available 9 months into the year following the year that the death was registered.

(ii) Injury deaths

The Australian Institute of Health and Welfare funds the National Injury Surveillance Unit (NISU), which is based at Flinders University Research Centre for Injury Studies. NISU uses ABS fatality data and hospitalisation data to study its specialised area of injury. All deaths nationwide are studied and there is no specialisation in the injuries and fatalities of children.

Injury deaths in NSW of children 0 to 15 years of age are the subject of the New South Wales Paediatric Trauma Death Registry, which is based at the New Children's Hospital.

(iii) Farm deaths

Farm-related fatalities in Australia are studied by the National Farm Injury Data Centre, which has recently released a national strategy for child safety on farms (Franklin, Mitchell, Driscoll & Fragar, 1999).

(iv) Occupational deaths

Work-related fatalities of young people up to 14 years of age are being studied by the National Occupational Health and Safety Commission (NOHSC, 1999).

(v) Suicides

The NSW Department of Health maintains data on suicides (for all age groups) in NSW. This system is based on police reports of death.

(vi) Drownings

The NSW Branch of the Royal Life Saving Society studies drownings, and is currently conducting a study on near drownings in NSW.

(vii) Infant and neonatal deaths

The NSW Department of Health reports on neonate deaths in its annual Mothers and Babies Report. This report combines data from the NSW Midwives Data Collection, the Neonatal Intensive Care Units' Data Collection and the NSW Birth Defects Register (NSW Health, 2000).

The National Sudden Infant Death Syndrome Council of Australia began the National SIDS Autopsy Protocol and Database project in1992. The funding for this project is currently under review.

(viii) Deaths subject to coronial investigation

A National Coronial Information System (NCIS) is currently being implemented in Australia. The system is based at Monash University and has been developed by national coronial working parties. The system is seeking to develop a standardised nationwide coronial dataset available to coroners and approved researchers.

(ix) Unique role of Child Death Review Team

Although there are specialised groups that are undertaking research on specific types of deaths of children in NSW, the role of the Child Death Review Team remains unique in NSW. It is the role of the Team to comment on trends and patterns in all child deaths with a view to making recommendations for prevention. Individual case file reviews are conducted which consider the circumstances surrounding the child's death. These reviews are conducted in order to identify systemic failures or deficiencies in the protection of children in New South Wales, and to identity areas requiring further research. The Team focuses on prevention rather than the culpability of alleged offenders or the individual performance of duty by human service workers (including child protection workers). Unlike investigating agencies, the Team does not formally report on each death reviewed.

It is not the role of the Child Death Review Team to investigate child deaths; the police and the Coroner have a statutory responsibility to investigate deaths in NSW. Complaints are also not part of the Team's mandate. These are investigated by the Community Services Commission, the Health Care Complaints Commission, and the NSW Ombudsman.

CHAPTER 2

The demographic and policy context

To provide a context for the review of child deaths in NSW, this chapter, provides information about the demographic and social characteristics of children and young people in NSW, and reflects on social policy in NSW regarding children and young people.

The following profile of children and young people in the state includes information on the demography, health, safety and well-being of children and young people in NSW.

2.1 Profile of children and young people in NSW

(i) Demography

Children make up 25% of the population of NSW. In 1997 in NSW there were 1,574,900 children 0 to 17 years of age; 806,900 (51%) were male and 767,900 (49%) were female (ABS, 1999a). Children make up 24% of the Australian population. In 1997 there were 4.7 million children aged 0 to 17 years in Australia; 2,409,000 (51%) were male and 2,289,800 (49%) were female (ABS, 1999).

In NSW in 1996 there were estimated to be 47,500 indigenous children aged 0 to 17 (ABS, 1996). Indigenous children represent approximately 4% of all children in Australia. In 1996, there were 177,800 indigenous children aged 0 to 17 in Australia. The indigenous birth rate is higher that the non-indigenous birthrate: between 1991 and 1996 the indigenous birthrate in Australia has increased by 12%, while the total number of children in the Australian population has increased by only 2% (ABS, 1999a).

In 1996, there were 121,561 children aged 0 to 17 living in NSW who had been born overseas. Of young people in NSW who were born in Australia, 317,082 (33%) had at least one parent who had been born overseas. Almost 21% (208,439) had at least one parent born in a non-main English speaking country (ABS, 1996). In 1996, 7% of all children living in Australia (321,500) had been born overseas (ABS, 1999a).

(ii) Health, safety, and well-being

(a) Birth rate

NSW accounts for 34% (85,000) of births that were registered in Australia in 1998 (ABS, 1998b). About 6% of live births in Australia were less than 2,500g, 1% were less than 1,500g and 0.4% were less than 1,000g. Only 6% of non-indigenous births were of low birth rate compared with 13% of indigenous births (ABS, 1998b). In NSW in 1995 there were 5,521 premature infants, 8.8% were less than 27 weeks gestation (NSW Health, 1996).

(b) Education

In NSW in 1996 there were 574,172 infant and primary school students and 419,611 secondary school students aged between 10 and 19 years. Seventy-three percent of all infant and primary students and 67% of all secondary students attended government schools (ABS, 1996). Participation in schooling beyond the compulsory attendance age of 15 years has increased since the late 1980s (ABS, 1999a). In 1996 in NSW, 76% of 15 to 17-year-olds were still attending school (ABS, 1996).

In Australia in 1997 there were 1.9 million primary school and 1.3 million secondary school students. Seventy-four percent of all primary students and 66% of all secondary students attended government schools. In 1997, almost 93% of children aged 15 were still attending school, only 60% were still attending school at aged 17. Participation rates were higher for girls than boys (ABS, 1999a).

(c) Children at risk

In 1997, hazardous/harmful alcohol use was practised by 26.4% of males aged 16 to 19 years in NSW and by 37.4% of females of the same age range (NSW Health on line), with 40% of 16 and 17-year-olds practising binge drinking (NSW Health on line).

In 1998-99, the NSW Department of Community Services received 72,762 reports and notifications concerning children and young people. Assessment determined abuse or neglect in 10,053 (13.8%) of those reports and notifications (NSW DoCS, 1999).

In 1998-99, 13,399 young people appeared in NSW Children's Courts. In NSW in 1998-99, on average, there were 388 young people in custody on any day. There were, on average, 24 females detained on a daily basis, representing approximately 6% of the juvenile detention population in NSW. On average, 110 Aboriginal young people were detained in NSW Juvenile Justice centres on any day (NSW Department of Juvenile Justice, 1999). In Australia in 1996, there were 716 young people [658 males (91.9%) and 58 females (8.1%)] aged 10 to 17 in juvenile corrective institutions. Indigenous young people are 20 times more likely than non-indigenous young people to be detained in corrective institutions (ABS, 1999a).

NSW data is not available for rurality, living arrangements and economic status of children and young people in NSW. For that reason, Australian data only are presented in the following sections.

(d) Rurality

The Australian population is highly urbanised. In 1996, 16% of children and young people 0 to 17 years of age lived in rural areas in Australia. Twenty-six percent of indigenous children were in rural areas (ABS, 1999a).

(e) Living arrangements

In Australia in 1997, there were 4.6 million children living with their parents. Of those, 82% were in couple families and 18% were in one-parent families. Of the children living in couple families, 8% (363,800) lived in step and blended families. In 1994 there was an estimated 21,000 homeless children and young people in Australia (ABS, 1999a).

(f) Economic status

In 1996-97, 54% of Australian children in couple families had both parents employed and 38% had one parent employed. Forty-four percent of children in one-parent families lived with a parent who was employed. When ranked on income adjusted for the differing needs of different sized families, 70% of children in one-parent families and 41% of children in couple families were in the lowest 40% of the income distribution (ABS, 1999a).

2.2 The policy context

To fully appreciate the CDRT reports, they need to be considered in two important contexts, first the last twenty-five years of child protection policy and responses to child abuse and neglect in NSW, and second the development of injury prevention strategies for non-accidental injuries.

(i) Child protection

This last twenty-five years has been characterised by rapid growth and development in child protection knowledge and practice, which has greatly improved NSW's response to the problem of child abuse and neglect.

These developments were a result of a number of factors. They were partly a result of greater advocacy by the survivors of abuse but also by a significant increase in community and professional awareness and research about child abuse and neglect.

(a) Development of the legislative framework

One of the most significant trends influencing the policy and practice context has been the changing legislative framework to child abuse and neglect over the previous twenty-five years in child welfare law and criminal law.

Reporting child abuse and neglect was made mandatory for doctors in 1977 and for teachers in 1987. The *Children (Care and Protection Act) 1987* commenced in 1988 followed by an amendment in 1996 that allowed a greater exchange of information between agencies involved in child protection. The 1987 Act has been reviewed and a new Children and Young Persons (Care and Protection) Act was passed by Parliament in 1998, further improving the NSW response.

New offences in criminal law were created along with significant reform to the structure of offences. There was also improved support for children giving evidence, including the introduction of Closed Circuit Television (CCTV). Recent legislative changes have strengthened the protection of children in the workplace.

(b) Development of service models

An increase in the number of services and the development of service models for responding to child abuse has accompanied these legislative changes.

Specialist services for child sexual assault and physical abuse and neglect counselling and therapy services have been established. Joint police/community services investigation teams; brokerage and accommodation services for homeless young people; intensive support services for families and specialist programs for indigenous families and families from particular cultural backgrounds have also been created.

Personal safety skills' training for children, developments in the school curriculum and programs such as peer support have been designed to increase children's ability to resist potential abusers and increased their confidence to tell an adult if they feel threatened or if abuse has occurred.

A collaborative approach to child abuse and neglect has been developed and promoted through the Interagency Guidelines on Child Protection Intervention (published in 1991 and updated in 1997).

(c) Development of organisational structures and information systems

The key child protection agencies – NSW Police Service, Department of Community Services and NSW Health – have been through a process of organisational restructure and realignment.

Originally services were designed as a specialist, centralised child protection system. In the 1990s they were restructured into services with a regional focus and generalist response. More recently, organisations have moved towards a specialised regional response that is backed up by a specialist-centralised team. Some of the larger non-government agencies have adopted similar structural changes.

The development of information technology has greatly improved the system's ability to track and collate information about individual cases and to aggregate it so that trends and gaps can be identified. Examples are the Police Computerised Operational Policing System (COPS), the Department of Community Services Client Information System and Disability Client Database and epidemiological and other databases in the health system.

Policy and casework practice have also been opened to significant external scrutiny through bodies such as the Community Services Commission, the Health Care Complaints Commission, the Police Integrity Commission, the Ombudsman and the Independent Commission Against Corruption.

(d) Broadening knowledge base about child protection

Empirical research into child protection has become a priority in the social sciences with an increasing number of journals, publications and PhD theses in the area. Specialist research centres have been established, including the National Child Protection Clearing House and the Childhood and Youth Policy Research Unit at the University of Western Sydney.

Policy and practice have integrated new knowledge about the behaviour of adult sex offenders; treatment options for juvenile sex offenders; the inter-relationship between domestic violence and child protection; the vulnerability of children with disabilities and homeless young people to abuse; risk and protective factors; the importance of the participation of children and families in casework decisions; and the effectiveness of prevention and early intervention programs.

The changes have been supported by improved professional knowledge and skills development. The need for specialist training and skills development in child protection was recognised through the Child Protection Council's training packages, the establishment of the Centre for Community Welfare Training and the Education Centre Against Violence and the development of national child protection competency standards.

Alongside the broadening professional knowledge base there has been improved community awareness about child abuse and neglect. During the 1970's there was a community reluctance to acknowledge the extent of child abuse and neglect with a perception of it largely in terms of 'stranger danger'. The community is now much more aware of the importance of child protection which may partly be a result of public reports such as the Premier's Taskforce on Child Sexual Assault, Child Protection Council reports, and the Wood Royal Commission Paedophile Inquiry.

Public education campaigns such as 'No Excuses' and 'Never Shake a Baby' and more extensive media coverage have also influenced community awareness.

(ii) Injury prevention

In 1979 the Commonwealth government was persuaded to establish the Child Accident Prevention Foundation now known as Kidsafe. The Foundation was a key organisation in attracting attention to non-intentional injury, publishing the first epidemiological overview of child injury in 1982. From this, a number of goals and strategies were established at the national level aimed at 'injury control' (Vimpani, 1997). This led to the establishment of the National Injury Surveillance Unit (NISU).

These organisations, amongst others established at individual state and territory levels, have been responsible for shifting the analysis of child injury from individual random 'accidents' to a systemic public health approach. Through the increased capacity to monitor childhood injuries and fatalities, specific risk and protective factors have been identified that increase or decrease the probability of injury. The identification of key risk and protective factors has been a crucial basis for credible interventions by policy makers. (Grossman, 2000). The Government acted on these factors through legislative and policy initiatives at an intersectoral level.

Some key policy initiatives that have been introduced in the last 20 years include the following: legislation requiring back seat passengers to use available seat belts (1981), compulsory installation of child restraints (1988), mandatory standards for all products for children under three years including labelling of small parts in toys (1987), introduction of mandatory cycle helmet wearing legislation in all states (1990-1992), building codes and regulations requiring the installation of smoke alarms in residential buildings (in most states and territories by 1995), and Australian standards on domestic hot water temperatures (1995) (NISU 1997).

CHAPTER 3

Methodology

3.1 Child Death Register

(i) Access to data

The *Children (Care and Protection) Amendment Act 1995* imposes a duty on all government departments, statutory bodies or local authorities to provide the Team with 'full and unrestricted access' to records that the Team reasonably requires for the purpose of exercising its functions.

Accompanying the Team's privileged access to information is a duty of confidentiality specified in the legislation. A Team member or staff may not reveal to any person any information acquired by reason of being a member of the Team or of its staff except through reports to Parliament. A penalty is specified in the Act for breach of this provision. With privileged access to information, the Team has exemption from Freedom of Information requests.

(ii) Data sources

The basis of the Child Death Register is death registration data from the NSW Registry of Births, Deaths and Marriages. These data include:

- date of birth
- the date of death
- date of registration of the death
- cause of death noted on the death certificate
- age of the child
- last known residence
- parents' names
- place and country of birth
- Aboriginal and Torres Strait Islander status
- gender

Demographic information for all the deaths (the child's age, last place of residence, and gender) is taken from the death registration data. For deaths where a medical certificate is issued, only death registration data are available for the Child Death Register. For each coronial case, however, additional information is available, including:

- a police record of death report (which includes narrative of the circumstances under which the death took place)
- a final post-mortem report (including autopsy, pathology and toxicology findings)
- a coronial report (or dispensation of inquest)

For the major coronial categories of death, which include death from external causes, the police records of the death were reviewed. For each subset of cases, variables relevant to the category were developed by the Commission's researchers. For example for drowning deaths, police information was reviewed for each death in order to code further information about the circumstances of the death (such as whether the child was alone, or whether there was a fence around the swimming pool).

(iii) Coding of cause of death

For each death in the Child Death Register one of the Team's paediatricians reviewed all the available information and coded the cause of death according to international coding (ICD-10 coding).

The World Health Organisation has promoted an international classification system for coding mortality data including external causes of death, the International Classification of Disease (World Health Organisation, 1992). The most recent version of this coding was used for this year's Annual CDRT Report. ICD coding is a classification system that includes codes for deaths from external causes of injury and poisoning. A framework for grouping the external causes of death has been suggested by the US National Center for Injury Prevention and Control and the National Center for Health Statistics (Centers for Disease Control and Prevention, 1997). The framework is a matrix which specifies mechanism by intent of injury (for example suffocation=mechanism, suicide=intent). This matrix has also been adopted in Canadian data (Child Injury Division, 1999). The US framework coding mechanism and intent was used to code CDRT data where data was available.

It was found that some specific causes of death of interest, such as driveway fatalities of toddlers, were not specified in ICD-10 coding. These cases were noted and coding was developed by the Commission's researchers.

For the category of deaths of infants in the context of sleeping, two Team members with expertise in forensic medicine and paediatrics conferred together to code the cause of death.

(iv) Coding of indigenous status

Indigenous status is recorded on Births Deaths and Marriages death registration data and the Police Report to the Coroner (Form P79A). It is highly likely that data from these sources undercounts the number of Aboriginal and Torres Strait Islander child fatalities.

Indigenous status was also coded by the Aboriginal team members for all deaths. A child was coded as Aboriginal when a team member could identify the family as an Aboriginal family. The results of this coding are reported in the following chapters.

(v) Coding of disability status

The identification of children who have died and had a disability remains problematic. There are difficulties in defining this population and reaching a working definition of what constitutes a disability. Additionally, it is not evident who would be equipped to make the determination of disability in the information that is routinely collected at the time of death.

(vi) Quality of data

As with all data sets that rely on administrative data sources, there are omissions of information. As well as missing information there is also likely to be a small number of errors. The validity and reliability of the information that is recorded for the Register has not been formally verified. However, for all coronial cases and cases that are subject to in-depth review, there are several different data sources, so the probability of reliable and valid data is increased.

(vii) Analysis of Child Death Register data

There have been several changes from prior CDRT reports in analysis of data for this year's Annual Report, including analysis of the data by the date of registration of the death and the calculation of prevalence rates and trends.

The Register is now analysed according to the date of registration of the death. (In former CDRT Annual Reports, the year of death – not registration – was used.) Analysis by date of registration of the death is in line with other national datasets (such as the Australian Bureau of Statistics and National Injury Surveillance Unit data).

Because of reordering the 1996-99 data by date of registration, it was discovered that 15 deaths from this period (all of which were coronial cases) are not registered with the NSW Registry of Births, Deaths and Marriages. For the purposes of this report, missing dates were estimated from available documentation so these cases could be used in the dataset.

As in past reports, the Child Death Register uses a financial year for data collection (new data for this year is collected from 1 July 1999 to 30 June 2000).

(viii) Prevalence

The 1999-2000 Annual Report uses crude death rates. These rates show how many deaths there were in a certain age group and gender group per 100,000 children in this age and gender group in the population. The advantages of using rates are that the number of girls and boys in an age group may change over time. Thus if comparing a 5 year period, it is possible to state if a trend has occurred taking into account any changes in the numbers of children in this age group in the population over this time period. Rates allow comparison across states and internationally. Thus although state and country populations may be markedly different, rates can be compared.

(ix) Trend data

In contrast to the analysis of new register data, which operates on a financial year, trends have been analysed according to a calendar year (January to December). Trend lines have not been continued from 1998 to 1999, as there have been changes in coding from July 1999. Each case is now individually coded according to ICD-10 codes.

3.2 In-depth child death reviews

(i) Identification of cases

One of the Team's statutory functions is to identify the deaths of children that are due to abuse or neglect or that occur in 'suspicious circumstances'. There are several processes that enable the Team to identify this group of cases. For medical certificate deaths, three of the Team's doctors review the stated cause of death on the death certificate. Further information is requested if the cause of death appears to be inadequate or suggests suspicious circumstances around the death.

The second process involves review of coronial cases. This includes cases of homicide, suicide, motor vehicle accidents, sleep accidents, overlaying, drowning, toxicity, poisoning, fire, choking, falls and undetermined causes of death. A subgroup of the Team meets to determine which coronial cases warrant indepth file review; that is, the group determines which child deaths are due to abuse or neglect or occur in suspicious circumstances. For all coronial cases, information is sought from the Department of Community Services to determine whether the child or sibling was a client of the Department. On the basis of the coronial information and the availability of a child welfare services history, the subgroup determines which cases warrant review.

There is a routine time lapse in the availability of documentation for coronial cases. Taking this time lag into account, the Team considered coronial cases for review in this Annual Report if the final post-mortem was available by the end of April 2000. Cases where information became available after April will be considered in next year's Annual Report.

(ii) Review

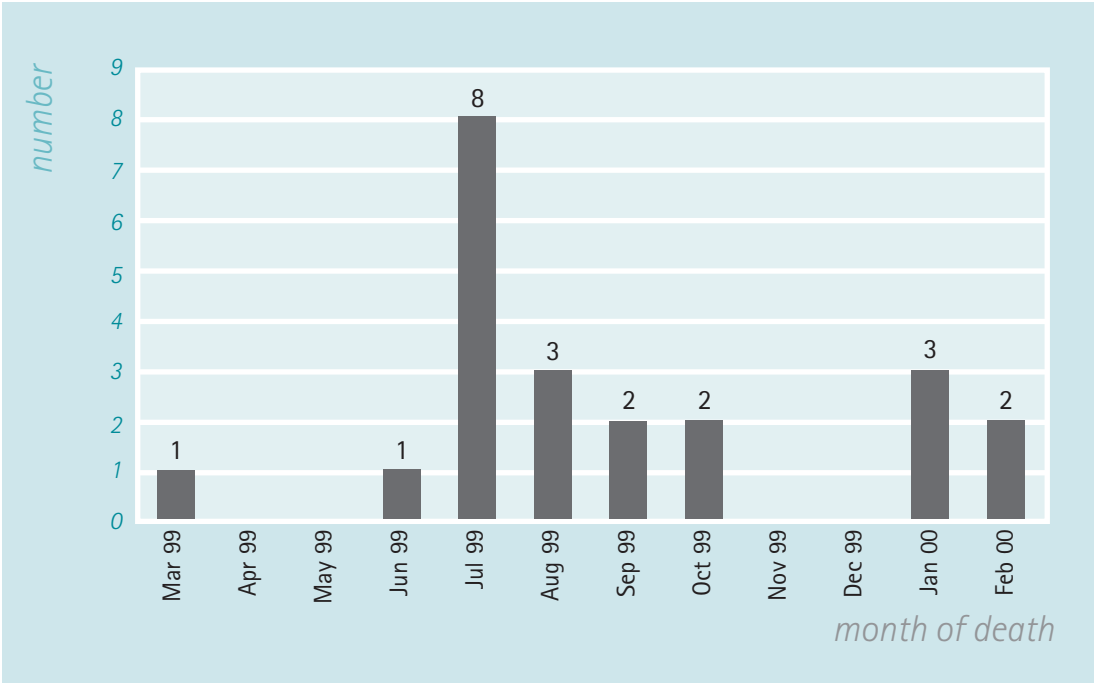
For cases for in-depth child death review, individual case file records are obtained. Child welfare files and police records are systematically examined, while medical records are sought where relevant and available. The case reviews followed a format that allowed the collection of standard information regarding a case, as well as narrative around the history and circumstances of the death.

(iii) 1999–2000 cases reviewed

Twenty-six cases were screened in for review by the Team in the 1999-2000 reporting period. Twenty-two cases were reviewed and four cases have not yet been reviewed because documentation was not supplied in the available timeframe.

The month of death of the cases reviewed is shown in Figure 1 below, which shows that the deaths occurred between March 1999 and February 2000.

FIGURE 1 *Cases reviewed in 1999-2000 reporting period: Month of death*



The cases that were reviewed (as shown in Table 1) had varied causes of death and included cases of SIDS, accidental suffocation in bed, suicide, assault, drug overdose, and undetermined causes of death. Cases have been included in the report only when, after review, it was judged that comment could be made on clear avenues for prevention.

TABLE 1 *Cases subject to in-depth review 1999-2000 reporting period*

Category		Age, Gender, Pseudonym*
Miscellaneous	Bronchopneumonia	2-month-old boy
	Respiratory failure	8-year-old girl (with cerebral palsy)
	Asthma	8-year-old boy
	Fall from cliff undetermined intent	16-year-old boy
	Undetermined	16-year-old boy
	Heroin overdose of undetermined intent	17-year-old girl (Tamy)
Drowning		11-month-old girl (Baby Rose)
		19-month-old boy
		2-year-old boy
		3-year-old girl (Amanda)
Assault	Shaking (alleged murder)	2-year-old boy (Gregory)
	Stabbing, strangulation (alleged murder-suicide)	4-year-old girl (Emma)
	Stabbing (alleged murder)	14-year-old boy (Kyle)
Suicide	Hanging	14-year-old boy (Tim)
Accidental suffocation in bed		3-week-old girl
		11-week-old boy
		2-month-old boy (Baby Daniel)
		3.5-month-old girl
SIDS		11-week-old girl
		7-week-old girl
		9-week-old boy
		9-week-old boy

* Cases that are described in this report are given pseudonyms to facilitate discussion and protect the privacy of the individuals involved.

CHAPTER 4

The Child Death Register – Overview of child deaths in NSW 1999-2000

4.1 Child fatalities 1999-2000

Eight hundred and nine children and young people aged 0 to 17 years died in the 12 month period, from July 1999 to June 2000. Four hundred and seventy seven were males (59%) and 332 were females (41%). Table 2 presents the ages of the children and young people at death by gender. Over half of the young people who died (472 deaths, 58%) were under 12 months of age. The next most common age category was 15 to 17 years (125 deaths, 15.4%).

TABLE 2 *Age at death by gender*

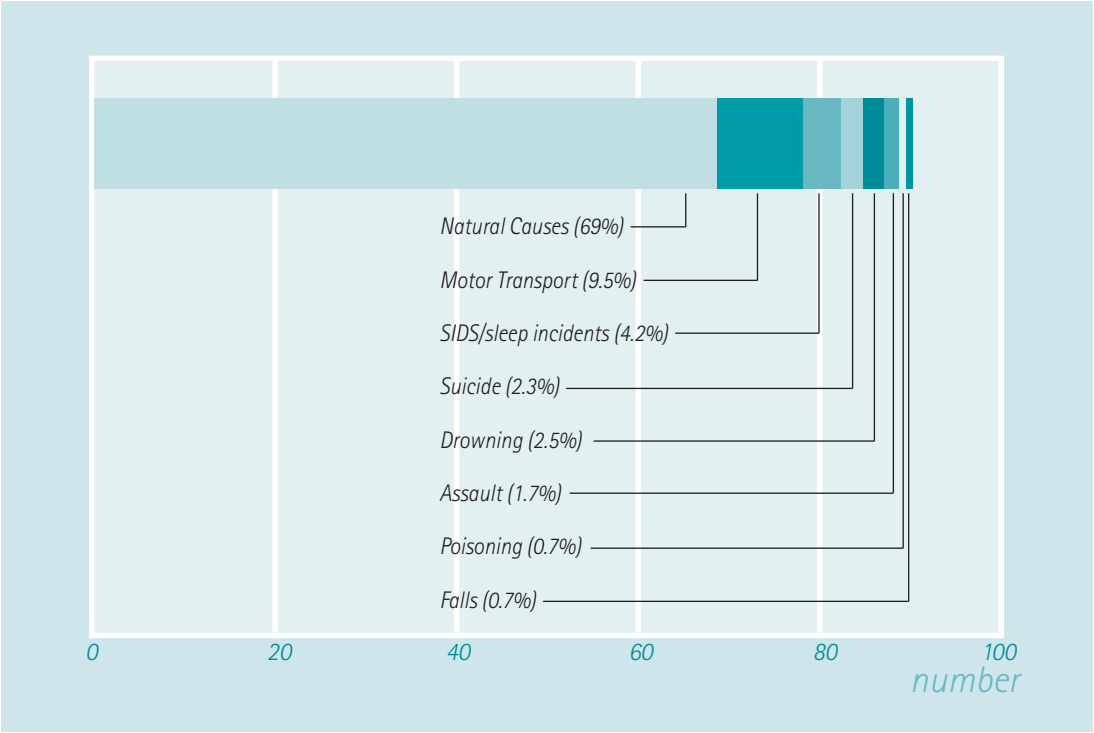
Age at death	Females		Males		Total	
	n	*% deaths*	*n*	*% deaths*	*n*	*%*
< 1 day	83	25.0	102	21.4	185	22.9
1 day to < 1 week	42	12.7	53	11.1	95	11.7
1 week to < 1 month	19	5.7	36	7.5	55	6.8
1 month to < 12 months	61	18.4	76	15.9	137	16.9
1 to < 2 years	16	4.8	26	5.5	42	5.2
2 to 4 years	31	9.3	35	7.3	66	8.2
5 to 9 years	23	6.9	23	4.8	46	5.7
10 to 14 years	13	3.9	45	9.4	58	7.2
15 to 17 years	44	13.3	81	17.0	125	15.4
Total	**332**	**41.0***	**477**	**59.0***	**809**	**100.0**

* Percentage of total deaths

(i) Causes of child deaths: Natural and external

The causes of child deaths are presented in Figure 2. As shown, the most common cause of death was natural causes, with just under 70% of all child deaths due to natural causes.

FIGURE 2 *Causes of child deaths*



- In this chart, natural causes do not include ICD-10 Chapter XVIII deaths, 'symptoms, signs and abnormal clinical findings not elsewhere classified'.
- External causes of death for which fewer than 6 children and young people died have been omitted from this chart. This accounts for percentages not totalling 100 percent.

Table 3 presents the causes of child deaths by gender. Five hundred and eighty-nine children died of natural causes (37.3 per 100,000 overall population); 336 were males (41.5 per 100,000 male population) and 253 were females (32.9 per 100,000 female population). As Table 3 shows, the most common natural causes of death were 'conditions originating in the perinatal period' (250 deaths; 42.4% of all natural causes), and 'congenital malformations, deformations and chromosomal abnormalities' (127 deaths; 21.6% of all natural causes). Table 3 also shows that 173 children died of external causes (21.8 per 100,000 overall population); 112 were males (13.9 per 100,000 male population) and 61 were females (7.9 per 100,000 female population).

TABLE 3 *Causes of child deaths by gender*

Broad ICD code descriptions	Females		Males		Total	
	n	*Rate*	*n*	*Rate*	*n*	*Rate*
Natural causes						
Infectious and parasitic diseases	3	*	8	1.0	11	0.7
Neoplasms	20	2.6	34	4.2	54	3.4
Diseases of blood and blood-forming organs	2	*	6	0.7	8	0.5
Endocrine, nutritional, metabolic diseases	6	0.8	8	1.0	14	0.9
Diseases of the nervous system	16	2.1	26	3.2	42	2.7
Diseases of the eye and adnexa	1	*	0	*	1	*
Diseases of the circulatory system	4	0.5	8	1.0	12	0.8
Diseases of the respiratory system	9	1.2	12	1.5	21	1.3
Diseases of the digestive system	4	0.5	0	*	4	0.3
Diseases of the skin & subcutaneous tissue	0	*	1	*	1	*
Diseases of the musculoskeletal system and connective tissue	4	0.5	1	*	5	0.3
Pregnancy, childbirth and the puerperium	4	0.5	4	0.5	8	0.5
Conditions originating in the perinatal period	107	13.9	143	17.7	250	15.8
Congenital malformations, deformations and chromosomal abnormalities	61	7.9	66	8.2	127	8.0
Symptoms, signs and abnormal clinical findings not elsewhere classified	12	1.6	18	2.2	30	1.9
Total number of fatalities from natural causes	**253**	**32.9**	**336**	**41.5**	**589**	**37.3**
External causes						
Injury, poisoning and certain other consequences of external causes	0	*	5	0.6	5	0.3
External causes of morbidity and mortality	60	7.8	107	13.2	167	10.6
Factors influencing health status and contact with health services	1	*	0	*	1	*
Total number of fatalities from external causes	**61**	**7.9**	**112**	**13.9**	**173**	**21.8**
Total	**314**	**40.8**	**448**	**55.4**	**762**	**48.3**
%	**41.2**		**58.7**		**100.0**	
Total number not yet determined	**18**		**30**		**48**	
Overall total	**332**		**477**		**809**	**51.2**

- Rates are per 100,000 population. Total rates for females were computed on the overall population of 0 to 17 year old females. Total rates for males were computed on the overall population of 0 to 17 year old males. Total rates for the overall sample were computed on the overall population of males and females combined.
- '*' indicates that rates are unreliable because they are based on less than four deaths.

(ii) Indigenous child deaths

The Registry of Births, Deaths and Marriage's Death Registration Form includes a question as to Aboriginal or Torres Strait Island status. The Police Report to the Coroner (P79A) was revised during 1997 to include a similar notation.

There were 52 children identified as indigenous (6.4% of child deaths in this period), which included 48 Aboriginal children and 4 Torres Strait Islander children. Table 4 shows how these children were identified. From death registration data from the Registry of Births, Deaths and Marriages, 39 children were identified as being Aboriginal and 4 as Torres Strait Islanders. Fifteen of these 39 children who were recognised as Aboriginal by the Registry were also identified as being Aboriginal by one of the Team's Aboriginal representatives. In addition, there were 9 children coded by the Registry as non-Aboriginal, and identified as being Aboriginal by one of the Team's Aboriginal representatives.

A 'low-range' population projection for 1999 for 0 to 14 year old[1] Aboriginal and Torres Strait Islanders in NSW is 46,609[2]. Using this population projection, the crude death rate for the indigenous child population is extremely high: being 100.8 deaths per 100,000 indigenous child population 0 to 14 years of age.

The CDRT data in this report does not allow direct comparison to be made between the indigenous and non-indigenous populations as only the death rate for the entire NSW child population (including all indigenous and ethnic groups) has been calculated. For all children in NSW the crude death rate for 0 to 14 year olds is 52 per 100,000 children in the population 0 to 14 years of age, while the rate for 0 to 17 year olds is 51.2 per 100,000 children 0 to 17 years of age in the population.

TABLE 4 *Indigenous death registrations*

	Females *n*	Males *n*	Total *n*	*%*
Recognised as Aboriginal by Registry and Team	10	5	15	1.8
Recognised as Aboriginal by Registry only	12	12	24	3.0
Recognised as Aboriginal by Team only	7	2	9	1.1
Recognised as Torres Strait Islander by Registry	0	4	4	0.5
Non Aboriginal	303	454	757	93.6
Total	**332**	**477**	**809**	**100.0**

1 Disaggragated data for 15 to 17 year old Aboriginal and Torres Strait Islander populations is not available, limiting calculations to the 0 to 14 year old Aboriginal and Torres Strait Islander population.

2 This population figure comes from ABS estimates (ABS 1998c). The figure is a 'low-range' projection of Aboriginal and Torres Strait Islander population growth, which assumes that the indigenous population as recorded in the 1996 Census will only change as a result of natural increase rather than an increased propensity to identify as indigenous in Census collections (see ABS 1998c).

Table 5 presents the age at death of the infants and children who were identified as being Aboriginal or Torres Strait Islander. Over two-thirds of Aboriginal and Torres Strait Islander children who died were under 12 months of age (36 children; 69.2%). Data for Western Australia, South Australia and the Northern Territory combined also indicate that indigenous infants under 12 months of age are at greatest risk (ABS, 1999b).

TABLE 5 *Aboriginal and Torres Strait Islander children: Age at death by gender*

Age at death	Females *n*	Males *n*	Total *n*	*%*
< 1 year	22	14	36	69.2
1 to 4 years	0	3	3	5.8
5 to 9 years	3	2	5	9.6
10 to 14 years	2	1	3	5.8
15 to 17 years	2	3	5	9.6
Total	**29**	**23**	**52**	**100.0**

Table 6 presents the causes of Aboriginal and Torres Strait Islander child deaths by gender and age at death. Thirty-one of the 52 (59.6%) children died from natural causes, 14 (26.9%) died from external causes, and the causes of death for 7 (13.5%) Aboriginal and Torres Strait Islander children are still to be determined. Over half of the deaths from natural causes were due to 'conditions originating in the perinatal period' (18 out of 31 deaths, 58.1%). The next most common natural cause of death among Aboriginal and Torres Strait Islander children was 'congenital malformations, deformations and chromosomal abnormalities' (7 out of 31 deaths, 22.6%). Although the numbers are small, Table 6 also shows that more indigenous females than males died from natural causes. This contrasts with the numbers of child deaths overall, as more males than females overall died from natural causes (refer to Table 3).

TABLE 6 *Aboriginal and Torres Strait Islander children: Natural and external causes of death by gender and age at death*

Age at death	Females	Males	Total
Natural causes			
< 1 year	19	8	27
1 to 4 years	0	0	0
5 to 9 years	1	0	1
10 to 14 years	1	0	1
15 to 17 years	0	2	2
Total number of fatalities from natural causes	**21**	**10**	**31**
External causes			
< 1 year	1	3	4
1 to 4 years	0	3	3
5 to 9 years	1	2	3
10 to 14 years	1	1	2
15 to 17 years	2	0	2
Total number of fatalities from external causes	**5**	**9**	**14**
Total number not yet determined	**3**	**4**	**7**
Overall total	**29**	**23**	**52**

(iii) Most common causes of death by age at death

Tables 7-11 present the most common causes of death for the age groups less than 1 year, 1 to 4 years, 5 to 9 years, 10 to 14 years, and 15 to 17 years.

Conditions originating in the perinatal period and congenital malformations, deformations and chromosomal abnormalities were the two leading causes of death for children aged under 1 year, accounting for 347 (73.5%) of deaths for children under 1 year (195 males, 152 females). This accounted for 92% of all deaths from these causes. For this under 1 year age group who died as a result of these conditions, 170 (49% of under 1 year olds) involved children who died within 1 day of birth. Congenital malformations were also the second leading cause of death for 10 to 14 year olds and the third most common cause of death for 1 to 4 year olds.

The leading cause of death for 1 to 4 year olds was drowning. Fifteen children aged between 1 and 4 years of age (13.9% of all deaths in this age group) died as a result of drowning fatalities in this reporting period.

Neoplasms were the leading cause of death for children aged between 5 and 9 years (4 females, 8 males), and 10 to 14 year olds (2 females, 9 males), predominantly malignant neoplasms of the eye, brain or central nervous system (ICD-10 C69-C72) or malignant neoplasms assumed to be primarily of lymphoid, haematopoietic and related tissue (ICD-10 C81-C96). Neoplasms were also the second leading cause of death in 1 to 4 year olds (5 females, 6 males) and 15 to 17 year olds (7 females and 10 males in this age group).

For 15 to 17 year olds, the leading causes of death were car passenger fatalities (18 deaths, 14.4% of deaths in this age group), intentional self-harm and neoplasms.

TABLE 7 *Most common causes of death for infants (less than 1 year)*

Rank	Cause of death	Number of deaths	Percentage of deaths*	Rate
1	Conditions originating in the perinatal period	243	51.5	286.6
2	Congenital malformations, deformations, and chromosomal abnormalities	104	22.0	122.7
3	SIDS, other sudden death – cause unknown, and other sleep incidents	34	7.0	40.1
4	Diseases of the nervous system	14	3.0	16.5
5	Diseases of the respiratory system	11	2.3	13.0
6	Pregnancy, childbirth and the puerperium	7	1.5	8.3
7	Certain infectious and parasitic diseases	6	1.3	7.1
8	Neoplasms	3	**	**
(8)	Diseases of the blood and blood-forming organs	3	**	**
(8)	Car passenger injured in transport accident	3	**	**
(8)	Assault	3	**	**

* This table does not include all causes of death. The percentage column, therefore, does not add to 100%. The percentage of deaths refers to the percentage of all infants aged less than one who died.

** Percentages and rates are unreliable because they are based on less than four deaths.

TABLE 8 *Most common causes of death for children (1-4 years)*

Rank	Cause of death	Number of deaths	Percentage of deaths*	Rate
1	Drowning and submersion: accidental or undetermined intent	15	13.9	4.3
2	Neoplasms	11	10.2	3.1
3	Diseases of the nervous system	9	8.3	2.6
(3)	Congenital malformations, deformations, and chromosomal abnormalities	9	8.3	2.6
5	Pedestrian injured in transport accident	7	6.5	2.0
(5)	Assault	7	6.5	2.0
(5)	Conditions originating in the perinatal period	7	6.5	2.0
8	Diseases of the circulatory system	6	5.6	1.7
9	Endocrine, nutritional & metabolic diseases	5	4.6	1.4
10	Certain infectious and parasitic diseases	4	3.7	1.1
(10)	Car passenger in transport accident	4	3.7	1.1

* This table does not include all causes of death and so the percentage column does not add to 100%. The percentage of deaths refers to the percentage of all children aged 1-4 who died.

TABLE 9 *Most common causes of death for children (5-9 years)*

Rank	Cause of death	Number of deaths	Percentage of deaths*	Rate
1	Neoplasms	12	26.1	2.7
2	Pedestrian injured in transport accident	6	13.0	1.4
(2)	Car passenger injured in transport accident	6	13.0	1.4
4	Diseases of the nervous system	5	10.9	1.1
5	Congenital malformations, deformations, and chromosomal abnormalities	2	**	**
(5)	Passenger, truck, van, heavy vehicle injured in transport accident	2	**	**
7	Endocrine, nutritional and metabolic diseases	1	**	**
(7)	Diseases of the respiratory system	1	**	**
(7)	Diseases of the musculoskeletal system and connective tissue	1	**	**
(7)	Effects/exposure to electric current	1	**	**
(7)	Suffocation/strangulation: accidental or undetermined intent	1	**	*
(7)	Assault	1	**	**
(7)	Choking	1	**	**

* This table does not include all causes of death. The percentage column, therefore, does not add to 100%. The percentage of deaths refers to the percentage of all children aged 5 to 9 who died.

** Percentages and rates are unreliable because they are based on less than four deaths.

TABLE 10 *Most common causes of death for young people (10-14 years)*

Rank	Cause of death	Number of deaths	Percentage of deaths*	Rate
1	Neoplasms	11	19.0	2.5
2	Congenital malformations, deformations, and chromosomal abnormalities	6	10.3	1.4
3	Diseases of the nervous system	4	6.9	0.9
4	Endocrine, nutritional and metabolic diseases	3	**	**
(4)	Diseases of the circulatory system	3	**	**
(4)	Intentional self-harm	3	**	**
7	Diseases of the respiratory system	2	**	**
(7)	Pedestrian injured in transport accident	2	**	**
(7)	Pedal cyclist injured in transport accident	2	**	**
(7)	Motor cycle rider injured in transport accident	2	**	**
(7)	Car passenger injured in transport accident	2	**	**
(7)	Water transport accident	2	**	**
(7)	Poisoning: accidental/undetermined intent	2	**	**
(7)	Assault	2	**	**

* This table does not include all causes of death. The percentage column, therefore, does not add to 100%. The percentage of deaths refers to the percentage of all young people aged 10 to 14 who died.

** Percentages and rates are unreliable because they are based on less than four deaths.

TABLE 11 *Most common causes of death for young people (15-17 years)*

Rank	Cause of death	Number of deaths	Percentage of deaths*	Rate
1	Car passenger injured in transport accident	18	14.4	6.8
2	Intentional self-harm	17	13.6	6.5
(2)	Neoplasms	17	13.6	6.5
4	Diseases of the nervous system	10	8.0	3.8
5	Congenital malformations, deformations, and chromosomal abnormalities	6	4.8	2.3
6	Diseases of the respiratory system	4	3.2	1.5
(6)	Pedestrian injured in transport accident	4	3.2	1.5
(6)	Motor cycle rider injured in transport accident	4	3.2	1.5
(6)	Car driver injured in transport accident	4	3.2	1.5
(6)	Poisoning: accidental/undetermined intent	4	3.2	1.5

* This table does not include all causes of death. The percentage column, therefore, does not add to 100%. The percentage of deaths refers to the percentage of all young people aged 15 to 17 who died.

CHAPTER 5

The child death register – typology of child deaths in NSW 1999-2000

5.1 Motor transport fatalities

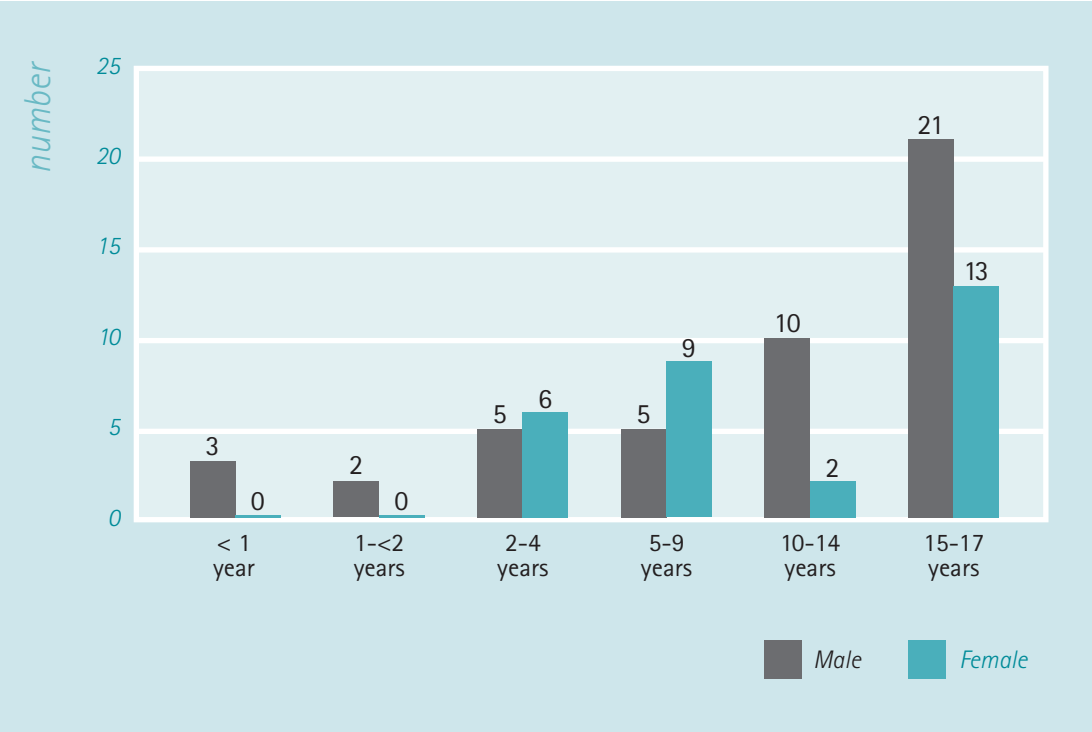
Table 12 shows that 76 children and young people died as a result of motor transport accidents (4.8 per 100,000 population). Males accounted for 60.5% of those fatalities. Nearly half of the children and young people who died as a result of motor transport accidents were passengers (37 out of 76 deaths, 48.7%) and just over one quarter were pedestrians (20 out of 76 deaths, 26.3%). Figure 3 illustrates the age and gender breakdown of the children and young people who died as a result of a motor transport incident.

Consistent with the prior three CDRT Annual Reports, the largest age group of motor related incidents involved 15 to 17-year-olds, especially 15 to 17-year-old males. Thirty-four of the 76 (44.7%) children and young people were in this age bracket. While 5 children died under the age of 2, a sharp increase in fatalities occurred for over 2 years of age, with 10 children aged between 2 and 4 years old, 14 children aged between 5 and 9 years of age and 12 children between 10 and 14 years of age all dying as a result of motor transport incidents.

TABLE 12 *Types of motor vehicle fatalities by gender*

Nature of fatality	Females *n*	Males *n*	Total *n*	Total *%*
Passenger	19	18	37	48.7
Pedestrian	7	13	20	26.3
Motorcycle	1	5	6	7.9
Car driver	3	1	4	5.3
Other	0	9	9	11.8
Total	**30 (39.5%)**	**46 (60.5%)**	**76**	**100.0**
Rate per 100,000 *(for ages 0-17)*	3.9	5.7	4.8	

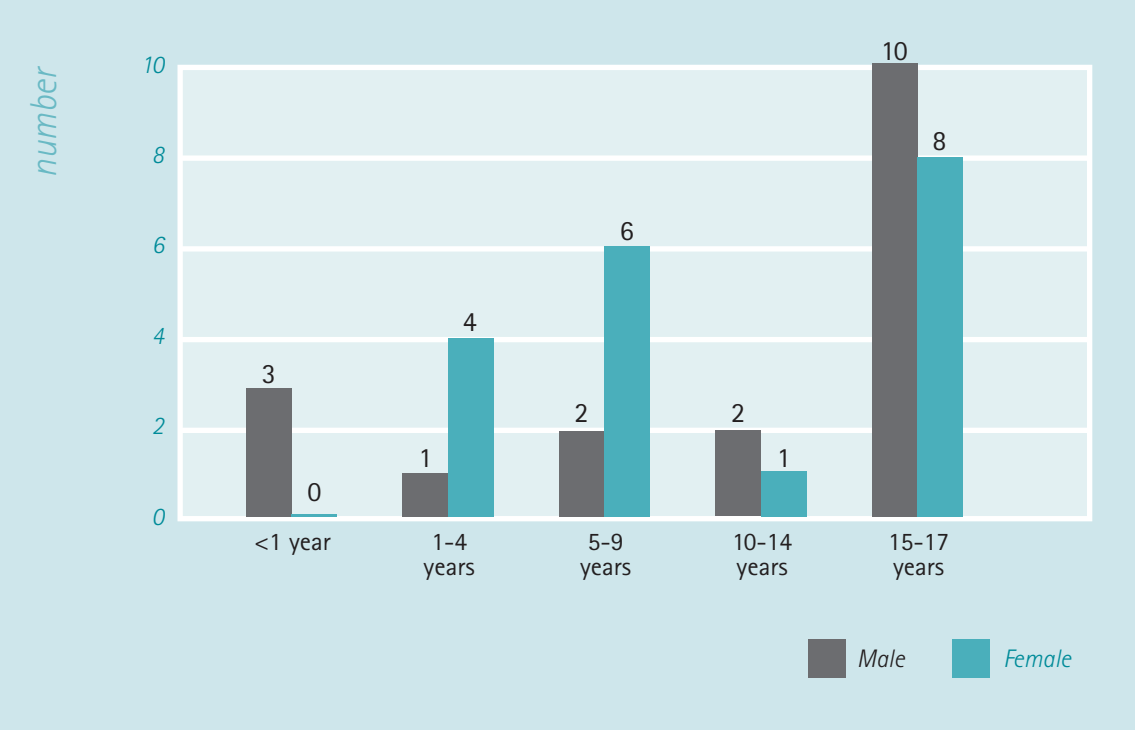
FIGURE 3 *Motor transport fatalities: Age at death by gender*



(i) Motor transport passenger fatalities

As Figure 4 illustrates, in the last reporting period, 37 children and young people died as passengers in motor vehicle accidents. These children died in 31 separate incidents. Five of these incidents involved multiple fatalities. Thirty-three of these fatalities involved the child or young person as a passenger in a car, the other four involved children as passengers in prime movers or table top trucks. This compares with 30 passenger deaths in 1998-99, 35 in 1997-98 and 31 in 1996-97. Nineteen of the fatalities involved females, 18 males.

FIGURE 4 *Passenger fatalities: Age at death by gender*



The mean age of the children and young people who died was just over 10 and a half years of age, the youngest child being 11 weeks old. Fifteen to 17 year olds were, however, the largest age group who died as passengers, accounting for 18 of the 37 fatalities (48.7%). Five to nine year olds accounted for the second largest age group of fatalities with eight (21.6%) in this age group.

(a) Position in car and time of incident

Table 13 indicates where the child or young person was sitting at the time of the incident.

TABLE 13 *Passenger fatalities by age at death and place in vehicle*

	Front passenger	Rear side	Rear centre	Other
<1 year	0	2	1	0
1 to 4 years	1	3	0	1
5 to 9 years	2	4	1	1
10 to 14 years	1	0	0	1
15 to 17 years	9	5	1	0

Table 14 indicates the age of the child or young person by the time at which the fatal incident occurred.

TABLE 14 *Passenger fatalities by age at death and time*

	6:01–12:00	12:01–18:00	18:01–24:00	24:01–6:00	Unknown
<1 year	3	0	0	0	0
1 to 4 years	4	1	0	0	0
5 to 9 years	3	5	0	0	0
10 to 14 years	1	2	0	0	0
15 to 17 years	4	0	9	3	2
Total	**15**	**8**	**9**	**3**	**2**

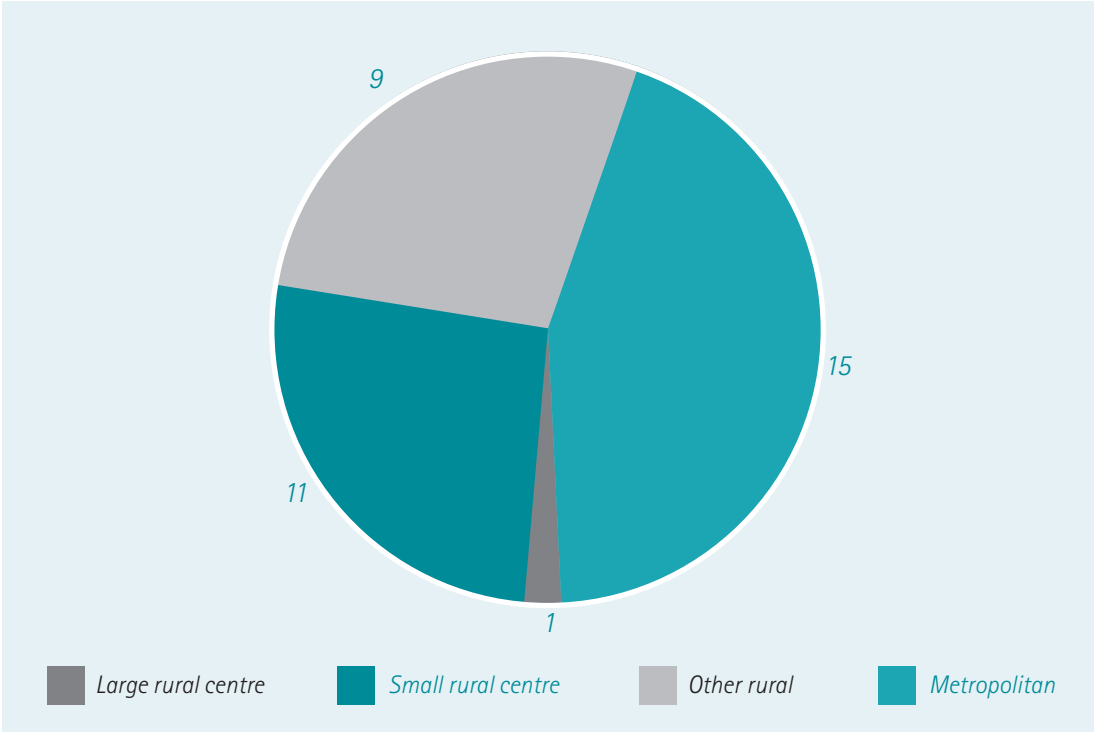
As Table 14 shows, the majority of these fatal incidents occurred between 6:00am and 12:00 noon. Fifteen of 37 deaths occurred in this time period. Moreover, all children aged under 14 years died during daylight hours. Seven of the 8 fatalities involving children under 5-years-old occurred between 6:00 am and 12:00 noon. Five of the 8 fatalities involving 5 to 9-years-old children occurred between 12:00 noon and 6:00 pm. From the information available to the CDRT it is unclear why this pattern exists, and it is difficult to make determinations regarding car use from only one year's data.

In contrast to fatalities involving younger children, at least 12 of the 18 fatalities involving 15 to 17-year-olds occurred in the evening, late at night or in the early morning. These 12 fatalities all occurred between 7:00 pm and 2:00 am. Incidents involving 15 to 17-year-olds are examined further below.

(b) Locality of fatal incident

Figure 5 illustrates the geographical destination of the incident, classified by the rural characteristics of the location of the incident[1].

FIGURE 5 *Fatality by region*



As Figure 5 indicates, the number of deaths on rural roads is an outstanding feature of these fatalities. Twenty-one of the 37 children and young people (56.8%) died on rural roads involving 18 separate incidents. These motor vehicle fatalities occurred predominantly in the vicinity of small rural centres or smaller rural localities. Thirteen of the 18 incidents occurred on rural highways or main roads. In addition, 15 deaths occurred in metropolitan areas involving 12 separate incidents. Of these, 8 occurred in Western Sydney, 2 in Northern Sydney, and 2 in the Blue Mountains.

In an examination of all road trauma fatalities in rural areas Graham (1999) found that while the number of traffic fatalities overall has decreased in the last twelve years, since 1996 an upward trend has been apparent in country areas. The increase in fatalities has been associated with increased incidents occurring on highways, involving 17to 25 year olds and involving risk-taking behaviours, particularly speeding, alcohol use, driving while fatigued and not wearing seat belts. In concluding Graham argues that an uneven share of the road safety burden occurs in the country. Passenger fatalities of 15 to 17 year olds in rural areas is also an especially concerning finding of this report.

1 These figures were determined from matching postcode data to rurality indicators. Statistical Local Areas are rated according to a seven point classification ranging from 'capital city' to 'other remote'. For further information see Arundell, 1991. The figures presented in Table 5 refer to the rurality of the location of the fatal incident, not the rurality of the usual residence of the child or young person.

(c) Precipitating events leading to fatal car incidents

The loss of control of motor vehicles by the driver of the car is indicated as the precipitating event leading to most of the incidents. The 'typical' scenario involves the driver losing control of the vehicle when attempting to negotiate a bend in the road, colliding with a fixed object, or veering onto the incorrect side of the road and causing fatal head on collisions with oncoming vehicles. In two incidents fatalities occurred when drivers attempted to overtake dangerously.

Two incidents involved heavy vehicles colliding with the rear of cars. A truck, loaded with heavy material failed to stop at an intersection, colliding into the rear of the vehicle and setting it alight. The truck was overloaded by two tonnes, and the rear brakes were out of alignment, resulting in negligible braking ability.

Four passengers in trucks, vans, or heavy vehicles were killed (2 males and 2 females). Three of the 4 children were unrestrained at the time of death. One of the fatalities involved driver fatigue. While exemptions to the use of seat restraints have existed for drivers of heavy vehicles, according to the Australian Road Rules (Commonwealth Guidelines), all persons under the age of 16 have to be suitably restrained in all vehicle types, including heavy vehicles. In these incidents the use of restraints may have prevented the deaths of several of these children.

(d) Passenger fatalities of 15 to 17-year-olds

The majority of incidents involving 15 to 17-year-olds involved situations similar to the other fatal incidents already described. Typical situations involved drivers losing control when negotiating bends, either veering into the path of an oncoming vehicle or colliding with a fixed object on the side of the road. For instance a 17-year-old driver veered over unbroken double lines when negotiating a bend, resulting in a head-on collision with an oncoming vehicle. The driver and the 16 and 17-year-old passengers were all fatally injured.

Of the 14 incidents, at least 8 incidents involved peer drivers. In at least 2 of these incidents the driver was under 18 years of age. The CDRT cannot be precise about the characteristics of the drivers in these incidents. The documentation received by the Team is limited to those of the children and young people who died. However in 4 incidents it is specifically mentioned that the driver had consumed alcohol. In 3 out of the 4 incidents there is specific mention that the fatal incident was alcohol related. In one fatality, the driver had been taking large doses of a pain killing drug, which may have affected her alertness, judgement and decision making ability.

Eight of the 14 incidents (57.1%) occurred in rural/regional settings. These rural incidents accounted for 10 of the 18 fatalities (55.6%) in this age group. Four of these incidents occurred on rural highways, 2 in residential areas and 1 on property. This incident involved a 15-year-old, who was unrestrained in the front passenger seat. The driver lost control of the vehicle on a dirt track and rolled.

(e) Key findings

While we cannot be conclusive regarding the reasons behind these fatalities, the high representation of young people, the nature of the traffic route and the locality of these incidents seem to be contributory factors. Key findings from this year indicate that 15 to 17 year olds are more likely to die as passengers than other age groups, that these incidents are more likely to occur in or around small rural centres or smaller rural localities, especially on highways or main roads, that passenger fatalities most predominantly involve front passengers and that such fatalities not only occur at night, but also occur in significant numbers during the morning and afternoon. Moreover younger children die in these incidents during the day, and older children die in incidents that occur at night.

(f) Conclusions: Passenger fatalities

These findings confirm that passenger fatalities will be prevented only when safe driving practices are continually reinforced. These incidents are suggestive of a fatal combination of difficult road conditions, developing driver capacity, and in some circumstances, speed and alcohol. The nature of these incidents should be investigated so that preventive measures can be developed. In particular this may involve determining the extent of public awareness of the numbers of fatalities on rural roads, examining the risk factors involved (including fatigue, drink driving, seat belt use, speed and driver experience) and the provision of safe road environments through safety auditing and identification of high risk sections of road. Again the importance of restraint use in all types of vehicles is a vital safety device. The use of seat belts may have prevented the deaths of some of these children.

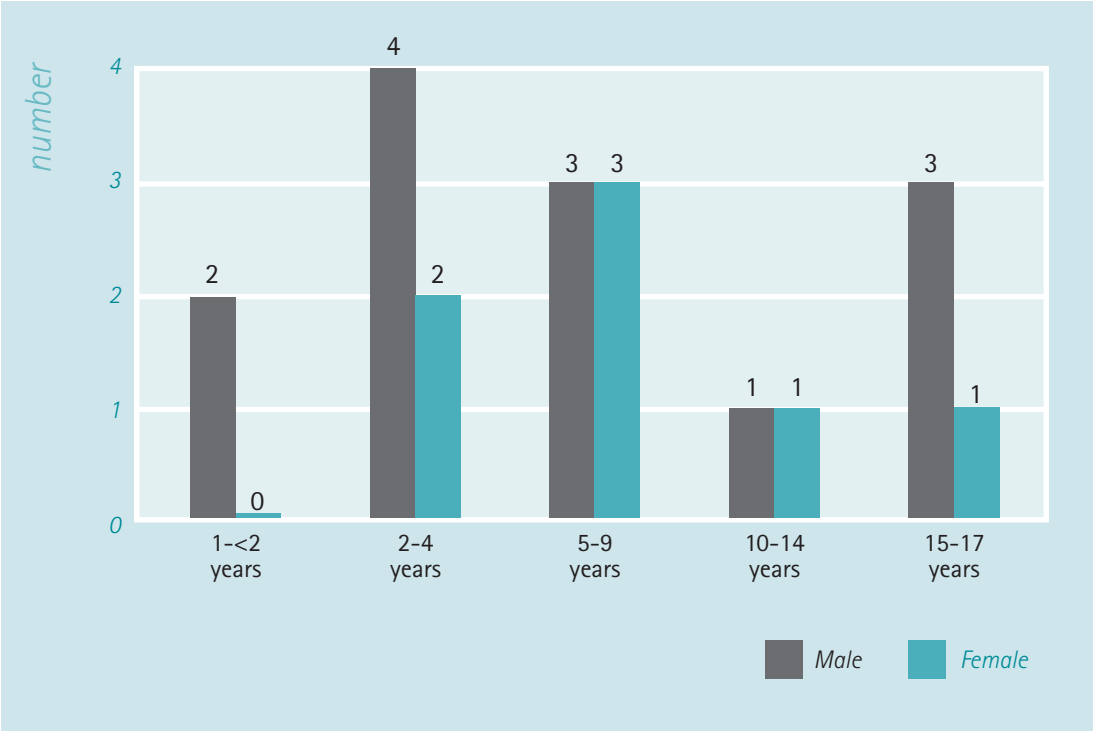
Recommendation 1

That the Motor Accidents Authority, in consultation with other relevant agencies, investigate fatalities of children and young people involving motor vehicles. This investigation should focus on fatal incidents that occur in regional and remote locations and continue to develop a range of practical measures to reduce the number of fatalities of children and young people involving motor vehicles across NSW.

(ii) Motor transport pedestrian fatalities

As Figure 6 illustrates, 20 children and young people died as pedestrians in this reporting period. Thirteen of the children and young people were male, 7 were female. Fourteen incidents involved cars, vans or pick-up automobiles, 3 incidents involved large trucks, 2 incidents involved passenger trains and 1 incident involved a public bus.

FIGURE 6 *Pedestrian fatalities: Age at death by gender*



The largest age groups represented are 2 to 4 year olds (6 fatalities) and 5 to 9 year olds (6 fatalities). While the numbers of deaths are small for comparative purposes, the age distribution is only partly consistent with other studies, which found that 5 to 9 year old males are over represented in pedestrian injuries and fatalities (Stevenson, Lo, Laing & Jamrozik, 1992).

(a) Road types and location

The distribution of road type involved is presented in Table 15.

TABLE 15 *Pedestrian fatalities by road type*

Age at death	Driveway/ Parking lot	Residential Street	Alternate traffic route	Highway/ causeway	Railway	Other
< 1year	0	0	0	0	0	0
1 to < 2 years	2	0	0	0	0	0
2 to 4 years	1	2	2	0	0	1
5 to 9 years	1	2	2	1	0	0
10 to 14 years	0	0	1	1	0	0
15 to 17 years	0	1	0	1	2	0
Total	**4**	**5**	**5**	**3**	**2**	**1**

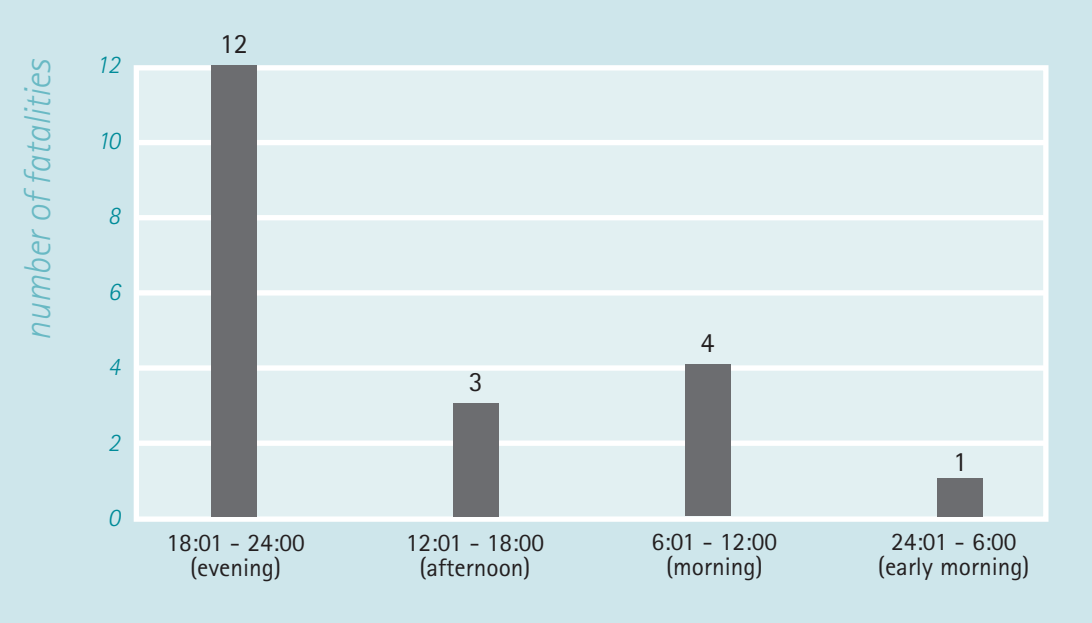
As can be seen in Table 15, 10 of the 20 incidents occurred on local unclassified residential roads or on alternate traffic routes. All 5 alternate traffic routes flow through urban residential areas. The incidents occurred at the intersection of dense traffic flows and residential vicinities. When including the four driveway fatalities, 14 of the 20 pedestrian fatalities occurred in close proximity to residential locales, and at least five incidents occurred where residential and dense traffic conduits were not separated.

That these incidents occur predominantly in urban environments is also confirmed by the geographical location of the incidents. Twelve of the 20 fatal incidents occurred in the Sydney metropolitan area. Eleven of these 12 incidents occurred in the South-Western and outer Western suburbs of Sydney. Of the other 8 incidents, 6 occurred in small rural centres, and 2 in other rural localities.

(b) Time of incident

Figure 7 indicates the time at which the fatal incident occurred.

FIGURE 7 *Time of fatal incident*



As can be seen 12 of the 20 incidents occurred between 6:00pm and 12:00 midnight. While all of the incidents involving young people aged 13 years or older occurred either in the evening or early morning (1 incident occurring at 2:00am) 8 incidents involving children under 7 years of age also occurred in the evening. This contrasts with previous research that has found that pedestrian injuries involving younger children occur in daylight hours, contrasting with incidents involving adolescents that occur at night (Guyer, Talbot & Pless, 1985).

While it is difficult to be conclusive from this information, visibility issues may have been a contributory factor in terms of the fatal outcome of these incidents. In at least 4 incidents, all involving children aged between 2 and 5 years, mention is made in Police statements that the combination of the child playing in the vicinity of the street or motor vehicle and the visibility issues resulted in the fatal circumstances. For instance a 5-year-old boy died while playing with other children running back and forth onto the road as part of their game. The young boy ran onto the road and was struck by a vehicle travelling at approximately 30-40 kph. It was dark and street lighting was poor. Cars parked on each side of the road also impaired visibility.

Several other incidents involved younger children in the care of older children. For example in one incident a 3-year-old ran onto the road after breaking free from the grasp of a 9-year-old friend. The child was killed by a car travelling at 50km in a 60kph zone[2]. Parked cars on the side of the road also contributed to the fatal outcome, obscuring the visibility of the children.

Two fatalities of children under 12 were directly the result of culpable driving. In one incident a car travelling approximately 50kph, failed to slow down or stop at a pedestrian crossing, in the other an unlicensed driver drove through a red traffic light colliding with a girl as she was crossing on the green walk signal.

(c) Incidents involving 15 to 17-year-olds

Four young people aged between 15 and 17 years died in pedestrian fatalities. Two were hit by trains, 1 by a semi-trailer and 1 by a sedan type vehicle. All the incidents involved either the presence of alcohol, speed, other circumstances implicating intentional self-harm, or a combination of several of these factors. All these incidents occurred in the evening, 3 late at night or in the very early morning on a weekend.

Three incidents involved high levels of alcohol. Two young people, 1 hit by a passenger train, the other run down by a semi-trailer travelling at 100kph in a 110 kph zone on an unlit highway, both had blood alcohol levels of over 0.15. A 17-year-old female was run over outside a residential property by a car, the driver of which had a blood alcohol reading of 0.125. High speeds were also involved in this incident.

A 15-year-old male was run over by a passenger train. As the train rounded a right veer in the line the young person made no attempt to move from the tracks and was run over by the train. While the police report excludes the possibility of suicide, the young person had a history of conflict with his family and had attempted suicide on one occasion. The morning prior to the fatal incident the young person had had an argument with his father and left home. That was the last time he was seen by his family.

(d) Driveway fatalities

In the 1998-1999 Annual Report the CDRT reported on 17 fatalities of children who had been killed in pedestrian incidents in driveways between January 1996 and June 1999. The Team reported on the large proportion of toddlers (under 4 years of age) who died as a result of these driveway incidents. The Team recommended that the NSW Motor Accidents Authority, in conjunction with other organisations, develop targeted strategies to reduce the number of these incidents, commission research into effective measures to reduce these fatalities and on completion of this research, make a case to amend Australian Vehicle Standards and Australian Building Standards accordingly.

2 While the likelihood of pedestrian death is less than 5% for vehicles travelling under 35 kph, the percentage death risk increases linearly for speeds over 35 kph, rising from approximately 25% death risk at speeds of 40 kph to approximately 80% death risk for vehicles travelling at approximately 60 kph (Roads and Traffic Authority, 2000).

In July this year authors from the New Children's Hospital released the results of a retrospective case analysis of driveway related injuries in children under 16 years of age admitted to the Hospital between November 1995 and February 2000 compared with driveway related deaths reported to the New South Wales Paediatric Trauma Death Registry (Holland, Rhea, Liang, Singh, Schell, Ross & Cass, 2000).

They found that typically, these incidents involved a parent or relative reversing a vehicle in the driveway over a pre-school age child in the late afternoon or early evening, and that four-wheel drive and light commercial vehicles were over represented and were associated with a 2.5 times increased risk of fatality. Given the association of fatalities with these types of vehicles and shared driveways, the authors recommended measures that would separate the child's play area from the hazard, as well as proximity warning devices to warn drivers of the presence of objects behind the vehicle.

In this report period, four further fatalities involved children under 5 years of age receiving fatal injuries in driveway incidents. The mean age of these children was 2 years and 7 months. The CDRT has information on 2 of the vehicles involved only, 1 being a four-wheel drive, the other a passenger van. The four fatalities involved 2 reversing and 2 forward moving vehicles. All were at low speed. Two of the incidents occurred in shared driveways, although 1 of these was a non-residential driveway, while the other 2 incidents took place in single driveways. In 2 incidents the driver was a parent of the child, in 1 incident the car was moved by a young sibling and the other incident involved an unknown adult. Two incidents occurred in the morning, between 8:30am and 11:00am, 1 occurred in the afternoon, and 1 occurred in the evening after 8:00pm.

(e) Key findings

The findings of this years report indicate several key issues. Pedestrian fatalities predominantly occurred in residential streets, or where alternate traffic routes flow through residential areas (showing the continued need for traffic separation and calming measures). In contrast to passenger fatalities, these incidents occurred in urban metropolitan environments, especially across south-west and outer-west Sydney metropolitan region. Visibility was a key factor contributing to many of the fatalities, both in terms of the time of day and parked cars obscuring the visibility of drivers. Several incidents also involved younger children in the care of older children or young children who were unsupervised at the time of their death. All incidents involving young people aged 15 to 17 years involved the interplay of 'traditional' risk factors including factors such as speed and alcohol. Four more driveway related fatalities occurred in this reporting period.

(f) Conclusions

Supervision remains a key issue in the prevention of pedestrian fatalities in young children. However strategies aimed at traffic calming and separating pedestrians from traffic are the key effective measure in reducing child pedestrian fatalities. Moreover these fatalities have broader implications regarding urban design and town planning for children and families. The adolescent deaths again indicte that risk-taking behaviours, especially involving alcohol can have fatal outcomes.

(iii) Motorcycle fatalities

Six motorcyclists were killed during this 12 month period. Alcohol was not identified as a contributing factor in any of these fatalities. Only one of the six, a 17-year-old, was female. The other five motorcyclists were males aged 11 and 14 to 17 years of age. The 11-year-old was a pillion passenger on a motorcycle ridden by his father. Three incidents involved young people riding unregistered bikes on roads, and one young person was killed while participating in an organised motocross event.

(iv) Car driver fatalities

Four drivers (3 females and 1 male) were killed in motor vehicle accidents. One of the females was 15 years of age, and the remaining females and the male were all aged 17. The 15-year-old had taken anti-depressants and was driving without a license at the time of the incident. She lost control of the car when it came onto a gravel surface and collided with several trees.

(v) Pedal cyclist fatalities

In this 12 month period, 2 males aged 13 and 16 years of age were killed while riding push bikes. The death of the 16-year-old happened under dark and foggy conditions. He was riding on a road side with another rider. Both riders were wearing dark clothing and had no lights on their bikes. A truck driver travelling along the same road saw the 2 cyclists only at the last moment and swerved to try and avoid them.

(vi) Water transport fatalities

Two males (aged 11 and 14 years) were killed in water transport accidents. The 11-year-old died when he was hit by a boat when he waded into waist deep water going directly in the path of the boat. The 14-year-old was the passenger in a boat that was being tested before a ski race. The boat flipped over while travelling at a speed of about 108 mph[3].

3 As a result of the accident, the Coroner made a recommendation to the Minister for Ports that no person under the age of 18 years be allowed to travel in any vessel on the waterways at a speed in excess of 70 mph.

5.2 Drowning

As Table 16 shows, 20 children and young people died as a result of drowning in this reporting period. Of the 20, 16 were males and 4 were females.

TABLE 16 *Drowning by gender and age at death*

Age at death	Females	Males	Total
Under 1 year	1	0	1
1 year	1	7	8
2 years	1	1	2
3 years	0	4	4
4 years	1	0	1
14 years	0	1	1
15 years	0	2	2
16 years	0	1	1
Total	**4**	**16**	**20**
Rate per 100,000	**1.4 (for ages 0-4)**	**2.2 (for ages 1-16)**	**1.3 (for ages 0-16)**

There were no 5 to 13 year olds or 17 year olds who died as a result of drowning in this reporting period.

Drowning was the third most prevalent external cause of death for all children and young people aged under 18 years and was the leading cause of death for 1 to 4-year-olds, accounting for 15 of the 108 child deaths in this group. This equates to a crude incidence of 4.3 per 100,000 population. This is a similar incidence to that determined by Mackie (1999) in an examination of all accidental non-boating drowning deaths in Australia between 1992 and 1997. This compares to a rate of 1.44 per 100,000 for all age groups. Ten of the 20 children (50%) were aged between 1 and 2 years of age. Sixteen of the 20 fatalities (80%) involved children under the age of 5 years. Overall children aged under 5, in particular those aged between 1 and 4 years of age are most vulnerable to drowning. The age distribution of deaths indicates that a range of factors relating to increasing developmental capacities of children in conjunction with increasing overconfidence in children's ability to remain safe for longer periods of unsupervised play, become fatal in the context of unsafe water environments.

While the majority of drowning fatalities involved children under 5 years of age, 4 of the 20 fatalities involved young males aged between14 to 17 years of age. No children aged between 5 to 13 years of age died as a result of drowning in this reporting period.

(i) Location of drowning

As Table 17 illustrates, private swimming pools and natural bodies of water (lakes, creeks, rivers and lagoons) were the most common location of drowning in the current reporting period. Seven children, all aged between 1 to 4 years died in private swimming pools and 7 children, including 3 aged between 1 to 4 years of age and 4 aged between 14 to 17 years of age died in natural bodies of water. With the exception of these 7 deaths (and 1 death about which the CDRT has no other information), 12 of the 20 fatalities occurred in the home environment of the child or of a carer of the child.

TABLE 17 *Location of drowning*

Location of Drowning	<12 months	1 to 2 years	2 to 4 years	10 to 14 years	15 to 17 years	Total
Swimming Pool	0	4	3	0	0	7
Bath tub	1	1	0	0	0	2
Dam	0	2	1	0	0	3
Lake/Creek/ Lagoon/River	0	1	2	1	3	7
Unspecified	0	1	0	0	0	1

(ii) Dams

Drowning in dams is the leading cause of farm related fatalities for 0 to 4 year olds. Nationally 30 children between 0 and 4 years of age drowned in dams between 1989 and 1992 (Franklin, Mitchell, Driscoll & Fragar, 2000).

In this reporting period 3 children aged between 19 months and 3 years drowned in dams on family rural properties. These incidents share some similar characteristics to drowning which occur in swimming pools. All 3 incidents involved mobile and curious children wandering off without the knowledge of a parent, most usually in close proximity at the time. In all the incidents the child wandered off when the parents attention was temporarily turned away from the child. In 1 incident the fatality occurred while the parent was attending to usual work activities. In 2 incidents the dam was in relatively close proximity to the house and in another close to work sheds. In 1 incident the dam had a flat area entry. Two dams were unfenced from the home residence. One of the dams was fenced from the residence and it is unclear how the child was able to access the dam.

While it is impractical to fence dams with isolation fences, mechanisms are necessary for separating children from these hazards, including boundaries between play areas and other areas of the property.

Currently the top priority of the National Water Safety Plan is the implementation of the Drowning Prevention Program to reduce the number of 0 to 5 year olds drowning and near drowning incidents by 50%. The National Plan also identifies rural communities as a target area for reducing drowning, specifically mentioning dams as a key location for rural drowning. These strategies need to be confirmed and strengthened at state level.

Recommendation 2

That the NSW Water Safety Taskforce develop targeted strategies as part of the NSW Water Safety Plan to reduce the number of child deaths, particularly of children under 5 years of age, caused by drowning on farms and especially in dams.

(iii) Bodies of natural water

Seven drownings occurred in natural bodies of water. Two fatalities occurred in lakes, 2 in creeks, 1 in a river and 1 in a lagoon adjacent to the ocean. Five of the 7 incidents occurred in the context of recreational activities or family outings. The number of drownings in bodies of water such as creeks and rivers indicates that these bodies of water can be exceptionally hazardous. One commentary has indicated that the difficulty in preventing these fatalities may be linked to lack of community understanding of the potential dangers of these types of waterways (Cass, Ross & Grattan Smith, 1991).

All the young people aged over 14 who drowned died in such waterways. Three of the 4 incidents involving 14 to 17-year-olds occurred while the young person was engaged in a recreational activity. In one instance the young person had a blood alcohol reading of 0.017. The fourth incident involved a 15-year-old male who fell from a jetty into a lake probably as a result of an epileptic seizure. It seems that the seizure occurred because of non-compliance with his medication. This young person had a blood alcohol reading of 0.012.

The three other fatalities involved a 16-month-old male, 3-year-old male and 4-year-old male. Two of these incidents occurred while the child was on a family outing. Both of these involved the child being momentarily unsupervised around bodies of water. The 16-month-old drowned in a lake after wandering away from her family whilst on a family picnic and the 3-year-old drowned after falling into a deep lagoon leading into the ocean. He was playing nearby unsupervised. The 4-year-old died after falling into a creek on his family's property after wandering off from the rear yard of his home with his younger sister who was later found in the surrounding paddocks.

(iv) Swimming pools

Swimming pools are the most prevalent bodies of water associated with the drowning deaths of under 5-year-olds (National Injury Prevention Advisory Council, 1999). Seven fatalities occurred in swimming pools in this reporting period. All the children who drowned in pools were aged between 1 and 4 years of age. Two children were female, 5 were male.

As in other years, accessible swimming pools represent a significant hazard to child safety. At least 6 of the 7 fatalities were the result of inadequate fencing or improperly used fencing. The *Swimming Pools Act 1992* requires owners and occupiers of premises containing a swimming pool to ensure that a functional child resistant barrier surrounds the pool. Different standards exist for pools built before and after 1 August 1990. Isolation fencing is required post August 1990, and for existing pools the dwelling may form part of the perimeter fencing. The law also provides for local authorities to examine barriers or other means of restricting access to the pool. This is non-mandatory and relies upon the resources of individual councils to conduct inspections. In response to the consistent pattern of drowning, in swimming pools over the last 3 reporting periods, the CDRT recommended that the Minister for Local Government and the Minister for Sport and Recreation develop targeted strategies to reduce these deaths, evaluate current measures to reduce pool drowning and examine the introduction of a mandatory pool inspection program.

Evaluations of pool fencing indicate that isolation fencing increases protective factors four fold when compared to pools with no fences, and are significantly more protective than perimeter fences (Thompson & Rivara, 1997).

As in previous reports, all the children who died gained access to the pool without their parents' or carers' knowledge. In one incident, a 20-month-old drowned when the carer left the child with other children while she prepared lunch. In the short time (unspecified) that the child was left unsupervised, the child was able to climb up on the pool filter and fall into the pool, described as an above ground pool and only partly filled to a depth of 500 mm. The pool was unfenced. The Coroner notes that the lack of a fence was not in breach of the *Swimming Pools Act, 1992* as it came under the exceptions for large properties under section 9 of the Act. It would appear from the Coroner's comments that the current legislation does not require pools of this type to be fenced. This has prompted the CDRT to make the following recommendation –

Recommendation 3

That the Department of Local Government, in consultation with the NSW Water Safety Taskforce, undertake a review of all exemptions to child proof fencing that exist in the *Swimming Pools Act 1992*. This legislative review should be guided by evaluating the most effective and appropriate amendments to ensure the prevention of drowning and near drowning incidents in swimming pools.

In another incident, a 19-month-old drowned in a pool surrounded by a 1.5 metre wire fence. It is unclear whether the gate was left open by siblings who had recently returned from the area. There was no information regarding the child proofing of the lock. It is unclear whether the child gained access through the fence or via an open gate.

In another incident, a 2-year-old used a chair to climb over a 1 metre fence. The child was left unsupervised inside the house. The pool was built next to the family home, and the fence was described as a temporary fence, made of light gauge wire mesh. Another incident involved a 4-year-old who gained access to the family swimming pool by crawling through a large opening in the veranda fence that leads onto the pool. The child was seen 5 minutes prior to her death. It is noted in the P79A that the large openings in the veranda fence are part of the design of the fencing rather than a result of damage or disrepair. In another incident a 3-year-old crawled underneath a wire cyclone fence to gain access to the pool.

In only one incident was the pool surrounded by isolation fencing. The child gained access to the pool because the gate to the pool was left open.

Again it appears that the coincidence of momentary lapses in supervision, and inadequate fencing can result in a fatal outcome. Assuming that older children will be able to supervise younger children at pool sites, especially where fencing provides inadequate or non-existent barrier is a false and possibly dangerous assumption.

(v) Baths

Bath tub drowning requires careful investigation to determine the nature of the incident. Epilepsy, substance use by parents, acute cardiac arrest and child abuse and neglect have all been implicated in studies of these deaths (Mackie, 1999). In this reporting period a 17-month-old and an 11-month-old drowned while in baths. The 17-month-old drowned in an indoor spa bath. The child had been left unsupervised but it was not clear from documentation for how long.

The 11-month-old died in the bath at home unsupervised. This child was the subject of review and is examined in the section on Neglect in this Annual Report.

(vi) Conclusion

Key findings indicate that young children are at risk of drowning, especially in bodies of water at home, and especially in swimming pools. Leaving young children unsupervised or in the care of older children, around accessible bodies of water can lead to a child drowning. Again isolation fencing around swimming pools, correctly used, would have saved the lives of a number of these children. Findings also suggest that separating children from other water hazards, particularly on farms, is an important step in reducing these types of fatalities. What these findings also point to is the need for continual measures to raise public awareness of the dangers of drowning in natural bodies of water. This is particularly so in relation to recreational activities involving young people in their teens.

These findings provide further reinforcement for the recommendations made by the CDRT in the 1998-99 Annual Report and those of Nixon and colleagues (1995). These recommendations focus on developing a range of measures to reduce child drowning, the need for compilation of better coronial information, more detailed police investigation of cases where toddlers have drowned in pools and baths, the need to evaluate mandatory inspection programs for outside pools, the need for greater scrutiny of drowning in bath tub deaths and the need for detailed study of adolescent drowning.

5.3 Suicide

Deaths were categorised as 'suicide' where the P79A (Police Report to the Coroner), final autopsy report or the Coroner's Action Cover Sheet described an intentional self-harming method, the young person left a suicide note or in some other way expressed an intention to take his or her life. Deaths associated with risk-taking behaviour (for example, drowning, dangerous use of motor vehicles with drugs and/or alcohol) have not been categorised as being due to suicide because there was inadequate evidence to determine whether the death was intentional or not.

Nineteen young people (11 males and 8 females) died as a result of suicide in this period (see Table 18).

TABLE 18 *Suicide by gender and age at death*

Age at death	Females	Males	Total
13 years	0	1	1
14 years	1	1	2
15 years	2	0	2
16 years	1	4	5
17 years	4	5	9
Total	**8**	**11**	**19**
Rate per 100,000	**4.7 (for ages 14–17)**	**4.9 (for ages 13–17)**	**4.3 (for ages 13–17)**

Table 19 shows the method of suicide by gender. Hanging was the most common suicide method, with 16 of the 19 (9 males and 7 females, 84.2%) young people dying as a result of hanging.

TABLE 19 *Method of suicide by gender*

Method of suicide	Females	Males	Total
Hanging	7	9	16
Jumping from high place	1	1	2
Gunshot	0	1	1
Total	**8**	**11**	**19**

(i) Youth suicide study

The NSW Commission for Children and Young People, the CDRT and the Centre for Mental Health are undertaking a research project on youth suicide. This project will investigate self-harm, risk-taking behaviour, and suicide in young people under 18 years of age and the factors that are associated with these behaviours. The findings will inform strategies for preventing the deaths of young people from self-harm, risk-taking, and suicide.

An in-depth review was undertaken of the death of 14-year-old Tim. The case shows the effects of long-term child neglect and abuse on the development of the young person.

Tim was 14 years old when he hung himself in his backyard. He was found by a neighbour who notified the police. When the police arrived at the house, they found Tim's father inside a bedroom sitting with a box of syringes. Drug paraphernalia was located in Tim's room. Low levels of methadone and methamphetamine and a sedative were found in Tim's body, and there were puncture marks on one of his arms.

Tim was the subject of reports of child maltreatment to the DoCS since he was 7 years of age. In the first notification to the Department Tim's mother had hit him 10 times and Tim had smashed a window. File review shows that there is a long history of chronic social problems in this family with varying levels of agency intervention.

Tim's father was reported to be a heroin addict. There was a history of long-term domestic violence in the family and Tim's father was the subject of Apprehended Violence Orders (AVOs). Tim's father had apparently threatened to commit suicide and blamed Tim for his problems. Six months before his death, Tim ran away to escape his father's violence. Tim's mother was ambivalent towards Tim, she refused to follow up counselling appointments, and did not believe a convicted paedophile was a threat to Tim's well-being.

Although DoCs at times adopted a supervisory and supportive role with Tim, it is not evident from review that there was adequate critical assessment about this family's capacity to change and promote Tim's well-being. The peak of DoCS intervention occurred when DoCS looked for alternative schooling for Tim. Then without any documented reasons on file, in the three months prior to Tim's death, there was no contact between DoCS and Tim and his family.

This case highlights the need for critical caseplanning in cases of chronic neglect and emotional abuse. These areas of child protection practice have been examined in past CDRT reports. The case suggests that recommendations 4.1, 5.1, and 6.1 of the 1997-1998 CDRT Report regarding Recognition, Assessment and Referral are still relevant.

5.4 Sudden Infant Death Syndrome and sleep accidents

A CDRT subgroup reviews all deaths attributed to SIDS, sleep accidents, bed-sharing, and undetermined causes in the final autopsy report. The function and purpose of the reviews by the subgroup is unique and is different from the role of the Coroner. The subgroup reviews sleep accidents as a group, looking for trends in order to make recommendations about systemic issues for prevention of this group of deaths. By reviewing the whole group of cases, the subgroup is able to highlight issues that may not be apparent from the Coroner's case-by-case determination. This not only includes noting trends, but discovering anomlies in attributing deaths in similar circumstances to SIDS, bed-sharing, positional asphyxia or as 'undetermined'.

In this reporting period, 35 infants died in bed. The Team determined that the deaths of 18 infants were attributed to Sudden Infant Death Syndrome (SIDS). A further 12 infants died from accidental suffocation in bed, 4 infants died from undetermined sleep accidents, and one infant died while sleeping, although the death was attributed to physical abuse.

Differences between the Coroner's and the Team's determination of cause of death were noted for 12 of the 35 cases. These are summarised in Table 20.

TABLE 20 *SIDS and sleep accidents: Cause of death determined by Coroner and CDRT subgroup*

Number of cases	Cause of death determined by Coroner	Cause of death determined by Team
5	SIDS	Accidental suffocation in bed
2	SIDS	Undetermined
3	Undetermined	Accidental suffocation in bed
1	Undetermined	SIDS
1	Undetermined	Physical abuse

As discussed in the Methodology section, the Team reviews every child death that is attributed to SIDS or that occurs in bed. Cases that are regarded as suspicious are given in-depth reviews. In this reporting period, 8 child deaths were given such in-depth reviews. Four of those reviews were of child deaths that were attributed to SIDS and 4 were of deaths that were attributed to accidental suffocation in bed.

(i) Sudden Infant Death Syndrome

(a) Characteristics

The 18 child deaths from SIDS (8 males and 10 females) are summarised in Table 21. Two of those infants were co-sleeping. Two of the 18 infants were Aboriginal (although there has been shown to be a higher rate of SIDS in the Aboriginal community in Western Australia; Eades, Read and the Bibbulung Gnarneep Team, 1999).

TABLE 21 *SIDS by gender and age at death*

Age at death	Females	Males	Total
Under 1 month	1	0	1
1 to under 2 months	3	0	3
2 to under 3 months	2	3	5
3 to under 4 months	1	3	4
4 to under 5 months	1	1	2
5 to under 6 months	1	1	2
7 to under 8 months	1	0	1
Total	**10**	**8**	**18**
Rate per 100,000	24.2	18.4	21.2

Sleeping location and position put to sleep have been factors studied in connection with SIDS (Mitchell, 2000). Eight of the 18 infants whose deaths were attributed to SIDS were put to bed in a cot and 3 were placed in bassinettes placed inside cots. A further 4 infants were sleeping in adult beds, 1 was in a stroller, 1 on a lounge, and 1 was placed on a bouncinette.

Nine of the 18 infants were placed on their backs when put to sleep, 4 were placed on their sides, 1 infant was placed partly on his side and partly on his stomach, and no information is available for 4 infants as to the position in which they were put down to sleep.

Six of the 18 infants whose deaths were attributed to SIDS were found lying face down, 5 were lying on their backs, 3 were on their sides, 1 was partly on his side and partly on his stomach, and no information is available for 3 infants as to the position in which they were found. For 1 of those infants, however, the police report indicated that a blanket was covering her face and she was wet from sweating.

It has been established that cigarette smoking increases the risk of SIDS (Eades, Read and the Bibbulung Gnarneep Team, 1999). For 6 of the 18 infants whose deaths were attributed to SIDS, one or both parents were smokers. For the remaining 12 infants, however, information was not provided as to whether the parents were smokers.

(b) In-depth case reviews – SIDS

Four cases of infants whose deaths were attributed to SIDS were given in-depth reviews. One infant died while sleeping in her bassinette that was placed inside a cot. The position in which she was put down was unknown, although she was found lying face down in the bassinette. One infant was asleep on a lounge. She was placed partly on her side and partly on her back and was found in the same position. Her mother had fallen asleep on the floor in the same room next to a heater that had been left on all night. One infant was put to sleep in a queen size bed. The position he was put down in is unknown, although he was found on his left side covered up to the chest area with a doona. One infant was lying in a stroller, although the position is unknown. He was found on his back in the stroller and the police report indicated that the room he was situated in was warm, humid, and stuffy, with poor ventilation.

The parents of 2 of the 4 infants whose deaths were attributed to SIDS were smokers. For the other 2 infants, no information was available.

(c) Comment

The analysis of the SIDS data and the in-depth case reviews of child deaths attributed to SIDS suggest the continued need for public education regarding the risk factors for SIDS, such as:

- the unsuitability of putting infants to sleep in unorthodox locations
- poor ventilation
- parents' smoking behaviour
- infants' sleeping position: 'back to sleep'

(ii) Accidental suffocation in bed

(a) Characteristics

The 12 deaths from accidental suffocation in bed (8 males and 4 females) are summarised in Table 22. Nine of the 12 deaths were in circumstances of bed-sharing.

TABLE 22 *Accidental suffocation in bed by gender and age at death*

Age at death	Females	Males	Total
Under 1 month	1	0	1
2 to under 3 months	1	4	5
3 to under 4 months	1	0	1
4 to under 5 months	0	1	1
5 to under 6 months	1	1	2
7 to under 8 months	0	1	1
8 to under 9 months	0	1	1
Total	**4**	**8**	**12**
Rate per 100,000	9.7	18.4	14.2

Eight of the 12 infants who died from accidental suffocation in bed were sleeping in an adult bed, 1 was in a water bed, 1 was in a cot, 1 was sleeping with his mother on a single mattress on the floor, and 1 was in a bassinette. Five of the 12 infants were lying on their backs when put to sleep, 2 were cradled in their mothers' arms, 1 was lying on his side, and no information is available for 4 infants as to the position in which they were put down to sleep.

Three infants were found lying on their backs, 3 were found lying face down, 1 was still cradled in mother's arm, 1 infant's face was nestled in mother's side, 2 were on their sides, 1 of whom was found wedged between the bed and the frame, and no information is available for 2 infants as to the position in which they were found.

Three of the 12 infants who died from accidental suffocation in bed had parents who were smokers, and for 8 of the remaining 9, information was not provided as to whether the parents were smokers.

Alcohol and other drug use was a factor for 4 infants whose deaths were attributed to accidental suffocation in the context of bed-sharing. In one case, the infant's parents were on methadone. In three cases, one or both parents had consumed alcohol during the day and/or evening of the infants' deaths. In one of those cases, the father's arm was covering the infant's face. For 7 of the remaining 8 cases of infants whose deaths were attributed to accidental suffocation in bed, information was not provided as to whether the parents used alcohol or other drugs.

(b) In-depth case reviews – accidental suffocation in bed

Four cases of infants whose deaths were attributed to accidental suffocation in bed were given in-depth reviews. For 3 of the 4, bed-sharing was a factor. Those 3 infants were put to sleep in their parents' bed, together with one or both parents. One was placed on his back, although the position in which he was found is not known. One infant went to sleep cradled in his mother's arms and was found on his back lying next to his mother. For the third infant the position in which he was placed and found is not known. The fourth infant was put to sleep in a bassinette and was found face down in the bassinette with a nappy partially covering her face.

For 3 of the 4 infants whose deaths were reviewed, one or both parents were smokers. In addition, for 2 of the 4 infants, one or both parents had consumed alcohol during the day and/or evening of the infants' deaths. Further, the parents of one of the infants, (Baby Daniel), were on methadone at the time of the infant's death.

> *The mother was on a daily dosage of methadone 40ml, and the father was on a daily dosage of methadone 130ml. The mother informed police that she frequently stole her husband's methadone and replaced it with water. She had done so on the morning of her son's death. She also said that because of her extra methadone that morning, her sleep may have been heavier than usual and she wondered whether this might have caused her to roll over her son. Toxicological analysis of the infant's samples taken at autopsy detected methadone at levels of 0.04mg/L in blood and 0.09mg/kg in liver. (These levels are below those reported to be fatal in children; Smialek, Monforte, Aronow & Spitz, 1977).*

The in-depth reviews of the child deaths caused by accidental suffocation in bed in circumstances of bed-sharing suggest that recommendation 18.3 of the 1998-1999 CDRT Report is still relevant. This recommendation states that NSW Health develops a range of targeted services to stress the dangers of bed-sharing when combined with parental intoxication and smoking, particularly regarding infants.

(iii) Undetermined sleep accidents

Four infants, 2 males (aged 6 and 10 weeks) and 2 females (aged 12 hours and 6 months) died from undetermined sleep accidents. One of those infants was co-sleeping.

Two of the 4 infants were put to sleep in cots. One was placed on her side and later found lying face down, and for the other infant no information is available as to the position in which she was put down to sleep or found. One infant was asleep on his mother's bed. He was put to sleep lying on his back and later found lying face down. One infant was sleeping in his mother's arms and later found in the middle of the bed.

Information was not provided for any of the 4 infants as to whether the parents were smokers. Drug use was a factor for 1 infant whose death was classified as an undetermined sleep accident. The infant's mother was on a methadone program. Her daily dosage had recently been reduced from 12 to 11ml.

(iv) Key findings

A summary of factors noted on files in deaths of infants from SIDS, accidental suffocation in bed, and undetermined causes is presented in Table 23.

TABLE 23 *Factors for SIDS, accidental suffocation in bed, and undetermined sleep accidents*

Factors		SIDS	Accidental suffocation in bed	Undetermined
Co-sleeping	Yes	2	9	1
	No	16	3	3
	Unknown	0	0	0
Smoking	Yes	6	3	0
	No	0	1	0
	Unknown	12	8	4
Alcohol/other drugs	Yes	0	4	1
	No	4	1	1
	Unknown	14	7	2

There were 35 deaths of infants in bed that were attributed to SIDS, accidental suffocation in bed, undetermined sleep accidents, and physical abuse. The analysis of these deaths shows that there is incomplete information on these deaths. It is unknown, for example, in 14 of SIDS cases whether parents were using alcohol or other drugs and whether parents were smokers in 12 SIDS cases. At present, insufficient information is available to give reliable advice to parents about infants' safety and sleeping yet significant numbers of children die in these circumstances.

Recommendation 4

That the Government fund the CDRT to undertake a research project to investigate the deaths of infants in bed. This project would include the appointment of a researcher to collect information from bereaved families at the time of the infant's death.

5.5 Assault

Fourteen children and young people died as a result of assault in the registration period July 1999 to June 2000, as shown in Table 24. The category of assault in this report is not comparable to prior CDRT report categories of 'non-accidental injury' and 'homicide', and direct comparison between these categories should not be made. Of the 14, 10 were males and 4 were females. Ten of the 14 young people were 5 years of age or under.

TABLE 24 *Assault by gender and age at death*

Age at death	Females	Males	Total
Under 1 year	1	2	3
1 year	0	1	1
2 years	0	2	2
4 years	2	1	3
5 years	1	0	1
13 years	0	1	1
14 years	0	1	1
16 years	0	1	1
17 years	0	1	1
Total	**4 (28.6%)**	**10 (71.4%)**	**14 (100.0)**
Rate per 100,000	1.6 (for ages 0-5)	1.2 (for ages 0-17)	0.9 (for ages 0-17)

There were no 3 year olds, 6 to 12 year olds, or 15 year olds who died as a result of assault in this reporting period.

Table 25 presents the causes of death of the 14 children and young people who died as a result of assault.

TABLE 25 *Assault: Cause of death by gender and age at death*

Age at death	Gender	Cause of death
1 hour	female	assault by knife in utero
6 months	male	'Shaken Impact Syndrome' – provisional autopsy
7 months	male	autopsy not available
1 year	male	assault by suffocation
2 years	male	physical abuse
2 years	male	non-accidental internal injuries – no other information
4 years	male	assault by suffocation
4 years	female	strangulation and stab wounds to chest
4 years	female	burns – autopsy not available
5 years	female	sexual assault and hanging
13 years	male	assault by gun
14 years	male	assault by sharp object
16 years	male	physical assault
17 years	male	assault by blunt object

In this reporting period there were 3 cases of assault that were subject to review (the other cases will be reviewed in following reporting periods when documentation becomes available)[4]. The 3 cases reviewed involved a murder-suicide of a 4-year-old girl (Emma), a stabbing of a 14-year-old boy (Kyle), and a 2-year-old boy (Gregory) who was assaulted and shaken to death. The review of the death of Emma, a murder-suicide, did not point to avenues for systemic prevention. In the 2 cases of alleged homicide, there are criminal charges pending, so case details will not be given. The in-depth review of the deaths of Gregory and Kyle, highlight continuing inadequacy in child protection work.

4 For cases subject to an inquest coronial documentation becomes available after a longer time period.

There were deficiencies in case planning, documentation and follow-up of decisions in the cases, including lack of review at case closure. Recommendations 4.1 and 7.1 from the 1997-1998 CDRT Report remain particularly relevant. Changes recommended in previous CDRT reports are still being implemented by departments (as shown in the monitoring of recommendations chapter). The Team will continue to monitor departments' progress on these issues.

The new *Children and Young Persons (Care and Protection Act) 1998* due for implementation should significantly impact on practice, policy and services. The Team anticipate that over the next two years, as these reforms are implemented the need for these recommendations should diminish. It is important this legislation is enacted in a timely way.

5.6 Neglect

Part of the Team's mandated role is to undertake detailed reviews of deaths of children that are due to child neglect. Neglect is characterised as the failure of a parent to act to ensure the health, safety and well-being of the child. Neglect can include inattention to the child's physical needs so the child is not adequately fed or clothed, or does not receive treatment for a medical condition. Other forms of neglect are failure of a parent to ensure the child's safety and welfare. For example, the child may not be supervised as is necessary according to the child's age and developmental stage.

Critical to a child's healthy growth and development is emotional nurturance by a parent (or constant caregiver). In some cases of neglect a child may not receive adequate social or cognitive stimulation to facilitate development and attachment.

The direct causal relationship between a parent's omission to act and a child's death is often difficult to determine. One difficulty is the reliability and accuracy of evidence from the suspect parent's account of the child's death. The role of the Team is not, however, a legal or investigatory role, but is rather to review the deaths which appear to be from neglect in order to make recommendations for structural change for prevention of child deaths.

There were 4 cases of drowning that were reviewed in the 1999-2000 reporting period and two of these cases indicate suspicious circumstances. In the case of Baby Rose there has not yet been a final coronial determination however the case points to the need for effective interagency work in cases of child neglect particularly in the following areas. These have been the focus of previous CDRT recommendations (4.1 and 5.1 of the 1997-1998 Report) and they remain relevant.

The new Interagency Guidelines will again provide a framework for effective interagency child protection intervention. It is expected that the implementation of these Guidelines will increase the effectiveness of interagency work in cases of child maltreatment including cases of neglect.

The second case of drowning reviewed indicates suspicious circumstances although there is insufficient information available to make a final determination.

The death of 3-year-old Amanda was not investigated by the Coroner, despite its unusual aspects. The Inquest was dispensed with and the reasons for this were not documented. Without a Coronial Inquiry there are missing pieces of information and questions remain around the circumstances of her death.

> *Three-year-old Amanda had a bath with her mother in the family home. The mother got out of the bath and left the child alone. A short time later, the father found Amanda floating in the bath water. The child had scalding to her face, neck, shoulders and armpits. Upon investigation it was found that the bath was completely full of water.*
>
> *Amanda had not been reported as a child at risk to the Department of Community Services. Her father had several children from a past relationship who had been reported and were the subject of child welfare services involvement. There were concerns regarding the supervision of these children and the alcoholism of both the parents.*

There is incomplete information about the death of Amanda to make a final determination and it is unclear why the Inquest was dispensed with.

Recommendation 5

That the State Coroner give reasons on file for dispensing with inquests, and conduct an annual audit to see if there is variation in the dispensing of inquests and if there is, specify its cause.

5.7 Less common causes of death

(i) Poisoning

Six young people aged 13 to 17 years of age (5 males and 1 female) died due to drug overdoses. For 3 of the cases the drugs noted in the P79A (Police Report to the Coroner) or in the autopsy report were heroin, and for 1 case the tricyclic anti-depressant Imipramine was noted. Two of the heroin overdoses were classified as 'accidental' according to the ICD-10 coding system, and 1 heroin overdose and the Imipramine overdose were classified as 'undetermined intent', meaning that the available information was insufficient to establish whether death was accidental or intended. One male aged 17 years died from butane gas inhalation of undetermined intent.

One male aged 13 years died from paracetamol toxicity. He was admitted to hospital for a pre-existing condition. The cause of death noted in the autopsy report was liver failure due to the toxic effect of paracetamol.

An in-depth review was undertaken of the death of 17-year-old Tamy who died from a heroin overdose.

> *Tamy had been a user of heroin for two years, during which time she had approximately one dozen heroin-related overdoses. About four months prior to her death, she began the Naltrexone program to assist her in overcoming her heroin addiction. At the end of September 1999, Tamy had her last shot of Naltrexone and was to renew her prescription the next day. On the same day, she met up with a friend and took a shot of heroin. Tamy did not take her Naltrexone for the following three days.*
>
> *A few evenings later, Tamy and her mother were at home watching a television film in which a scene depicted a woman engaging in intravenous drug use. Shortly afterwards Tamy went upstairs to have a bath. After twenty minutes her father went to check on her but received no reply to his calls. He forced entry to the locked bathroom.*
>
> *When Tamy's parents entered the bathroom, they found her lying face down in the bath with her head completely submerged. There was a used syringe on the basin of the bathroom. She was admitted to hospital although her condition continued to deteriorate. Four days later, assisted ventilation was removed. She died shortly afterwards.*

The pathologist's report highlights the risks associated with concurrent heroin use and Naltrexone treatment. When Naltrexone is not taken, even for several days, heroin users can become sensitive to the effects of narcotics and their ability to judge their tolerance levels for narcotics is impaired. Due to the lack of information regarding the medical and psychological treatment of Tamy's heroin addiction, it is difficult to know whether there had been a comprehensive assessment of her suitability for the Naltrexone program, or whether she had been told of the risks of using narcotics while taking Naltrexone.

(ii) Falls

Nationally, accidental falls are the leading cause of hospitalisations due to injury among 0 to 14 year olds. Falls are a leading cause of injury in the home, (Scott, 1992) related particularly to falls from household furniture, walkers, bunk beds and play and leisure equipment. Fall related injuries have been identified by the National Injury Prevention Advisory Council as a priority area for action (National Injury Prevention Advisory Council, 1999).

In New South Wales the rate of fatalities from falls has decreased significantly for children under 4 years of age, dropping from 1.8 deaths per 100,000 population in 1979 to 0.2 deaths per 100,000 in 1998. The fatality rate for 10 to 14 year olds has fluctuated significantly in that period, with no significant evidence of improvements in the rates. In 1979, 2.2 per 100,000 fall related fatalities were recorded, in 1998, 2.0 fatalities per 100,000 population were recorded (NISU 1998).

In this reporting period, 6 males aged between 1 year and 17 years of age died from falling incidents. These are summarised in Table 26.

TABLE 26 *Summary of falls*

Age at death	Location of incident	Height of fall
1 to < 2 yrs	Hotel	4 to 5 metres
2 to 4 yrs	Home	From window (unspecified height)
10 to 14 yrs	Falls	170 metres
15 to 17 yrs	Home	1.5 to 2 metres
15 to 17 yrs		Water storage container (unspecified height)
15 to 17 yrs	Cliff	60-80 metres

The youngest child slipped underneath a balcony railing at a motel and fell approximately 4 to 5 metres. The 15 to 17-year-old who fell 1.5 to 2 metres died of head injuries sustained from falling from a fence onto a rockery.

One of the fall fatalities has been the subject of review.

> *This young person was 16 years of age at the time of his death. On a visit to relatives he was located, dead at the base of the cliff, a drop of approximately 80 metres from the top. The location was wet and slippery. There was no safety fence. Also found on his body was a small amount of cannabis and smoking utensils. The young person had recently attended counselling but relatives were unable to say why. The Coroner, in the inquest findings, outlined his concerns regarding the lack of fencing around the edge of the cliff. The inquest did not, however, determine whether the incident was an accident or suicide.*

(iii) Effects/exposure to electric current

Two males aged 9 and 16 years both died as a result of exposure to electric current. While no other documentation has been received regarding the 16-year-old, the 9-year-old died of electrocution when he touched the exposed live filament of a broken globe in an unshaded bedside lamp[5].

(iv) Choking

In this 12-month period, 3 male infants and children died as a result of choking. One 5-month-old infant died from aspiration of gastric contents. One 2-year-old choked on a grape or grapes, and one 5-year-old died from laryngeal obstruction due to inhalation of a tablet.

(v) Crushing between objects

During this reporting period 2 children died as a result of being crushed between objects. Both incidents occurred on rural properties. One 4-year-old female was crushed between 2 fallen trees.

One 11-year-old male was crushed under a wheat bin containing an estimated 25 tonnes of grain. He was with his father and an assistant who were filling the wheat bins in preparation for sowing. The child was playing in excess grain in the outlet hopper when the frame supporting the bin collapsed.

Farmsafe Australia is promoting a national framework for action to'achieve the goal of reducing the incidence of injury and deaths of children on Australian farms and rural properties' (Farmsafe Australia, 1999). The strategy involves identifying key hazards for children on farms, identifying effective strategies to control injuries, identifying educational needs, child care options, promoting strategies in the broader farm community, identifying further research and evaluating the plan. While the taskforce has Farmsafe representation from most States, individual State action plans may be a necessary further step for implementation of key areas for action. The CDRT will consult with Farmsafe on the most appropriate ways to advance the national strategy in NSW.

5 The Coroner in this case recommended that the Minister for Fair Trading, or alternatively the appropriate Minister, consider making the installation of Residual Current Devices (RCD) or safety switches mandatory in all homes by such a date as directed by the Minister, and that Energy Australia undertake an appropriate education campaign in relation to the use of Residual Current Devices (RCD) or Safety Switches, so as to ensure the public are aware of the benefits and limitations of the devices.

(vi) Other causes of death

Among those children whose deaths could not be determined was a 7-month-old infant who was born 3 months prematurely due to being born with hydrocephalus. The child had also been diagnosed with cerebral palsy at 5 months of age. While the cause of death could not be determined, the child had also been taking the reflux drug Cisapride. Cisapride, also known as Propulsid, is a gastrointestinal stimulant drug, prescribed for severe reflux and heartburn. One pharmaceutical company in the United States stopped marketing the product in July 2000. Its use has been associated with heart rhythm abnormalities. Adverse events have most usually occurred in patients taking other medications or suffering from underlying conditions known to increase risk of cardiac arrhythmia. Cisapride use in premature infants of less than 36 weeks gestation and 3 months of age has been associated with complications and adverse events when administered in excessive dosages or in combination with another drug that inhibits its metabolism.

One 5-year-old male died from an anaphylactic shock. He was transferred to hospital and treated, but died the following day.

One 15-year-old female suffering from Cerebral Palsy died from complications following surgery. She died due to intravenous fluids entering the pericardial sac that surrounds the heart. She died several hours later from 'pericardial tamponade', which caused her heart to stop functioning.

One 17-year-old female died from complications of anorexia nervosa. Over a three-year period, she is reported to have lost 25kg; her initial body weight was 65kg.

(vii) Case reviews with mixed typologies

After review, several cases did not indicate suspicious circumstances or clear avenues for prevention. A 2-month-old baby boy died in his sleep of pneumonia and acute bronchitis. He had not seen a doctor. An 8-year-old male, who was a chronic asthmatic, died from an asthma attack.

The death of a 16-year-old male was reviewed, as there was no clear indication of the cause of death. He had consumed small amounts of alcohol and cannabis. After a second cone of cannabis he collapsed and was taken to hospital. There was insufficient medical evidence to establish the cause of the young man's death. Police investigation did not produce evidence of suspicious circumstances.

CHAPTER 6

Trends in child fatalities 1996-1999

As discussed in the Methodology section, trends in child fatalities for the period 1996-1999 were calculated using calendar years (January to December). Table 27 shows the numbers of young people who died (by year of registration of death) for the calendar years 1996-1999, as well as for the first six months of 2000. As Table 27 shows, more child deaths were registered in 1999 than in previous years.

It was also noted in the Methodology section that, during the reordering of the 1996-1999 data by date of registration, it was discovered that 15 deaths from this period (which were all coronial cases) are not registered with Births, Deaths and Marriages. This has prompted the CDRT to make the following recommendation:

Recommendation 6

That the State Coroner audits the process of coronial registration of deaths.

TABLE 27 *The Child Death Register (by year of registration)*

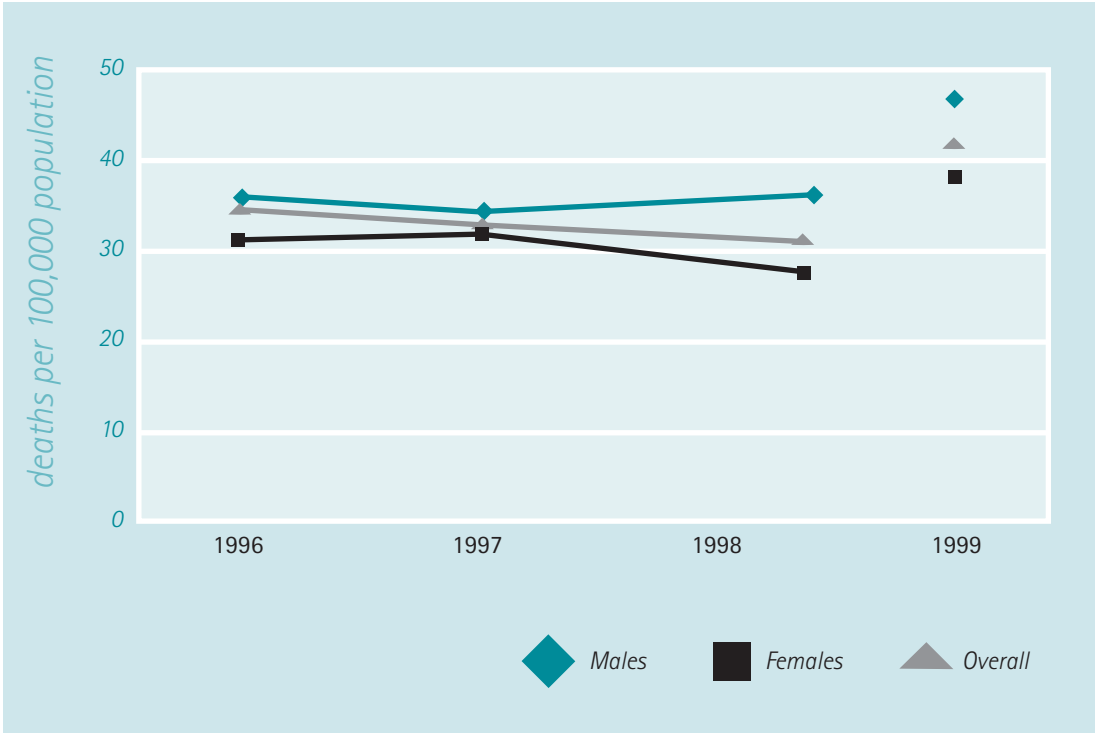
Child Death Register	Females		Males		Total
	n	%*	*n*	%*	*n*
January to December 1996	317	40.4	468	59.6	785
January to December 1997	323	42.4	439	57.6	762
January to December 1998	284	39.7	431	60.3	715
January to December 1999	383	43.3	502	56.7	885
January to June 2000 (six months)	139	38.4	223	61.6	362
Total number of child deaths Registered in NSW between 1 January 1996 to 30 June 2000	**1,446**	**41.2**	**2,063**	**58.8**	**3,509**

- *Percentage of deaths by gender within each time period
- 15 deaths have not yet been registered. For 13 of those deaths, the date at which they would have been registered has been estimated from the date of death and they are tabled in their respective years. For the remaining 2 deaths, the date of death is not known.

6.1 Trends in child deaths from natural causes

Figure 8 shows the natural causes rates by gender for the years 1996 to 1999. As can be seen, for each year, more males than females have died from natural causes. The data for 1999 cannot be compared with the data for 1996-1998 because the coding system that was used this year has been changed from previous years.

FIGURE 8 *Trends in natural causes of death by gender*



• Trend lines have not been continued from 1998 to 1999 as there have been changes in coding.

Figure 9 shows the natural causes rates for infants less than 1 year for the years 1996-1999. Across all years, the highest rates are for infants under one day, although across all age brackets, the rates for 1999 are higher than those for the earlier years. The difference between 1999 rates and the rates for previous years is most pronounced for infants under 1 day and infants between 1 day and under 1 week.

FIGURE 9 *Trends in natural causes of death by age (less than 1 year)*

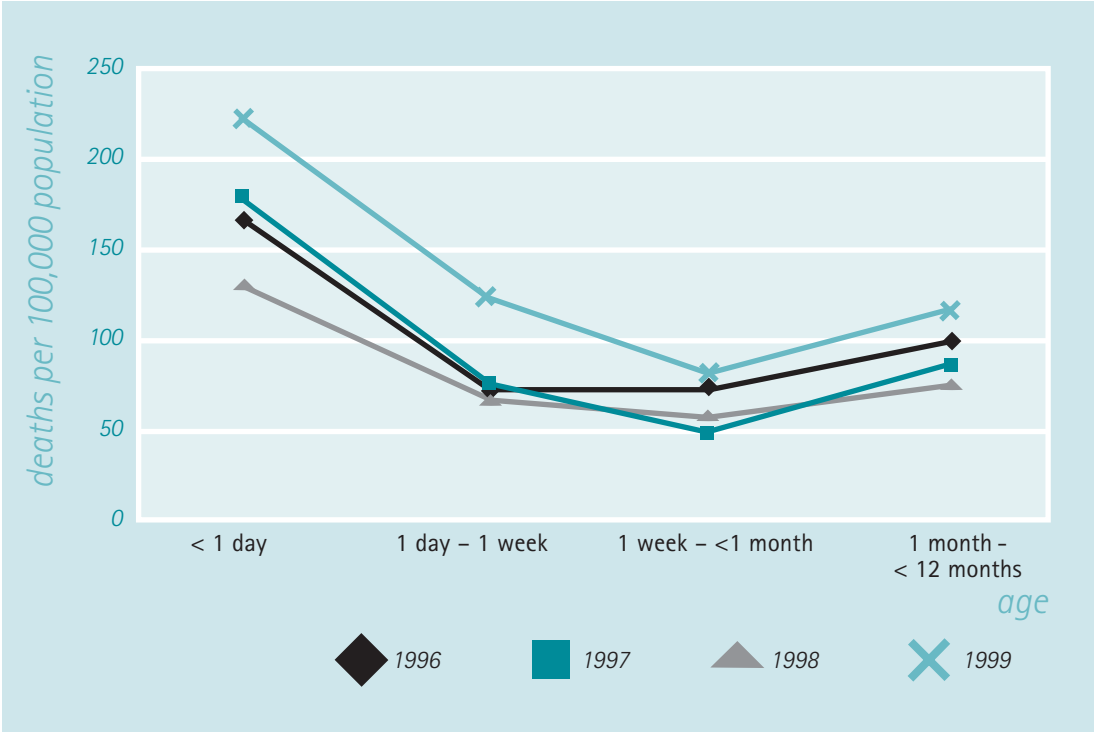
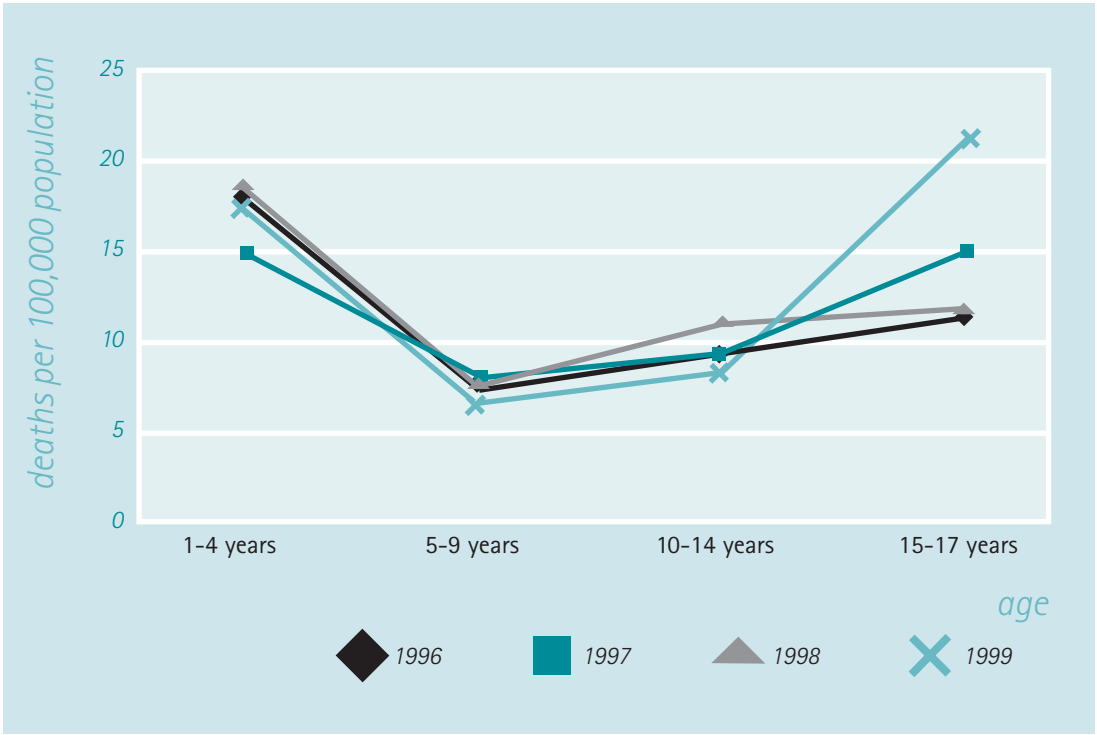


Figure 10 shows the natural causes rates for children and young people aged between 1 and 17 for the years 1996-1999. For the years 1996 and 1998, the highest rates were for children aged between 1 and 4 years, followed by young people aged between 15 and 17 years. For 1999, however, the highest natural causes rates were for young people aged between 15 and 17 followed by children aged between 1 and 4. It is noteworthy that the natural causes rates for young people aged 15 to 17 years increased sharply in 1999.

FIGURE 10 *Trends in natural causes of death by age (1-17 years)*



6.2 Trends in child deaths from external causes

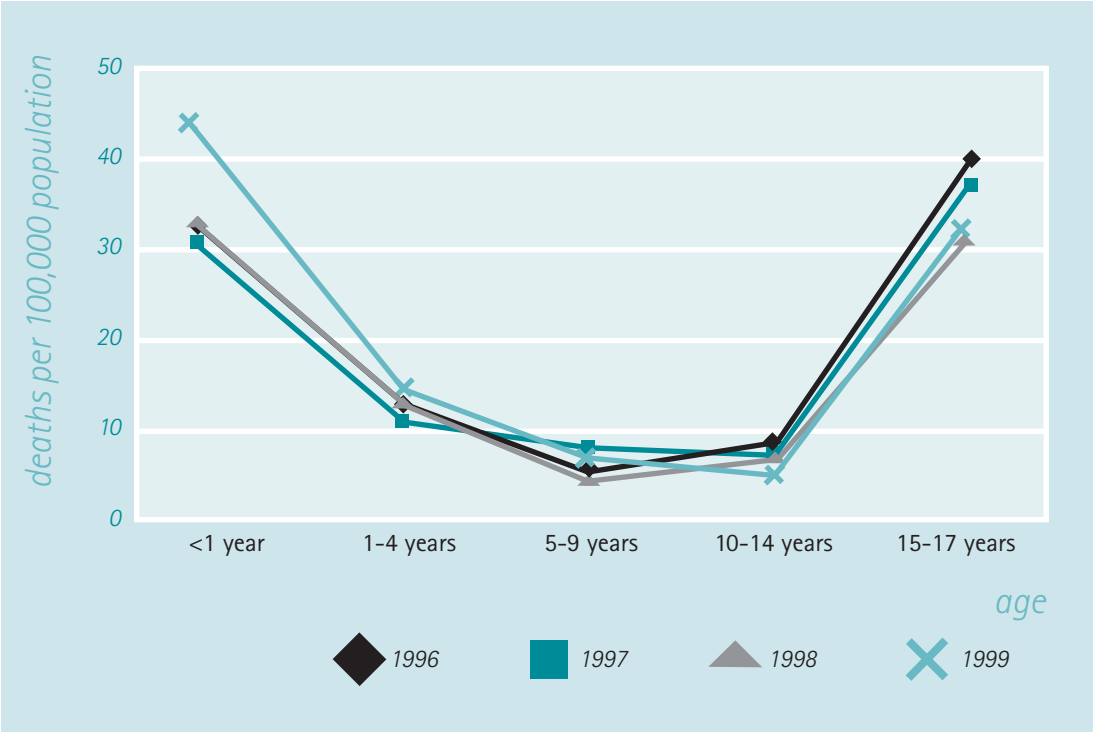
The external causes rates by gender for the years 1996 to 1999 are presented in Figure 11. As was the case with the natural causes rates, for each year, more males than females have died from external causes.

FIGURE 11 *Trends in external causes of death by gender*

• Trend lines have not been continued from 1998 to 1999 as there have been changes in coding.

The external causes rates for children and young people aged between 0 and 17 for the years 1996-1999 are presented in Figure 12. For 1999, the highest rates were for infants less than one year, followed by young people aged 15 to 17 years. For years 1996-1998, the highest rates were for young people aged 15 to 17 years, followed by infants less than one year.

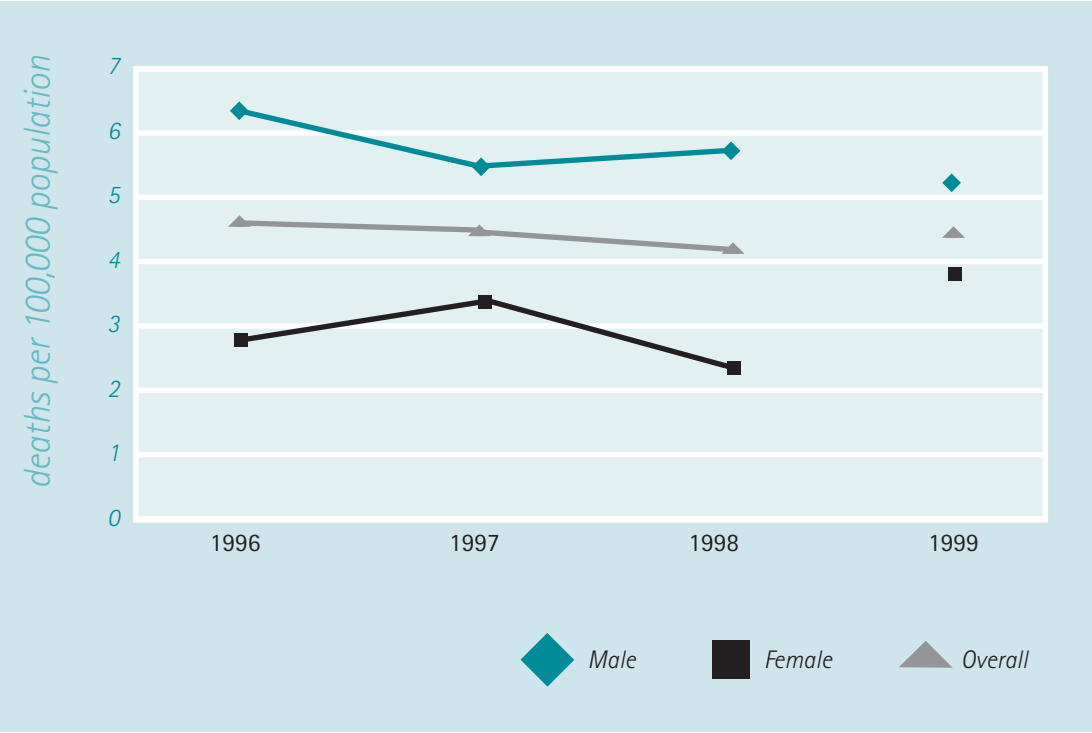
FIGURE 12 *Trends in external causes of death by age (0-17 years)*



6.3 Trends in child deaths from motor transport accidents

Figure 13 presents the motor transport fatality rates for the years 1996-1999. For each year, more males than females have died from motor transport accidents.

FIGURE 13 *Trends in motor transport fatalities*



• Trend lines have not been continued from 1998 to 1999 as there have been changes in coding.

6.4 Trends in child deaths from drowning

The drowning rates for the years 1996-1999 are presented in Figure 14. As with the motor transport accident rates, for each year, more males than females have died as a result of drowning.

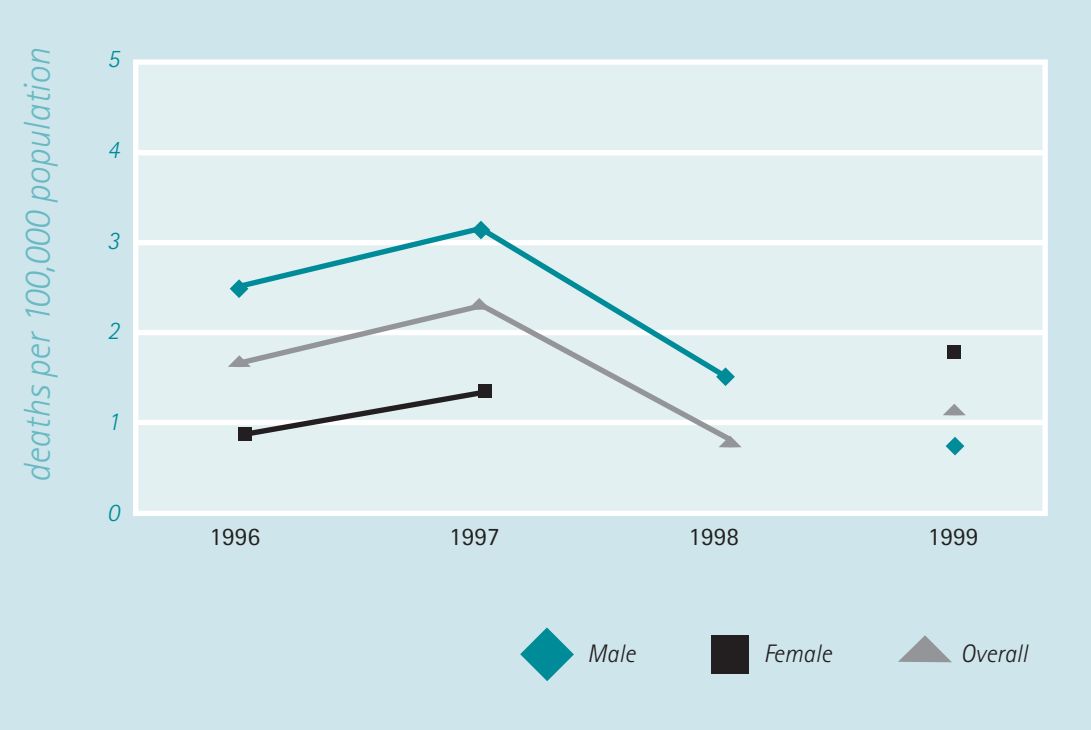
FIGURE 14 *Trends in drowning*

- Trend lines have not been continued from 1998 to 1999 as there have been changes in coding.
- Rate for females for 1996 cannot be computed because less than four females died from drowning in that period. Rates are therefore unreliable.

6.5 Trends in child deaths from suicide

The suicide rates for the years 1996-1999 are presented in Figure 15. For the years 1996-1998, more males than females died as a result of suicide, although the rates for both males and females declined sharply in 1998. In 1999, however, the suicide rate was higher for females than for males.

FIGURE 15 *Trends in suicide*



- Trend lines have not been continued from 1998 to 1999 as there have been changes in coding.
- Rate for females for 1998 cannot be computed because less than four females died of suicide in that period. Rates are therefore unreliable.

CHAPTER 7

Monitoring previous Child Death Review Team recommendations

Under Section 103 of the *Children (Care and Protection) Act 1987,* the primary function of the CDRT is to make recommendations for the prevention or reduction of child deaths. The Team operates on the premise that the prevention of child deaths lies with the community and the whole of government, not with any single organisation or group. Recommendations can be directed to government, private organisations and community to achieve this end. Consequently it makes recommendations that are designed to improve co-ordination, communication and co-operation in child protection and childhood injury prevention.

The CDRT reports directly to Parliament through its Annual Reports and these reports are required to include comment on the extent that previous recommendations have been accepted. The Team may also comment on the extent to which recommendations have been implemented in practice.

To undertake this task the CDRT contacted all the relevant agencies and government departments who the CDRT had directed recommendations to in its 1998-1999 and 1997-1998 Annual Reports. Each agency and department was asked to provide a progress report, noting the extent that each recommendation has been implemented and plans for continuing implementation. This also included outlining reasons for non-implementation and any alternative action that had been taken.

As a result of this a database has been developed to store all previous recommendations, to monitor the extent to which recommendations are being implemented, and to record the Team's analysis of the implementation of recommendations. Recommendations

were categorised around key policy and practice themes. Broadly, these themes relate to legislative compliance, injury prevention standards and regulations, program development, strategic policy development, practice issues around assessment, investigation, case management and planning, skill development, information management and research and development.

The following table presents summary versions of each recommendation and agency action, as well as the CDRT response. In particular, the CDRT has indicated a need for ongoing monitoring of some of the recommendations.

The CDRT would like to express their thanks to the many organisations that have diligently committed their skills and resources in the ongoing implementation of many of the recommendations. In this way a joint commitment in promoting the safety, welfare and well-being of children has been undertaken.

Legislation: Compliance and Monitoring

Recommendation 1 1997-98	In implementing the new *Children and Young Persons (Care and Protection) Act 1998*, all relevant government departments and non-government agencies, and the relevant medical Colleges and Associations ensure that mandated reporters understand the importance of, and comply with, their reporting responsibilities.
Agency Action	**Department of Education and Training** DET is currently developing new reporting procedures and will ensure all staff mandated to report are aware of their obligations and the procedures to be followed by December 2000. This will build on the 1997 training for all staff. Compliance mechanisms will be developed and implemented. **NSW Health** NSW Health provides systemic training of all NSW health staff in reporting. Over 11,000 health workers have been trained in recognition and notification. The Department is currently examining strategies for training medical practitioners through a working party of Senior Advisors Committee for PANOC.
CDRT Response	**Department of Education and Training and NSW Health** The CDRT is satisfied with the Agency response. No further comment is required. **Other Agencies** The CDRT notes that no other agency has responded. The CDRT is aware however that this issue will be covered in the EnAct training material accompanying the introduction of the *Children and Young Persons (Care and Protection) Act 1998*.
The Office on Drug Policy Recommendation 3 1998-1999	**The Office on Drug Policy –** • Monitor the implementation of Part C of the 1998-1999 CDRT report. • Report to the Cabinet Committee on Drugs at least biannually on the extent agencies have complied with the recommendations, including non-compliance. • Identify alternative strategies that are being developed and implemented to achieve the objectives of the CDRT recommendations.
Agency Action	The Office on Drug Policy has established management procedures to track progress in implementing the recommendations. Regular reporting will occur to facilitate this and provide data for progress reports to the Cabinet Standing Committee on Drugs. The Office on Drug Policy is liaising with other government agencies to set milestones and timeframes in achieving recommendations. In addition a forum for drug and alcohol and child protection workers is being planned for early 2001. The Expert Advisory Group on Drugs has asked to be kept informed of the progress and stressed that Area Health CEO's need to actively respond to the Report.
CDRT Response	The CDRT is satisfied with the agency response. No further comment is required.
NSW Health Recommendation 9.3 1997-98	NSW Health and the relevant medical Colleges and Associations emphasise the importance of recognising Non-Organic Failure to Thrive and Psychosocial Growth Failure in ensuring that mandated reporters comply with their statutory obligations regarding mandatory reporting (Recommendation 1).
Agency Action	NSW Health provides systemic training of all NSW health staff in reporting. Over 11,000 health workers have been trained in recognition and notification. The Department is currently examining strategies for training medical practitioners through a working party of Senior Advisors Committee for PANOC.
CDRT Response	Implementation of this recommendation will be reviewed in the next Annual Report in relation to recognition of Non-Organic Failure to Thrive and Psychosocial Growth Failure.

Regulations: Injury Preventions Standards

The Motor Accidents Authority, 1998-99 Recommendation 1.1	The Motor Accidents Authority, in consultation with other relevant agencies- – develop targeted strategies including public education programs to reduce the number of child deaths occurring in low speed, reversal incidents on residential property. – commissions research to determine the effectiveness of the use of refractive panels and rounded mirrors and the extent to which fenced shared driveways act as protective factors in the prevention of driveway fatalities. – upon completion of this research, if appropriate, makes a case to the Federal Office of Road Safety to cause an amendment to the Australian Vehicle Standards, and makes a case to the Australian Building Standards Board for the inclusion of a requirement for fenced shared driveways.
Agency Action	A working party of the agencies nominated in the 98-99 Report has been convened with the addition of representatives from Kidsafe Australia and the NSW Injury Risk Management Research Centre. The working party held its first meeting on 4th May 2000. The working party will develop a program to address the recommendations, especially with a view to developing a multi-agency prevention strategy. The working group has employed a consultant to conduct research and produce a report with recommendations for further research. The draft report was released in August 2000. Finalisation of implementation of the proposed activities will occur in September/October, with a final report to be produced in October 2000.
CDRT Response	The CDRT is satisfied with the Agency response. No further comment is required.
Department of Fair Trading 1997-98 Part A	The Minister for Fair Trading advise the CDRT as to the enforcement status of Australian Standard AS/NZS 4220:199 concerning bunk beds, and actions taken regarding the recall of bunk beds that do not comply with this Standard.
Agency Action	The Minister has advised that the current voluntary standard is under review by the Standards Australia Committee on Safety Requirements for Children's Furniture. Amendment to the current Standard was considered at the Committee meeting of 23 May 2000. The Consumer Affairs Division of the Commonwealth Treasury has proposed introduction of a mandatory safety standard based on standard AS/NZS 4220. This standard requires Commonwealth alteration via amendment of the Trade Practices Act before a complementary product safety standard under the NSW Fair Trading Act can be examined in detail.
CDRT Response	The CDRT is satisfied with the Agency Response. The CDRT will review the progress of this recommendation in the next Annual Report.
Department of Local Government and Department of Sport and Recreation 1998-99 Recommendation 2.1	The Minister for Local Government and the Minister for Sport and Recreation, in consultation with other relevant government and non-government agencies (such as the NSW Water Safety Council, NSW Health, Kidsafe (NSW), and the Royal Life Saving Society), develop a range of targeted strategies to reduce the number of child deaths, particularly of children under five years of age, caused by drowning in private swimming pools and baths.
Agency Action	**Department of Local Government** A public awareness campaign regarding legislative requirements for private swimming pools was launched in Sept. 1994. This campaign involved two brochures about the safety requirements for pools. One of the brochures included safety tips for residents. The campaign was aimed at occupiers of residential buildings, moveable dwellings, hotels and motels with swimming pools, pool manufacturers and fencing installers. The campaign was conducted in conjunction with the Department of Sport and Recreation's 'Be Pool Wise' Campaign.

Regulations: Injury Preventions Standards

Agency Action	The Swimming Pools Act requires councils to promote awareness regarding legislative requirements. The Department in its newsletter reminds councils of their obligations. The *Swimming Pools Act 1992* and *Swimming Pools Regulation 1998* require child resistant barriers around swimming pools located in a residential building, a moveable dwelling, or a hotel/motel and display of a sign giving a supervision warning and information regarding supervision techniques. The NSW Water Safety Council last met in Sept 1999 and has been replaced by the NSW Water Safety Taskforce (amalgamated with Premier's Water Safety Taskforce Sub-committee). The Taskforce first met in March 2000. The CDRT Report was discussed at its second meeting. It was agreed that the recommendations be considered part of the development of the NSW Water Safety Plan. Brochures are currently being updated and made available on the Department's website. Local councils will be advised when the brochures are available and encouraged to distribute them to residents and relevant organisations. **Department of Sport and Recreation** A range of strategies exist to reduce deaths across a number of waterways. The Royal Life Saving Society's Keep Watch program specifically targets the reduction of deaths of children under five years of age. This program attempts to reduce the number of drownings in this age group by educating parents and carers, highlighting the need for constant adult supervision, the need and proper use of pool fencing, promoting water awareness skills for young children from six months of age and resuscitation training. Other strategies include the Swimsafe – Learn to Swim Program (intensive swimming lesson program conducted for all ages between November and February each year – currently being reviewed); Water Safety Grants Program (financial assistance for peak organisations to extend their water safety education programs), Safewaters (television commercials and brochures in multiple languages relating to beach safety, inland waterway safety and general water safety); and Surf Life Saving NSW – Beach to Bush (lectures on surf awareness and safety in schools in rural areas).
CDRT Response	The Child Death Review Team notes that a NSW Water Safety Plan is being developed and will review the progress of this recommendation in the next Annual Report.
Department of Local Government and Department of Sport and Recreation 1998-99 Recommendation 2.2	The Minister for Local Government and the Minister for Sport and Recreation, in consultation with the NSW Water Safety Council, develop sound evaluation methodologies for the State's current investment in child pool drowning prevention education and amend these programs in accordance with the findings of such evaluations.
Agency Action	**Department of Local Government** Evaluation of the Campaign is expected to be a key component of the NSW Water Safety Plan. The NSW Water Safety Taskforce has also established a sub-committee that is concerned with providing advice to the Taskforce to improve research and data collection. A Drowning and Near-Drowning Research register is being developed in conjunction with NSW Health and the Royal Life Saving Society. The pilot has indicated that parents and carers are reluctant to provide information and it is expected the Register will be unsuccessful. **Department of Sport and Recreation** The NSW Water Safety Taskforce through the Water Safety Plan will address formal evaluation methodologies. The Research/Data Collection Sub-committee is currently collecting drowning and near drowning pro formas to identify gaps and develop strategies. Few formal mechanisms exist. The Royal Life Saving Society has formal responsibility to compile annual NSW drowning

Regulations: Injury Preventions Standards	
Agency Action	statistics. NSW Health and other key agencies have established the NSW Study of Near Drowning Incidents with Infants from Private Pools, to determine factors that contribute to the near drowning and drowning of infants aged 0 to 4 years. This information will allow for evaluation of the *Swimming Pools Act 1992*. Difficulty in obtaining information means it is unlikely that the register will be successful.
CDRT Response	The CDRT will review how this evaluation has been incorporated in the NSW Water Safety Plan, in the next Annual Report.
Department of Local Government and Department of Sport and Recreation 1998-99 Recommendation 2.3 and 2.4	The Minister for Local Government and the Minister for Sport and Recreation, in consultation with the NSW Water Safety Council, consult with the Western Australian Government concerning the swimming pool inspection program in that State in order to formulate recommendations for the administration of a mandatory swimming pool inspection program in NSW and, The Minister for Local Government and the Minister for Sport and Recreation, in consultation with the NSW Water Safety Council, develop a public education program specifically to support the introduction of a mandatory inspection swimming pool inspection program by local government.
Agency Action	Dept. of Sport and Recreation has been advised by the WA Health Dept. that the study is yet to commence. The WA Health Department has agreed to keep NSW Government informed of developments as they occur. The Departments will consider any evaluation findings and assess the need to amend the legislation.
CDRT Response	The CDRT awaits the outcomes of this research.

Policy: Program Development	
NSW Health Recommendation 8 1998-99	That the Accreditation and Service Standards for Drug and Alcohol Service Providers, includes standards that require drug and alcohol agencies which provide services to substance using women to provide information about the effects of drug use on the mother and developing foetus, referral to appropriate user-friendly services and referral to appropriate specialist antenatal services.
Agency Action	NSW Health is currently developing accreditation standards for non-government services funded by NSW Health and for methadone clinics. The Accreditation and Service Standards will address the need for drug and alcohol agencies providing services to substance using women to provide information about the effects of drug use on mother and developing foetus and to make appropriate referrals. Funding will be tied to accreditation and this recommendation will be incorporated within the accreditation process.
CDRT Response	The Team is satisfied with the Agency response. No further comment is required.
NSW Health Recommendation 19.1 1998-99	The Drug Treatment Services Plan ensures that there are well-resourced drug and alcohol services in rural communities receiving ongoing funding which offer culturally appropriate support and are staffed with workers who are: – adequately trained to address issues of chronic drug and alcohol use – aware of child protection issues – able to develop good links with other agencies including DoCS – easily accessible by the Aboriginal community – accessible and relevant for young people.
Agency Action	NSW Health is preparing an Aboriginal and Torres Strait Islander Plan for the Prevention and Management of Substance Misuse that will provide a strategic framework to address drug issues in Aboriginal communities. It is planned this will be finalised by mid 2001. The Drug Treatment Services Plan makes specific mention of services, directions and key directions for Aboriginal and Torres Strait Islanders. Training of Aboriginal workers will be referred to the Training Taskforce.
CDRT Response	The CDRT notes that no explicit measures have been outlined in the Interim Drug Treatment Services Plan that deal with this recommendation. The CDRT will review progress of this recommendation in the next Annual Report.
NSW Department of Community Services Recommendation 22 1998-99	The Department of Community Services, in collaboration with its relevant community partners, develops strategies to enhance the recruitment, assessment, training and support of Aboriginal carers.
Agency Action	At the Area level DoCS and Aboriginal community partner agencies providing out of home care services are developing joint strategies to assist in the recruitment, training and support of Aboriginal carers as identified in the Child and Family Business Plan for 2000/1. DoCS will shortly call for expressions of Interest for the establishment of a statewide Aboriginal Foster Care Service. In addition to providing support to carers the service will develop and deliver culturally sensitive and appropriate training to Aboriginal foster carers in a range of flexible formats. As part of the Standards and Accreditation Project DoCS has undertaken a series of extensive consultations with Aboriginal out of home care service providers. A number of strategies are being developed during these consultations that will assist with the training, recruitment and support of Aboriginal carers. It is anticipated that Aboriginal communities, service providers and DoCS staff will be involved in this process. (.../over)

Policy: Program Development	
Agency Action	Funds have also been allocated to support Out of Home Care providers through the change process, enhance existing out of home care services and develop new services to meet unidentified need. Part of these funds will be provided to Aboriginal Out-of-Home Care services for service viability, training and development, staff and carer recruitment campaigns.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Cabinet Office Recommendation 20.2 1998-99	The Cabinet Office ensures that the Aboriginal Youth Strategy, currently in development, includes cross-government and cross-community proposals to promote life opportunities and employment prospects for young Aboriginal people.
Agency Action	The Aboriginal Youth Strategy was commenced in January 1999. A number of consultations and youth gatherings have occurred to date. The Youth Action Policy Association (YAPA) has employed an Aboriginal young person to work with YAPA to develop the youth strategy. Once the strategy has been developed there will be opportunity to link the strategy to other activities for Aboriginal communities focusing on improved life opportunities and employment outcomes. It is anticipated that the strategy will be completed by mid 2001.
CDRT Response	The Team is satisfied with the Agency Response. No further comment is required.
NSW Cabinet Office Recommendation 20.3 1998-99	The Cabinet Office ensures that the Families First initiative continues to place a high priority on planning and providing for: – parenting programs for young Aboriginal people that recognise the loss of parenting skills caused by the historical removal of Aboriginal children from their families – culturally appropriate support to Aboriginal parents that is available from the birth of their children and is easily accessible in rural and urban areas.
Agency Action	Families First in the six implementation areas is implementing or developing several initiatives with Aboriginal families. These include increased antenatal care through home visiting and outreach strategies and Aboriginal family workers, supported playgroups and mentoring programs. A range of models are being tested.
CDRT Response	The Team is satisfied with the Agency Response. No further comment is required.
NSW Department of Community Services Recommendation 11.1 1997-98	The Department of Community Services, in implementing the *Children and Young Persons (Care and Protection) Act 1998*, ensures that: – the clinical assessment procedure for potential adoptive, foster and kinship caregivers be equally thorough, and that all potential carers of children needing alternative placement are comprehensively assessed – the well-being of all children placed by the Department or a designated agency in kinship care is monitored – that children be monitored for a minimum of the first 12 months of their placement with relatives to ensure that their wellbeing and safety needs are met.
Agency Action	The issue will be considered further during the development of policies and procedures to support the implementation of the legislation. Kinship care is included within the out of home care section of the Practice Framework that is replacing the case coordination framework. Guidelines for the assessment and support of kinship carers will be included in the new Child and Family Manual.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.

Policy: Program Development

NSW Department of Education & Training Recommendation 19.2 1998-99	The NSW Board of Studies develops strategies and support materials to assist teachers working with Aboriginal young people to provide effective education regarding family planning and parenting skills.
Agency Action	**Board of Studies** BOS core responsibility is syllabus development. DET has core responsibility in the provision of support material and strategies. This includes broad based K-6 syllabus development promoting protective behaviour and Aboriginal Studies, syllabus support regarding ATSI students. Revision of Stage 6 Exploring Early childhood is to incorporate parenting skills. **Department of Education and Training** A range of strategies and support materials are available to teachers of Aboriginal students in the context of syllabuses within Personal Development, Health and Physical Education which provides sexuality education. Schools develop programs so they are locally appropriate. The Parents and Teachers program provides specific support to young mothers in ten schools across the State, including playgroups for Aboriginal families in Moree. The allocation of responsibility for this recommendation will be reviewed with the Office of the Board of Studies and the CDRT.
CDRT Response	The CDRT, DET and the Board of Studies will review responsibility of this recommendation.
NSW Health Recommendation 6.1 1998-99	Through the Families First strategy and the network of early childhood services, NSW Health take steps to ensure that parenting support and education are offered following the birth of a child, and that there is assertive follow up by early childhood services if parents have not attended follow up visits or made alternative arrangements with a general practitioner
Agency Action	In June 1999, NSW Health issued the NSW Midwives Data Collection Form that alerts early childhood health services to the birth of a baby. The receipt of the Midwives Data Collection Form alerts the early childhood service to the birth of a baby in the local area and contact can be made with the family by the service. This policy encourages Area Health Services to facilitate stronger links between Maternity and early childhood services, other community health services and GP's. In addition NSW Health is implementing the NSW Child Health Policy – *The Start of Good Health-Improving the health of children in NSW,* the *Families First* program and *Making Mental health Better for Children and Adolescents Strategy.*
CDRT Response	The Team is satisfied with the Agency Response. No further comment is required.

Policy: Strategic Policy Development	
Department of Education & Training Recommendation 14.1 1998-99	The Drug and Alcohol Training Taskforce (Drug Summit Recommendation 5.1) includes expert child protection representation.
Agency Action	A Senior Child Protection Co-ordinator has been included as a child protection representative on this taskforce.
CDRT Response	The Team is satisfied with the Agency response. No further comment is required.
Department of Health Recommendation 4 1998-99	NSW Health considers the findings of the Child Death Review Team concerning clinical evaluation and management of substance dependent parents and their children and, as part of the development of the Interagency Guidelines for the Early Detection and Management of Drug Misuse (Drug Summit recommendation 3.5) and the Accreditation and Service Standards for Drug and Alcohol Service Providers (Drug Summit recommendation 4.3): – identifies existing relevant policies and procedures and develops policies and procedures where none currently exist; – assesses the effectiveness of existing relevant policies and procedures; and – develops procedures to monitor compliance with all relevant policies and procedures.
Agency Action	These recommendations will be implemented in the development of the Interagency Guidelines and Accreditation and Service Standards. The Guidelines should be ready for adoption by mid-2001. The CDRT findings regarding clinical evaluation and management of substance dependant parents are on the agenda of the Guidelines working group. Implementation will aim to improve referral processes, link clients of treatment services with other social services, assist early detection and intervention and define key roles and responsibilities. Issues which the Guidelines should address are child protection issues for clients under 16, ability of drug dependant parents to care for their children and child protection issues and principles relating to statutory reporting requirements. NSW Methadone Maintenance and Treatment Program will require that methadone clinics have in place appropriate child protection policies and procedures. The Accreditation and Service Standards for Drug and Alcohol Service Providers will include standards for drug and alcohol agencies providing services to substance using women to be aware of their child protection responsibilities.
CDRT Response	The Team is satisfied with the Agency Response. No further comment is required.
Department of Health Recommendation 20.1 1998-99	NSW Health develops, in collaboration with other relevant agencies, an Aboriginal and Torres Strait Islander Drug and Alcohol strategy with particular reference to drug and alcohol use by Aboriginal children and young people, including petrol sniffing. This Strategy is to be developed within the context of the partnership agreement between NSW Health and the Aboriginal Health and Medical Research Council.
Agency Action	NSW Health is developing an Aboriginal and Torres Strait Islander Plan for the Prevention and Management of Substance Misuse. The Aboriginal Health and Medical Research Council has received funding for mental health promotion and prevention in Aboriginal communities with a special emphasis on young people and suicide, and to examine the effects of trauma, loss and grief on Aboriginal health and well-being.
CDRT Response	The Team is satisfied with the Agency Response. No further comment is required.

Policy: Review and Evaluation	
NSW Health Recommendation 5.1 1998-99	The Chief Executive Officers of each Area Health Authority consider the findings of the Child Death Review Team concerning clinical evaluation and management of substance dependent parents and their children and undertake a review of relevant local area policies and procedures to: – identify existing relevant policies and procedures and to develop policies and procedures where none currently exist; – assess the effectiveness of existing relevant policies and procedures; and – develop procedures to monitor compliance with all relevant policies and procedures.
NSW Health Recommendation 5.2 1998-99	The Chief Executive Officers of each Area Health Authority consider conducting the above review of relevant policies and procedures by consulting with a reference committee which includes representatives from PANOC, drug and alcohol, child and adolescent health, mental health, maternity services and community health services.
Agency Action	As a result of the Drug Summit all Area Health Services are required to produce long-term drug and alcohol plans to be approved by the Director-General of Health. These will include a review of policies and procedures regarding substance dependent parents and their children. Area Health Services are being asked to establish a reference group to prepare the plan, including PANOC, drug and alcohol service, child and adolescent health, mental health, maternity service and community health representatives.
CDRT Response	The Team is satisfied with the Agency Response. No further comment is required.
NSW Health Recommendation 17 1998-99	The Drug Treatment Services Plan (Drug Summit Recommendation 3.1) includes a re-evaluation of the policy of providing take-home methadone to homes where children are living.
Agency Action	NSW Health does not support this recommendation. A number of changes have been made to the operation of the methadone program in the last two years. Further restrictions in the application of the current take-away policy will not result in improved outcomes or reduced risk for children. Client Treatment Agreements are being introduced which set out the rights and responsibilities of clients and service providers. This includes sanctions for non-compliance and inappropriate use of take-aways including review of treatment and removal from the methadone program. An information booklet for GP prescribers, clients, syringe programs and clinics states child safety practices, and accreditation processes for clinics and prescribers have been developed and improved.
CDRT Response	Implementation of the Clinical Treatment Agreements will be reviewed in the next Annual Report with a view to ensuring child safety. In particular, evaluating the extent to which the protective measures outlined in the booklet are implemented by clients and prescribers, and the extent to which these protective measures are terms of Client Treatment agreements.
NSW Department of Community Services Recommendation 10 1997-98	In order to resolve issues surrounding unallocated cases, the Department of Community Services evaluates the outcome of its 'Priority One' policy and 'Mandatory Response Procedures for Babies Under One Year of Age'.
Agency Action	The review reports of the Priority One and Babies Under One policies and procedures are in final draft and have been presented to the Reference Group. This Reference group is composed of NCOSS representatives, the Commission for Children and Young People, the Community Services Commission and ACWA in addition to DoCS staff. Once the Report has been finalised it will be made available to interested bodies including the Child Death Review Team.

Policy: Review and Evaluation	
Agency Action	The Looking After Children case management system will be introduced in 2000/1 for all children and young people in DoCS out of home care placements where DoCS is the official provider.
CDRT Response	The Team will review the Priority One policy and evaluation in the next Annual Report.
NSW Health Recommendation 12 1997-98	NSW Health, in consultation with the Child Death Review Team, revises and reissues the NSW Health 'Protocol for Unexpected Infant Death' and advises the Child Death Review Team regarding compliance with this protocol.
Agency Action	The protocol was revised July 1997 The protocol provides guidelines for action at local hospital Emergency Departments including nomination of a key person to coordinate care of parents; outlines the role of Police as the representative of the Coroner; outlines the role of forensic pathologist to conduct further diagnosis at either Glebe or Westmead; obtaining brief medical history of the child; manner of informing parents regarding the process of coronial investigation; care of surviving twin; provision of practical support to parents and guidelines for support available to the family. NSW Health has consulted with the CDRT who proposed that the Protocol be broadened to apply to unexpected infant death on a ward and in any hospital facility, not only Emergency Departments. NSW Health has referred this matter to the NSW SIDS Advisory Committee for consideration and review.
CDRT Response	The CDRT is satisfied with the Agency response. No further comment is required.

Practice Issues: Assessment and Investigation

NSW Health Recommendation 11.1 1998-99	It is recommended that the development of the Drug and Alcohol Training Scheme and Interagency Guidelines for the Early Detection and Management of Drug Misuse include requirements that: • When serious child at risk concerns exist due to parental substance dependence, a thorough multi-disciplinary psychosocial assessment, as described in Part C section 4.5, be undertaken by workers with the relevant expertise, preferably on the obstetric ward before the baby is discharged from hospital.
NSW Health Recommendation 11.2 1998-99	• NSW Health trains relevant health professionals involved with substance using parents and children to conduct thorough multi-disciplinary psychosocial assessments as described in Part C section 4.5.
Agency Action	These recommendations will be addressed in the Interagency Guidelines for the Early Detection and Management of Drug Misuse. This matter will be referred to the Drug and Alcohol Taskforce in determining priorities for the Drug and Alcohol Training Scheme.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Department of Community Services Recommendation 5.1 1997-98	In developing the capacity of district officers, assistant managers, and child protection specialists, and where training is offered to non-government child protection workers, the Department of Community Services pays particular attention to the neglect of children by: – requiring that assessments be undertaken on infants and children, where there are issues of neglect, including ongoing growth measurements and formal developmental assessments and in severe cases of neglect, referring parent(s) and their children for comprehensive psychosocial and parenting capacity assessment. – making available as part of initial and ongoing training, specialised training about the effects of severe and especially early neglect on infants' and children's development and wellbeing. This should include training about the recognition of neglect, and indicators for referral for further assessment. Such training should be carried out for DoCS staff on a formalised basis across the state by specialists in infant and child development and neglect.
Agency Action	Whilst the effects of neglect are covered in District officer entry level training and it is a component of the DV training package it is acknowledged that DoCS needs to give careful consideration to the most appropriate way to progress this area. One strategy will be ensuring that the Client System will feature information on early childhood development and the consequences of neglect. The development of the Safety and Risk Assessment tool has ensured that the effects of neglect are included as risk and safety issues. In addition, indicators of neglect are included in the Interagency Guidelines for Child Protection Intervention.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.

Practice Issues: Assessment and Investigation

NSW Department of Community Services Recommendation 6.1 1997-98	In developing the capacity of district officers, assistant managers, and child protection specialists, and where training is offered to non-government child protection workers, the Department of Community Services pays particular attention to the effects of severe domestic violence on children by: – focusing on the effect of violence on children, including interviewing the child where appropriate, following-up with relevant services to monitor the child's ongoing wellbeing and referring the child and family for appropriate specialist child and family assessment and/or treatment. – making available as part of initial and ongoing training, specialised training about the effects of severe domestic violence on children's early cognitive development, attachment development and emotional, behavioural and personality adjustment. Such training should be carried out on a formalised basis across the state by specialists in infant and child development.
Agency Action	Ensuring that staff recognise the impact of domestic violence on children is a high priority for DoCS. A domestic violence training package was developed in 1999 which takes into account the damaging effects on children, in the short and long term, who witness domestic violence. In the development of the package attention was paid to the research that identifies the increased likelihood of these children becoming victims or perpetrators of domestic violence. 16 DoCS staff were trained as train the trainers in June 1999. With the introduction of the *Children and Young Persons (Care and Protection) Act 1998* domestic violence has been recognised in legislation as having the potential to impose serious harm on a child or young person. The Act will therefore require that those children assessed to be at risk of serious physical or psychological harm will be grounds for reporting. The development of the Recognition and Response Tool for use by community partner's agencies will include domestic violence. DoCS are currently reviewing its domestic violence policy and operational guidelines. The review will be based on current research findings, will be consistent with the new Act and will be aimed at ensuring families receive the sort of help they need to prevent or stop domestic violence.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
Office of the State Coroner Recommendation 13 1997-98	The State Coroner advises the Child Death Review Team regarding the feasibility of: – directing that Police do not describe an infant death as being due to 'SIDS' on their Report of Death to Coroner (P79A), as this can only be determined after autopsy – considering alternatives to the use of the phrase 'no suspicious circumstances' on the Police Report of Death to Coroner (P79A), as all circumstances are not known at the time this form is completed by Police at the death scene – ensuring that the specialist forensic pathologists conducting autopsies for children under five years of age are provided with adequate social histories to inform the autopsy process, including whether the child's family was known to the Department of Community Services and any history of abuse, neglect, domestic violence, or parental substance dependence.

Practice Issues: Assessment and Investigation

Agency action	The State Coroner agrees that the terms 'SIDS' and 'possible and probable SIDS' will not be used. If necessary a term such as 'unexpected child death' should be used. Strategies agreed to educate Police regarding this – The Commander, Coroner's Support Section to consider ways in which he would get the message to Police. The State Coroner to issue an article in the State Coroner's Circulars to all Coroner's that the attention of Police providing such a report that it was inappropriate to make such a statement in a report and that if necessary a term such as 'unexpected child death' should be used. The State Coroner and others giving talks or lectures or involved in the educational role of the State Coroner would bring to attention of Police the inappropriateness of the use of such terms. The State Coroner believes that use of the term 'no suspicious circumstances' is appropriate. The Coroner needs to know the opinion of Police on this matter at the time of the writing of the P79A report. The State Coroner has directed that specialist forensic pathologists conduct autopsies of all deaths less than five years of age. A mandatory protocol has been established with DoCS to advise the Forensic Pathologist on whether the child or their siblings had been the subject of a report as stipulated under section 22 of the *Children (Care and Protection) Act 1987*. The State Coroner requests that this information be sought and supplied to the duty pathologist at the NSW Institute of Forensic Medicine in all cases where the deceased is under five years of age. SIDS Death Scene Investigation Checklist has been introduced.
CDRT Response	The Team is satisfied with the Agency response. No further comment is required.

Practice Issues: Case Management and Planning	
NSW Health Recommendation 12 1998-99	NSW Health ensures that where parental substance use has been identified on the obstetric ward, hospital staff, in consultation with a health worker with expertise in child protection, conduct a preliminary assessment of risk to the infant, and where child protection concerns are identified (including where a parent is seeking to discharge an infant against medical advice): – a report to DoCS should be made – a protection planning meeting should be held prior to discharge in accordance with the guidelines and timeframes identified in the Interagency Guidelines for Child Protection Intervention, or if parental substance use is identified but the assessment of hospital staff, in consultation with a health worker with expertise in child protection, is that a report to DoCS is not warranted: – a case conference should be convened by obstetric ward staff to formulate a discharge plan with clear responsibilities and timeframes. This should be attended by the parents, a hospital child protection worker and representatives from relevant services, such as the Early Childhood Health Centre, drug and alcohol services, Community Health Centres, and family support services – infants should not be discharged from hospital without a discharge plan which attends to the parents' and child's needs, including referral to drug and alcohol services.
Agency Action	The implementation will be considered as part of NSW Health response to the *Children and Young person (Care and Protection) Act 1998*. This includes identifying best practice models for application in the public sector. Some Area Health Services have already undertaken activities suggested in the recommendation. Lismore Base Hospital will pilot an Integrated Care Project for high risk pregnancies and South Western Sydney Area Health Service has protocols around protective planning and parental substance use.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 13.1	The Interagency Guidelines for the Early Detection and Management of Drug Misuse include provisions that: – drug affected babies are not discharged before there is full recovery from drug withdrawal and the medication program has been completed – a report to DoCS is considered if a parent seeks to discharge an infant before the infant is fully recovered from drug withdrawal against medical advice – obstetric hospitals should provide rooming-in facilities for mothers while the baby is in the ward to support the attachment process.
NSW Health Recommendation 13.2 1998-99	NSW Health develops clinical guidelines for the management and treatment of drug-withdrawing babies.
Agency Action	The Government is still considering this issue. Interventions could commence prior to birth. Further consideration that babies remain in hospital until they have completed their drug treatment is required. It is proposed that a Joint Working Party comprising relevant clinicians and health professionals and the Commissioner for Children and Young People examine the effectiveness of various models, including the Drug Use in Pregnancy Team model operated by Western Sydney Area Health. The NSW Methadone Clinical Practice Guidelines and existing hospital guidelines on neonatal care addresses the issue of drug withdrawing babies.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.

Practice Issues: Monitoring and Follow-up	
NSW Department of Community Services Recommendation 9.1 1997-98	In developing the capacity of district officers, assistant managers, and child protection specialists, the Department of Community Services pays particular attention to the growth failure syndromes sometimes associated with abuse and neglect in children: Non-Organic Failure to Thrive (NOFTT) and Psychosocial Growth Failure (PSGF) by: – making available as part of initial and ongoing training, specialised training about Non-Organic Failure to Thrive (NOFTT) and Psychosocial Growth Failure (PSGF). Such training should be carried out on a formalised basis across the state by paediatricians or other specialist clinicians experienced with these disorders, requiring ongoing growth measures of children registered with DoCS, including children in care, and that supervision by DoCS includes provision for regular monitoring of the growth of 'at risk' children by qualified practitioners.
Agency Action	The strategies to address this have yet to be determined.
CDRT Response	The Team is concerned that the agency has not provided adequate details. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 9.2 1997-98	NSW Health ensures that such measuring be performed on standardised growth-measuring equipment by trained staff (for example health centres, hospitals, private paediatricians, and general medical practitioners).
Agency Action	NSW Health has a child health screening and surveillance policy that identifies a recommended schedule of health checks for children under 5 years of age. This is detailed in the Personal Health Record given to all parents after the birth of a baby. Child health surveillance and screening is offered to all parents through Early Childhood Health Services. Health professionals are trained in the use of standardised growth charts. All NSW Health personnel have access to standardised equipment. A minimum number of visits are recommended for all children however it is expected that this number of visits is increased to address the needs of vulnerable or at risk children. It is anticipated that families First will facilitate this process to ensure a more integrated response to children at risk of Non-Organic Failure to Thrive.
CDRT Response	The CDRT is satisfied with the Agency response.

Skill Development: Recognition, Assessment and Referral	
NSW Health Recommendation 6.2 1998-99	The Drug Treatment Services Plan (Drug Summit recommendation 3.1) ensures that training is provided for general practitioners to emphasise the important role of general practitioners throughout childhood and to build the skills of general practitioners in identifying, managing and appropriately referring substance dependent parents and their children.
Agency Action	The NSW Drug Treatment Services Plan includes a focus on ensuring improved training and liaison with GP's. All Area Health services will have a GP liaison officer in the next two years and from 2001 all Areas will receive funding for GP integration and collaborative care. GPs involved in the Methadone Maintenance Treatment Program will be encouraged to introduce comprehensive case management, including referral of substance dependant parents and awareness of child protection issues. Treatment plans provide for three monthly case review with GPs or area health staff and all children under 5 are to be seen by a case manager at least once every reporting period. All Area Health Services are conducting a needs review to determine the training and support needs of GPs.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 9 1998-99	That the Drug and Alcohol Training Scheme (Drug Summit recommendation 5.4) ensures that all staff in drug and alcohol agencies which provide services to substance using women: – are familiar with the provisions of the *Children And Young Persons (Care and Protection) Act 1998* (to be proclaimed) including the provision for antenatal reporting of risk to an infant – are aware of the importance of early intervention and interagency collaboration in child protection.
Agency Action	All staff of drug and alcohol services are routinely involved in early intervention and interagency collaboration in child protection initiatives. NSW Health is currently progressing a train the trainer strategy in relation to the new Act. Drug and alcohol workers with an experienced child protection worker, will train other drug and alcohol workers. Training of child protection services and management will be completed by November 2000. Training of frontline staff impacted by the Act will be completed by June 2002. The Drug and Alcohol Training Scheme will incorporate child protection issues where relevant.
CDRT Response	The CDRT is satisfied with the Agency response. No further comment is required.
NSW Health Recommendation 10.1 1998-99 NSW Health Recommendation 10.2 1998-99	It is recommended that the development of the *Drug and Alcohol Training Scheme* and *Interagency Guidelines for the Early Detection and Management of Drug Misuse* include requirements that: • A hospital professional who has expertise in child protection be accessible to medical and other health workers on each obstetric ward to assist with the recognition of child protection issues arising from parental substance use and appropriate case planning and referral. • medical and other health workers in obstetric wards: – be trained to recognise the indicators of substance use – be trained to deal with avoidance and resistance in substance using clients – receive training about the impact of parental substance use on the ability to parent and on infant and child health and development – receive training in and have a clear understanding of their roles and responsibilities regarding child protection.

Skill Development: Recognition, Assessment and Referral	
NSW Health Recommendation 10.3 1998-99	Due to staff turnover, all recommended training be ongoing and provided as part of induction for new workers.
Agency Action	These recommendations will be considered in the development of the Interagency Guidelines for the Early Detection and Management of Drug Misuse. These recommendations will be referred to the Drug and Alcohol Training Taskforce in determining priorities for the Drug and Alcohol Training Scheme. The Framework for Programs 2000-2003 and Clinical Guidelines will assist nurses to manage people with alcohol and other drug related issues. NSW Health has employed a trainer for in-service training. The Framework requires all Areas and Corrections Health Services to submit implementation plans which include familiarisation with child protection issues. Area Health Services have been funded to implement a client tracking database, which will allow tracking of referrals from one system to another. A second data system is being developed to link with non-government organisations, providing on-line service access assessment, appointment and treatment referral. Ongoing training will be considered as part of the training strategy in the implementation of the *Children and Young Persons (Care and Protection) Act 1998*, via the train the trainer strategy.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 18.2 1998-99 NSW Health Recommendation 18.3 1998-99	NSW Health develops and conducts an information program for pre-natal and obstetric ward staff and early childhood nurses so that these staff can advise parents about the dangers of bed-sharing when combined with parental intoxication and smoking, particularly regarding infants. NSW Health develops a range of targeted strategies to stress the dangers of bed-sharing when combined with parental intoxication and smoking, particularly regarding infants.
Agency Action	NSW Health will implement this recommendation in the context and in association with the revised Reducing the Risks of Sudden Infant Death Syndrome Campaign in conjunction with the National SIDS Council. The Final Report of the review of the RTR campaign is still to be completed. When this has occurred NSW Health will participate in the campaigns for the public and relevant health professionals.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Department of Community Services NSW Department of Education & Training Recommendation 14.2 1998-99	The Drug and Alcohol Training Scheme and the DoCS Drug and Alcohol Training Team ensure that all training that is provided for professionals, including general practitioners, volunteers and community members in drug and alcohol issues emphasises: – the potentially deleterious effects for children of parental substance dependence, issues involved in intergenerational, chronic drug and alcohol use, professional responsibilities in relation to reporting children at risk to DoCS; and the importance of interagency collaboration in child protection

Skill Development: Recognition, Assessment and Referral

NSW Department of Community Services NSW Department of Education & Training Recommendation 14.2 1998-99	– Obstetric ward staff, staff at methadone dispensing points and needle exchange units, all health and other workers involved with substance dependent parents, and workers in non-government services participate in this training and training is provided for pharmacists dispensing methadone regarding recognition and reporting of children at risk; – Drug and alcohol workers are trained to conduct family focused assessments, including questions about their clients' children and advising about harm minimisation approaches and aim to increase the care and safety of the children when parents are using drugs; – Training for drug and alcohol workers emphasises the importance of sighting the children.
Agency Action	**NSW Department of Community Services** Introduced into DO and Assistant Manager training in 2000 and will be ongoing. Strategies are being developed with the Centre for Education in Drug and Alcohol (CEIDA) stressing interagency collaboration and increasing health worker awareness of their professional reporting responsibilities. A pilot project is currently in progress to undertake the training needs analysis for CSGP services. The aim of the pilot is to develop a model for A & OD training for prioritised community partner workers that is integrated with DoCS training for front line staff. The Minister for Community Services and Minister for Health will convene a forum for drug and alcohol workers and child protection workers to be held in 2001. The forum will assist collaboration between these groups, increase awareness of substance abuse related child abuse, improve assessment, understanding of services and resources and knowledge of Interagency Guidelines in Child Protection. **NSW Health** The training of pharmacists is part of the Drug summit Plan. The Pharmacy Guild will train pharmacists who will dispense methadone, including child protection issues. Pharmacists will provide three monthly reports on client status. Training to new pharmacists via Charles Sturt and Sydney Universities will include training on child protection. These recommendations will also be addressed through the NSW Methadone and Maintenance Clinical Guidelines. This includes case management as part of treatment programs, treatment goals which attend to the wider needs of clients and their families seeing under 5 year olds on a regular basis. The Centre for Education on Information on Drugs and alcohol will manage the Drug and Alcohol Training Scheme. **NSW Department of Education & Training** Discussion of these recommendations will take place at the first meeting of the Drug and Alcohol Training Taskforce on 22 June 2000. The Child Protection representative will introduce the recommendations and relevant actions will be incorporated into the work of the Taskforce.
CDRT Response	The CDRT is satisfied with the Agency response. No further comment is required.
NSW Department of Community Services Recommendation 16 1998-99	The Drug and Alcohol Training Scheme and the DoCS Drug and Alcohol Training Team ensure that the training clarifies the content, aims and efficacy of drug and alcohol treatment programs and addresses common misconceptions regarding such programs.
Agency Action	**NSW Department of Community Services** A 2 day Alcohol and Other Drugs Issues in Risk Assessment training program has been developed and included in District Officer Entry Level Training. The program addresses the treatment programs that are available, and the need to match the program to the needs of the child and family.

Skill Development: Recognition, Assessment and Referral	
Agency Action	The Drug and Alcohol Training Scheme and the DoCS Drug and Alcohol Training Team ensure DoCS has purchased 'Drug Net' website for use by all DoCS staff, containing information on drug and alcohol issues. **NSW Health** The training needs review currently being undertaken by the Drug and Alcohol Training Taskforce is considering these issues. A training forum for universities, vocational and educational training organisations, Area Health Services, Rural Health Training Units, professional organisations and industry training advisory bodies will be held in early 2001.
CDRT Response	CDRT will review the recommendation in the next Annual Report in regard to the training material addressing the issue of treatment efficacy.
NSW Department of Community Services Recommendation 18.1 1998-99	The Department of Community Services develops and implements specific strategies to ensure that district officers, assistant managers, and child protection specialists are aware of the dangers of bed-sharing when combined with parental intoxication and smoking, particularly regarding infants.
Agency Action	Drug and alcohol issues are addressed in the District Officer Entry l Level Training modules. The dangers of bed sharing with infants, when combined with parental intoxication and smoking are addressed in these modules. These issues are included in the review of training to ensure that there is ongoing input into course content. Parental bed sharing, in the context of parental substance use for under 1 year olds, will be included as a measure of risk in the Department's new risk assessment tools.
CDRT Response	The CDRT will review this recommendation in the next Annual Report.
NSW Department of Community Services Recommendation 4.1 1997-98	The Department of Community Services develops and implements specific strategies including casework supervision for enhancing the capacity of district officers, assistant managers, and child protection specialists to conduct risk assessments. In doing this, the following issues should be addressed: – building an accurate picture of the risk to the child – the importance of past behaviour and family history in building a picture of the risk factors – seeking independent corroboration of information given by relatives and other notifiers, including interviewing children when appropriate – the circumstances where a comprehensive risk assessment is required including referrals for paediatric assessments, developmental assessments of parents and children, psychosocial assessments (including bonding and attachment assessments), drug and alcohol assessments, and mental health assessments.
Agency Action	The corporate training strategy 1997/98 included the development of resource materials and accredited trainers for face to face delivery in all DoCS Areas of the following training components: – 3 day risk assessment – 2 day family assessment – 4 day investigative interviewing and – 3 day case management Training was completed in all Areas in 1997/98 and is an ongoing component of District Officer entry level training. The package is available for Area level training as required. Area Practice Review Teams have been established in each area. The Transformation strategy will further reduce the supervision span of case work managers. This will allow for more focus on casework issues. The Senior Practitioner strategy will also assist staff in focussing on casework issues and responsibilities.

Skill Development: Recognition, Assessment and Referral

CDRT Response	The CDRT will review this recommendation in the next Annual Report.
NSW Department of Community Services Recommendation 7.1 1997-98	In developing the capacity of district officers, assistant managers, and child protection specialists, and where training is offered to non-government child protection workers, the Department of Community Services pays particular attention to the effects of Parental Personality Disorder on children by: – making available as part of initial and ongoing training, specialised training about recognition and indicators for referral for assessment of parental Personality Disorder. This training to include its effects on personal functioning and parenting capacity; the issues in treatability of such disorder; the ability of workers to recognise a pattern of repeatedly self-defeating behaviours and failure to learn by mistakes in their clients; and the need to appropriately refer such clients to mental health clinicians for assessment. Such training should be carried out on a formalised basis across the state by mental health clinicians providing to mental health clinicians a full referral background (if known) regarding the parents' own history of abuse or neglect; relationship history; general psychological functioning; substance dependence history; any previous cognitive, psychiatric or medical reports; any known criminal history; any known psychiatric history and the parents' previous use of treatment services.
Agency Action	DoCS have contacted the Institute of Psychiatry to develop and deliver a Mental Health program to Assistant Managers in April-June 1999. As from April 2000 this is also addressed in the Assessment Skills module in DO entry level training that is delivered by the Institute of Psychiatry. The training packages have been evaluated. A review of training is currently being undertaken to ensure that training is appropriate. This includes contracting other organisations to provide specific courses for staff.
CDRT Response	The CDRT is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 5.2 1997-98	NSW Health pays particular attention to neglect of children by: – building the capacity of appropriate health professionals to conduct timely and comprehensive psychosocial and parenting capacity assessments including formal developmental and paediatric assessments of the child(ren), cognitive assessments of parent(s); drug and alcohol assessments; parental and child attachment; and assessments of parental capacity to utilise treatment service – providing to the Department of Community Services, specialists in infant and child development to conduct training about the effects of severe and especially early neglect on infants' and children's development and wellbeing – considering, with the Department of Community Services, joint strategies for the provision of the above training and assessment services, including provision at no charge to the Department of Community Services.
Agency Action	Within the NSW Health system there are the appropriate professionals who can conduct specialised assessment. The instigation of the Families First initiative should facilitate these assessments being conducted in a timely and comprehensive manner. NSW Health has serious concerns in relation to the recommendation which requires provision of training to DoCS in a formalised way at no cost. NSW Health has specialist knowledge that is available but has limited capacity to provide training without additional resources. NSW Health will meet with DoCS to discuss the implementation of this recommendation.

Skill Development: Recognition, Assessment and Referral	
CDRT Response	The CDRT awaits the outcome of the discussions between NSW Health and DoCS regarding the implementation of this recommendation. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 6.2 1997-98	NSW Health pays particular attention to severe domestic violence by: – building the capacity of specialist health workers to provide timely child and family assessment and treatment services for families subject to severe domestic violence; – providing to the Department of Community Services, specialists in infant and child development to conduct training about the effects of severe or ongoing domestic violence on children; – considering, with the Department of Community Services, joint strategies for the provision of the above training and assessment services, including provision at no charge to the Department of Community Services.
Agency Action	The use of the term severe should be reviewed as this may mean less obvious forms of domestic violence could be overlooked. Building the capacity of specialist health workers is reflected in the current NSW Health Domestic Violence Policy and Guidelines for Health Workers in Contact with Perpetrators of Domestic Violence. NSW Health has serious concerns in relation to the recommendation which requires provision of training to DoCS in a formalised way at no cost. NSW Health has specialist knowledge that is available but has limited capacity to provide training without additional resources. NSW Health will meet with DoCS to discuss the implementation of this recommendation.
CDRT Response	The CDRT awaits the outcome of the discussions between NSW Health and DoCS regarding the implementation of this recommendation. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Health Recommendation 7.2 1997-98	NSW Health pays particular attention to parental Personality Disorder by: – building the capacity of mental health clinicians to conduct timely assessments regarding Personality Disorder in parents – providing to the Department of Community Services specialist training about Personality Disorder (as detailed in recommendation 7.1) – considering, with the Department of Community Services, joint strategies for the provision of the above training and assessment services, including provision at no charge to the Department of Community Services – advising mental health clinicians who undertake assessments of parents for child protection purposes that they should request a full background history from child protection workers as part of the referral process.
Agency Action	It is unlikely that a small amount of training can provide an understanding of the complexities and management of a range of these disorders. There are several prevention and mental health programs being implemented across NSW which individuals with 'Personality Disorders' have access to. Provision of evidence based treatment for people with 'Personality Disorders' is an issue being considered at a national level. Other systemic interventions, rather than just reliance on improvement in parental functioning may also be required. Onus is upon child protection workers to provide full history's when referring cases to mental health clinicians for assessment. NSW Health has serious concerns in relation to the recommendation which requires provision of training to DoCS in a formalised way at no cost. NSW Health has specialist knowledge that is available but has limited capacity to provide training without additional resources. NSW Health will meet with DoCS to discuss the implementation of this recommendation.

Skill Development: Recognition, Assessment and Referral

CDRT Response	The CDRT awaits the outcome of the discussions between NSW Health and DoCS regarding the implementation of this recommendation. Implementation of this recommendation will be reviewed in the next Annual Report.
NSW Attorney-General's Department Recommendation 8 1997-98	The Attorney-General's Department, in implementing the *Children and Young Persons (Repeal and Amendment) Act (1998)*, and the Judicial Commission, in its provision of education for magistrates, pay particular attention to neglect, domestic violence, and parental Personality Disorder by: – building the capacity of Children's Court Registrars and Magistrates, and Children's Court Clinic personnel to recognise level of risk for children inherent in circumstances of neglect, domestic violence, and parental Personality Disorder – providing specialised training for Children's Court Registrars and Magistrates, and Children's Court Clinic personnel regarding the effects of neglect, domestic violence, and Personality Disorder on children – providing training for Children's Court Registrars and Magistrates, and Children's Court Clinic personnel regarding the constituent elements of proper assessment reports involving neglect, domestic violence and Personality Disorder, emphasising that only comprehensive assessment reports will be acceptable to inform the decision-making processes of the Children's Court in such cases.
Agency Action	**Judicial Commission of New South Wales** The Judicial Commission is responsible for educational activities of judicial officers only. The Commission has conducted a number of educational programs and produced publications on the matter of children, neglect and domestic violence for judicial officers in New South Wales. Monographs relating to children's issues and articles in the Judicial Officer's Bulletin have been produced. A number of educational sessions have been held on children's matters, including this year a series of sessions in Sydney and regional areas on the *Children and Young Persons (Care and Protection) Act* and Youth Drug Court project. An update of these sessions regarding the Act is being planned for later this year when the Act commences. We are hoping to conduct further seminars for magistrates on children's matters in 2001.
CDRT Response	The CDRT will review this recommendation in the next Annual Report in relation to the extent to which the training focuses on issues of neglect, domestic violence and parental personality Disorder, including specialised training on the elements of proper assessment reports regarding these issues.

Information Management: Case Management and Planning

NSW Health Recommendation 7.1 1998-99 Recommendation 7.2 1998-99	NSW Health develops a standardised statewide antenatal intake form that includes a comprehensive physical, medical and psychosocial history, including substance use. The development of the Interagency Guidelines for the Early Detection and Management of Drug Misuse provides for notation on antenatal intake forms of the frequency, amounts and duration of use of specific drugs (eg. Tobacco, alcohol, cannabis, heroin, methadone, heroin etc) and prescription drugs such as analgesics and codeine related linctus medications.
Agency Action	NSW health is considering as part of Families First the development of a 'screening tool' for use ante-natally and post-natally to identify vulnerable and 'at risk' families. South Western Sydney Area Health is piloting a standardised intake form which includes a psychosocial history. The Centre for Mental Health has funded the expansion of this initiative. A training package is being developed to expand this initiative to other Area Health Services.
CDRT Response	The CDRT is satisfied with the Agency response. No further comment is required.
NSW Health Recommendation 15 1998-99	NSW Health ensures that the Accreditation and Service Standards for Drug and Alcohol Service Providers require Area Health Services to develop guidelines concerning obstetric records to ensure that: – patient behaviour, which indicates possible parental substance dependence or issues affecting the care and safety of the baby, is clearly documented in medical records – where a patient may have accessed a variety of services within the one hospital, and therefore several files exists, a system is developed where files are routinely collated. One consolidated main file for each patient should be maintained. Where it is not appropriate for all the contents of a sub-file to be placed on the main file (for instance, psychiatric or psychotherapy sub-files), regular summaries and relevant correspondence from the sub-file should be added to the consolidated file – parenting issues which could affect a child's wellbeing and safety are documented on both the baby's and the mother's medical files – file notes are clearly written or typed and signed particularly when observations are recorded by different health care staff – health care facilities comply with the NSW Health child protection policy guidelines requiring procedures for flagging medical records to alert treating staff to concerns about children who are at risk of abuse.
Agency Action	Given the privacy issues involved, this recommendation is more appropriately addressed through the Training and Communication Strategy regarding the new child protection legislation. It would be difficult to mandate the keeping of obstetric records as set out in this recommendation. Area Health services accept the need to flag files. Areas which do not currently flag files will be asked to implement such a system by the end of 2000.
CDRT Response	The CDRT will review implementation of this recommendation in the next Annual Report in relation to the extent to which it has been addressed through the proposed Training and Communication Strategy.
NSW Department of Community Services Recommendation 2.1 1997-98	In developing and implementing the new Client Information System, the Department of Community Services ensures mandatory recording on the CIS, during the various stages of the case management process, of – (.../over)

Information Management: Case Management and Planning

NSW Department of Community Services Recommendation 2.2 1997-98	– all information received in relation to allegations of child abuse or neglect, – all the child's significant relationships, all names which a client may be known by in a way that allows them to be easily located, – the reasoning behind decisions, – a clearly identified summary of key events and – details of any child who dies from abuse or neglect or under 'suspicious' circumstances, their familial details and the child's significant relationships
Recommendation 2.3 1997-98	In developing and implementing the new Client Information System, the Department of Community Services consider how the system will; – permit linkage between paper and electronic files and integrate all client information in a comprehensive and accessible manner, and – requires a mandatory check at intake of prior Departmental contact with a child, his/her family members, and other significant people in his/her life
Agency Action	Consideration is currently being given to what information should be included as mandatory on the CIS. Procedures at the Teleservice Centre will allow for a mandatory check at intake of prior DoCS contact on the Client Information System. The client System will assist staff in doing their work in addition to representing DoCS business. The Client System will have the capacity to record the number of client files so files can be tracked. In addition the Client system will have the ability to print a file.
CDRT Response	The Team is satisfied with the Agency response. Implementation of this recommendation will be reviewed in the next Annual Report.

Information Management: Notification and Intake

NSW Department of Community Services NSW Police Recommendation 4.2 1997-98	The Department of Community Services investigates and reports to the Child Death Review Team on the feasibility of developing a systematic form of review for cases where multiple notifications have been received, including cases with multiple 'intake only' and not-confirmed notifications, to emphasise the importance of history to the assessment of present risk.
Agency Action	**Department of Community Services** Interagency Area Practice Review Committees were established in 1999. The focus of these committees is practice planning, monitoring and review of service provision. The commencement of the centralised intake system at the Teleservice Centre and the introduction of the Safety Assessment and Risk Assessment tools will assist with the identification of cases where there have been multiple notifications. **NSW Police** Covered by s 22 7(B) of the *Children (Care and Protection) Act 1987*. Information exchange protocol developed for use by DoCS. Information obtainable from the Criminal Records Unit of the Police Service.
CDRT Response	The Team is satisfied with the Agency response. No further comment is required.

Research and Development	
NSW Department of Community Services Recommendation 11.2 1997-98	That further research be undertaken that looks at: – the most appropriate assessments to ensure the best outcomes for children in kinship care placements; – outcomes for children in kinship care placements
Agency Action	ACWA in conjunction with UWS Macarthur is undertaking research to identify the extent and appropriateness of kinship arrangements for children and young people in kinship care in NSW. Children, carers, workers and birth parents will be interviewed to gain an understanding of satisfaction with kinship care arrangements.
CDRT Response	The Team is satisfied with the Agency response. No further comment is required.
NSW Health Recommendation 1.2 1998-99	NSW Health instigates a specific variation on the ICD coding system to include an additional code in inpatient data collections specifically for driveway crushing incidents involving motor vehicles.
Agency Action	These codes are consistent with ICD-10 AM which allows for place of occurrence ('driveway to home'). The NSW Inpatient Statistics Collection (ISC) allows for this coding. Given that this is a large data source however, it may be unsuitable for rare events such as driveway crushing incidents of children, and thus its use for these types of incidents needs to be reviewed. For instance case ascertainment of events through ISC and Trauma registries at the Children's Hospital could be carried out periodically by the Injury Risk Management and Resource Centre. NSW Health will peruse this issue with the Centre.
CDRT Response	The CDRT is satisfied with the Agency Response. No further comment is required.
NSW Health Recommendation 13.3 1998-99	NSW Health commissions research regarding drug toxicity levels in infants related to prenatal exposure and through breastfeeding, in particular including the effects of varying levels of methadone on neonates and infants susceptible to respiratory distress due to prematurity.
Agency Action	The Statewide Medication in Pregnancy and Lactation Service will be approached to undertake a literature review on this issue. The John Hunter Hospital is also conducting preliminary research.
CDRT Response	The CDRT is satisfied with the Agency Response. No further comment is required.

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Appendices

Appendix 1

Data fields

NSW Police Service

Report of Death to Coroner: (P79A)

Sex
Address
Dob
Time and date of death
Place of death
Time and date found
When last seen alive
Deceased a native of
Torres Strait Islander/Aborigine
Next of kin
Relationship to deceased
Address
Identifying person
Deceased's doctor
Criminal charges preferred
Suspicious circumstances
Crime scene (investigation)
Crash scene (investigation)
Narrative of circumstances under which death took place

Appendix 2

TABLE 28 *Detailed causes of death by gender and age at death*

Cause of death	Gender	Age at death <1 day	1 day – < 1 wk	1 wk – < 4 wks	1–<12 months	1–4 years	5–9 years	10–14 years	15–17 years	Total
Natural causes										
Infectious and parasitic diseases	M	0	0	2	2	3	0	1	0	8
	F	0	1	0	1	1	0	0	0	3
	Total	0	1	2	3	4	0	1	0	11
Neoplasms	M	0	1	0	0	6	8	9	10	34
	F	0	0	0	2	5	4	2	7	20
	Total	0	1	0	2	11	12	11	17	54
Diseases of blood & blood forming organs	M	1	0	0	2	2	0	1	0	6
	F	0	0	0	0	0	0	0	2	2
	Total	1	0	0	2	2	0	1	2	8
Endocrine, nutritional, & metabolic diseases	M	0	0	1	0	4	0	1	2	8
	F	0	1	0	0	1	1	2	1	6
	Total	0	1	1	0	5	1	3	3	14
Diseases of the nervous system	M	2	0	0	5	6	2	3	8	26
	F	0	0	3	4	3	3	1	2	16
	Total	2	0	3	9	9	5	4	10	42
Diseases of the eye and adnexa	M	0	0	0	0	0	0	0	0	0
	F	0	0	0	0	0	0	1	0	1
	Total	0	0	0	0	0	0	1	0	1
Diseases of the circulatory system	M	0	1	0	0	3	0	3	1	8
	F	0	0	0	1	3	0	0	0	4
	Total	0	1	0	1	6	0	3	1	12
Diseases of the respiratory system	M	0	0	0	6	1	0	2	3	12
	F	0	0	0	5	2	1	0	1	9
	Total	0	0	0	11	3	1	2	4	21
Diseases of the digestive system	M	0	0	0	0	0	0	0	0	0
	F	1	0	0	1	1	0	0	1	4
	Total	1	0	0	1	1	0	0	1	4
Diseases of the skin and subcutaneous tissue	M	1	0	0	0	0	0	0	0	1
	F	0	0	0	0	0	0	0	0	0
	Total	1	0	0	0	0	0	0	0	1
Diseases of the musculoskeletal system & connective tissue	M	0	0	0	0	0	0	1	0	1
	F	0	0	0	1	1	1	0	1	4
	Total	0	0	0	1	1	1	1	1	5
Pregnancy, childbirth and the puerperium	M	3	0	0	0	1	0	0	0	4
	F	3	1	0	0	0	0	0	0	4
	Total	6	1	0	0	1	0	0	0	8
Certain conditions originating in the perinatal period	M	75	37	18	11	2	0	0	0	143
	F	62	25	7	8	5	0	0	0	107
	Total	137	62	25	19	7	0	0	0	250
Congenital malformations, deformations & chromosomal abnormalities	M	19	14	12	9	4	1	3	4	66
	F	14	14	6	16	5	1	3	2	61
	Total	33	28	18	25	9	2	6	6	127

TABLE 28 *(continued)*

Cause of death	Gender	Age at death <1 day	1 day – < 1 wk	1 wk – < 4 wks	1–<12 months	1–4 years	5–9 years	10–14 years	15–17 years	Total
Symptoms, signs & abnormal clinical & laboratory findings not elsewhere classified	M	0	0	0	3	1	0	0	0	4
	F	0	0	0	0	0	0	0	0	0
	Total	0	0	0	3	1	0	0	0	4
External causes										
Effects/exposure to electric current	M	0	0	0	0	0	1	0	1	2
	F	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	1	0	1	2
Transport accident – no other information	M	0	0	0	0	0	0	1	3	4
	F	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	1	3	4
Pedestrian in transport accident	M	0	0	0	0	6	3	1	3	13
	F	0	0	0	0	2	3	1	1	7
	Total	0	0	0	0	8	6	2	4	20
Pedal cyclist in transport accident	M	0	0	0	0	0	0	1	1	2
	F	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	1	1	2
Motorcycle rider in transport accident	M	0	0	0	0	0	0	2	3	5
	F	0	0	0	0	0	0	0	1	1
	Total	0	0	0	0	0	0	2	4	6
Car passenger in transport accident	M	0	0	0	3	0	2	1	10	16
	F	0	0	0	0	4	4	1	8	17
	Total	0	0	0	3	4	6	2	18	33
Car driver in transport accident	M	0	0	0	0	0	0	0	1	1
	F	0	0	0	0	0	0	0	3	3
	Total	0	0	0	0	0	0	0	4	4
Truck passenger in transport accident	M	0	0	0	0	1	0	1	0	2
	F	0	0	0	0	0	2	0	0	2
	Total	0	0	0	0	1	2	1	0	4
Water transport accident	M	0	0	0	0	0	0	2	0	2
	F	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	2	0	2
Fall: accidental/ undetermined intent	M	0	0	0	0	1	0	1	3	5
	F	0	0	0	0	1	0	0	0	1
	Total	0	0	0	0	2	0	1	3	6
Drowning/submersion	M	0	0	0	0	12	0	1	3	16
	F	0	0	0	1	3	0	0	0	4
	Total	0	0	0	1	15	0	1	3	20
Suffocation/hanging/ strangulation/other threat to breathing	M	0	0	0	0	1	1	1	1	4
	F	0	0	0	0	0	1	0	2	3
	Total	0	0	0	0	1	2	1	3	7
Poisoning: accidental/ undetermined intent	M	0	0	0	0	0	0	1	4	5
	F	0	0	0	0	0	0	0	1	1
	Total	0	0	0	0	0	0	1	5	6

TABLE 28 *(continued)*

Cause of death	Age	Age at death <1 day	1 day – < 1 wk	1 wk – < 4 wks	1–<12 months	1–4 years	5–9 years	10–14 years	15–17 years	Total
External causes continued										
Intentional self-harm	M	0	0	0	0	0	0	2	9	11
	F	0	0	0	0	0	0	1	7	8
	Total	0	0	0	0	0	0	3	16	19
Assault and Neglect	M	0	0	0	3	4	0	2	2	11
	F	1	0	0	1	3	1	0	0	6
	Total	1	0	0	4	7	1	2	2	17
Crushing between objects	M	0	0	0	0	0	0	1	0	1
	F	0	0	0	0	1	0	0	0	1
	Total	0	0	0	0	1	0	1	0	2
Other external causes – specified	M	0	0	0	0	0	1	0	0	1
	F	1	0	0	0	0	0	0	2	3
	Total	1	0	0	0	0	1	0	2	4
SIDS or other sudden death (cause unknown) and other sleep incidents	M	0	0	0	18	0	0	0	0	18
	F	1	0	2	13	0	0	0	0	16
	Total	1	0	2	31	0	0	0	0	34
Choking	M	0	0	0	1	1	1	0	0	3
	F	0	0	0	0	0	0	0	0	0
	Total	0	0	0	1	1	1	0	0	3
Other ill-defined or unspecified cause of death or to be determined	M	1	0	3	13	2	4	3	8	34
	F	0	0	1	7	6	1	0	3	18
	Total	1	0	4	20	8	5	3	11	52
TOTAL	M	102	53	36	76	61	24	45	80	477
	F	83	42	19	61	47	23	12	45	332
	Total	185	95	55	137	108	47	57	125	809

Appendix 3

Explanatory Notes for Appendix 3

All Tables were constructed by allocating the postcode of the last residence of the child to Australian Bureau of Statistics Statistical Local Areas (SLA). Postcodes were ascribed to SLA's that accounted for the largest proportion of each postcodes population.

Each table employs the child or young persons last place of residence to determine frequencies, not the location of the fatal incident. In several places the CDRT has made reference to the location of the fatal incident in the text of the Report. Place of last residence is determined through data provided by the NSW Registry of Births, Deaths and Marriages.

All rates have been calculated using population estimates by sex by single year of age by statistical local area for June 1998 on Australian Standard Geographical Classification (ASGC). These were provided to the CDRT by the Australian Bureau of Statistics.

Table 29: Fatalities by child's last residence- Rural, metropolitan, was created by coding each SLA to the 7 category rural, remote and metropolitan areas classification (see Arundell, 1991).

Table 30: Fatalities by child's last residence- Statistical Division, classifies each SLA by ABS statistical divisions.

Table 31: Fatalities by child's last residence- Sydney Statistical Sub-Division, clusters SLA's by Statistical Sub-Divisions (SSD's) within the statistical division of Sydney. Two amendments have been made. The SSD's of Lower Northern Sydney, Hornsby, Ku-ring-gai and Northern Beaches have been aggregated to form the Northern Sydney category. The SSD's of Canterbury-Bankstown, Fairfield-Liverpool and outer South Western Sydney have been aggregated to form the category South West.

For further information on the Australian Standard Geographical Classification see ABS (2000).

TABLE 29 *Fatalities by child's last residence – Rural, metropolitan*

Cause of death	Capital City	Other Metro	Large rural centre	Small rural centre	Other rural	Other remote	Outside NSW	Total
Natural causes								
Infectious and parasitic diseases	9	0	1	1	0	0	0	11
Neoplasms	36	4	3	3	6	1	1	54
Diseases of blood & blood forming organs	7	1	0	0	0	0	0	8
Endocrine, nutritional & metabolic diseases	7	3	1	0	3	0	0	14
Diseases of the nervous system	28	7	2	4	1	0	0	42
Diseases of the eye and adnexa	1	0	0	0	0	0	0	1
Diseases of the circulatory system	6	4	0	1	1	0	0	12
Diseases of the respiratory system	7	4	2	1	7	0	0	21
Diseases of the digestive system	2	1	0	1	0	0	0	4
Diseases of the skin & subcutaneous tissue	1	0	0	0	0	0	0	1
Diseases of the musculoskeletal system and connective tissue	3	0	1	0	1	0	0	5
Pregnancy, childbirth and the puerperium	2	0	0	3	3	0	0	8
Certain conditions originating in the perinatal period	156	34	6	27	24	2	1	250

TABLE 29 *(continued)*

Cause of death	Capital City	Other Metro	Large rural centre	Small rural centre	Other rural	Other remote	Outside NSW	Total
Congenital malformations, deformations & chromosomal abnormalities	75	12	8	8	19	1	4	127
Symptoms, signs & abnormal clinical findings, not elsewhere classified	4	1	1	3	1	1	0	11
External causes								
Effects/exposure to electric current	1	1	0	0	0	0	0	2
Transport accident – no other information	3	1	0	0	0	0	0	4
Pedestrian in transport accident	12	1	0	3	3	0	1	20
Pedal cyclist in transport accident	2	0	0	0	0	0	0	2
Motor cycle rider in transport accident	3	1	0	1	1	0	0	6
Car passenger in transport accident	19	1	1	3	8	0	1	33
Car driver injured in transport accident	0	0	1	2	1	0	0	4
Truck passenger in transport accident	2	0	0	1	0	0	1	4
Water transport accident	1	0	0	0	0	0	1	2
Fall	3	0	0	1	1	0	1	6

TABLE 29 *(continued)*

Cause of death	Capital City	Other Metro	Large rural centre	Small rural centre	Other rural	Other remote	Outside NSW	Total
Drowning	12	1	2	3	1	1	0	20
Suffocation	4	0	0	0	3	0	0	7
Poisoning	3	0	0	1	1	1	0	6
Intentional self-harm	11	3	0	2	2	1	0	19
Assault	8	2	1	2	2	1	0	16
Crushing between objects	0	0	0	0	2	0	0	2
Other external causes – specified	3	0	0	0	0	0	0	3
SIDS or other sleep incidents	23	1	4	1	3	2	0	34
Choking	2	1	0	0	0	0	0	3
Cause of death to be determined	26	6	3	3	9	0	0	47
Total	**482**	**90**	**37**	**75**	**103**	**11**	**11**	**809**
Estimated Resident Population, 0 to 17 years (1998)	953,258	191,623	85,657	126,951	205,161	15,887	–	1,578,537
Incidence per 100,000 Estimated Resident Population, 0 to 17 years (1998)	50.6	47.0	43.2	59.1	50.2	69.2		51.2

TABLE 30 *Fatalities by child's last residence – Statistical Division*

Cause of death	Sydney	Illawarra	Hunter	Mid North Coast	Nthrn Tablelands	Nth & Central West	South Eastern	Murrumbidgee	Murray	Far West	Richmond Tweed	Outside NSW	Total
Natural causes													
Infectious and parasitic diseases	9	0	0	0	1	1	0	0	0	0	0	0	11
Neoplasms	36	0	5	2	1	3	4	1	0	0	1	1	54
Diseases of blood & blood forming organs	7	0	1	0	0	0	0	0	0	0	0	0	8
Endocrine, nutritional & metabolic diseases	7	1	2	1	1	1	0	1	0	0	0	0	14
Diseases of the nervous system	28	6	4	1	2	0	0	1	0	0	0	0	42
Diseases of the eye and adnexa	1	0	0	0	0	0	0	0	0	0	0	0	1
Diseases of the circulatory system	6	1	3	0	1	0	0	0	0	0	1	0	12
Diseases of the respiratory system	7	2	3	2	3	2	1	1	0	0	0	0	21
Diseases of the digestive system	2	0	1	1	0	0	0	0	0	0	0	0	4
Diseases of the skin and subcutaneous tissue	1	0	0	0	0	0	0	0	0	0	0	0	1
Diseases of the musculoskeletal system and connective tissue	3	0	0	0	1	1	0	0	0	0	0	0	5
Pregnancy, childbirth and the puerperium	2	2	0	1	0	0	2	1	0	0	0	0	8
Certain conditions originating in the perinatal period	156	15	29	9	8	16	4	6	2	1	3	1	250

TABLE 30 *(continued)*

Cause of death	Sydney	Illawarra	Hunter	Mid North Coast	Nthrn Tablelands	Nth & Central West	South Eastern	Murrumbidgee	Murray	Far West	Richmond Tweed	Outside NSW	Total
Natural causes													
Congenital malformations, deformations & chromosomal abnormalities	75	4	12	7	5	9	6	2	0	0	3	4	127
Symps, signs & abnormal clinical findings including SIDS & sleep incs	26	4	1	1	1	4	1	2	1	0	1	0	42
External causes of morbidity and mortality	**90**	**12**	**9**	**7**	**5**	**9**	**9**	**7**	**2**	**1**	**6**	**5**	**162**
Cause of death to be determined	26	4	3	0	3	6	1	0	2	0	2	0	47
Total	**482**	**51**	**73**	**32**	**32**	**52**	**28**	**22**	**7**	**2**	**17**	**11**	**809**
Estimated Resident Population, 0 to 17 years (1998)	953,258	98,355	143,657	71,769	48,552	82,268	47,609	41,907	30,418	6,156	54,521	–	1,578,537
Incidence per 100,000 Estimated Resident Population, 0 to 17 years (1998)	50.6	51.9	50.8	44.6	65.9	63.2	58.8	52.5	23.0	32.5	31.2	-	51.2

TABLE 31 *Fatalities by child's last residence – Sydney Statistical Sub-Division*

Cause of death	Inner Sydney	Eastern Suburbs	Northern Sydney	Inner West	Central West	South West	Outer West	Blacktown-Baulkham Hills	St George-Sutherland	Gosford & Wyong	Total
Natural causes											
Infectious and parasitic diseases	1	3	0	0	0	1	0	2	1	1	9
Neoplasms	2	3	6	2	2	13	2	2	1	3	36
Diseases of blood & blood forming organs	1	0	1	0	2	1	0	2	0	0	7
Endocrine, nutritional & metabolic diseases	1	1	1	0	1	2	1	0	0	0	7
Diseases of the nervous system	1	1	2	1	4	8	5	2	1	3	28
Diseases of the eye and adnexa	0	0	0	0	0	0	0	0	1	0	1
Diseases of the circulatory system	1	0	1	0	2	0	1	1	0	0	6
Diseases of the respiratory system	0	0	0	0	3	2	1	0	0	1	7
Diseases of the digestive system	0	0	0	0	0	2	0	0	0	0	2
Diseases of the skin and subcutaneous tissue	0	0	0	0	0	0	1	0	0	0	1
Diseases of the musculoskeletal system and connective tissue	0	0	0	0	1	0	0	0	1	1	3
Pregnancy, childbirth and the puerperium	0	0	1	0	0	0	0	0	0	1	2

TABLE 31 *(continued)*

Cause of death	Inner Sydney	Eastern Suburbs	Northern Sydney	Inner West	Central West	South West	Outer West	Blacktown-Baulkham Hills	St George-Sutherland	Gosford & Wyong	Total
Natural causes											
Certain conditions originating in the perinatal period	7	9	33	3	10	44	9	9	17	15	156
Congenital malformations deformations and chromosomal abnormalities	3	5	12	1	11	18	5	9	8	3	75
Symptoms, signs & abnormal clinical findings, not elsewhere classified, including SIDS & sleep inc.	0	0	4	0	6	7	2	4	1	2	26
External causes of morbidity and mortality	**5**	**2**	**11**	**1**	**9**	**27**	**6**	**16**	**3**	**10**	**90**
Cause of death to be determined	2	2	4	1	0	7	3	3	1	3	26
Total	**24**	**26**	**76**	**9**	**51**	**132**	**36**	**50**	**35**	**43**	**482**
Estimated Resident Population, 0 to 17 years (1998)	41,974	40,370	163,039	31,324	69,007	239,774	90,476	108,963	95,356	72,975	953,258
Incidence per 100,000 Estimated Resident Population, 0 to 17 years (1998)	57.2	64.4	46.6	28.7	73.9	55.1	39.8	45.9	36.7	58.9	50.6

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