The Hon Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast

NSW GOVERNMENT

Your Ref: 2013/361922
Our Ref: COR23/12

The Hon. Michael Daley, MP
Attorney General
52 Martin Place
SYDNEY NSW 2000
office@daley.minister.nsw.gov.au

Coronial inquest into the death of Baylen Pendergast

Dear Attorney General Michael

I write in relation to the findings and recommendations made on 23 June 2023 by Deputy State Coroner Derek Lee regarding the death of Baylen Pendergast.

Baylen died aged 21 months on 30 November 2013 at the Sydney Children's Hospital, Randwick, from complications of blunt head injury resulting from at least two separate acts of trauma. It is most likely that these acts of trauma occurred on 17 and 28 November 2013. The expert medical evidence establishes that it is most likely that Baylen's injuries were the result of the application of significant non-accidental force by another person or persons.

Magistrate Lee made 4 recommendations to Hunter New England LHD, which are supported.

Baylen's coronial findings were sent to the Ministry of Health Prevention and Response to Violence and Neglect Unit on 25 August 2023 as per Magistrate Lee's request that *"a copy of the findings in the Inquest into the death of Baylen Pendergast be forwarded to NSW Health for consideration by the Child Protection and Wellbeing Unit in the development of any NSW specific guidelines regarding management of physical abuse and neglect cases involving children and young people."*

Recommendation 1

The Deputy State Coroner recommended:

That urgent consideration be given to prioritising completion of Child Protection Training for firstly, paediatric medical staff and secondly, for emergency department medical staff at Tamworth Base Hospital.

The district confirmed their commitment to prioritising completion of Child Protection training for paediatric medical staff and ED medical staff at Tamworth Base Hospital. Medical officers undertake face-to-face training and online modules.

Medical officers who had not yet undertaken training were each contacted and advised to complete training by the end of 2023. Additional training sessions were scheduled, with an audit planned for December 2023, and escalation strategy for any non-compliant medical officers.

Recommendation 2

The Deputy State Coroner recommended:

That appropriate steps are taken to confirm or ensure that parents and caregivers of children presenting with head injury are being provided with appropriate fact sheets or handouts explaining what symptoms they should be particularly alert for upon discharge and what to do if such symptoms arise.

The Hunter New England LHD Children, Young People and Families Directorate has a Mild Head Injury and Concussion factsheet on the HNEkidshealth website. The website is accessible to clinicians and consumers.

An A4 sheet placed at the front of the patient's notes will remind staff to provide the head injury factsheet, if required. With the future introduction of the State-wide Single Digital Patient Record, a request will be made to include factsheets with discharge summaries.

HNEkidshealth has reviewed all Hospital Health Pathways and prioritised a pathway for head injury. The head injury pathway has commenced, with information added to the Hospital Health Pathway document to support clinicians in relation to suspected head injuries and the referral process.

Recommendation 3

The Deputy State Coroner recommended:

That urgent consideration be given to prioritising the completion of Paediatric Clinical Guidelines training for paediatric medical staff, if same has not already completed.

Head Injury Clinical Practice Guidelines education sessions have occurred at Tamworth Hospital. The district advises that in November 2022 a presentation was provided to Tamworth Hospital paediatric clinicians about head injury clinical practice guidelines and a further session took place on 29 August 2023, as part of the Tamworth Paediatric Service education program. It was presented by the paediatric fellow and attended by paediatric consultants and junior medical officers. The education will continue to be provided every year.

Recommendation 4

The Deputy State Coroner recommended:

That an audit be conducted of the completion of discharge summaries, and the provision of discharge summaries to general practitioners, to ensure that such summaries are being completed and provided in a timely manner following discharge of a paediatric patient.

Facilities across the district undertake audits of discharge documentation in accordance with Hunter New England Policy Compliance Procedure PD2019_020: *PCP 5 - Discharge Documentation (Medical and Nursing) for Patients being Discharged from Hospital*. As per the requirements of the policy compliance procedure, Tamworth Hospital undertakes regular audits of discharge summaries for adult and paediatric patients.

The Tamworth Hospital Communicating for Safety Standard[1] Committee meet every 2 months regarding safety and quality. Electronic discharge summary audit results are tabled at each meeting. On 19 October 2023, the Committee reviewed the September 2023 audit results. Tamworth

[1] Communicating for Safety is a National Safety and Quality Health Service Standard of the Australian Commission on Safety and Quality in Health Care.

Hospital Children's ward and Special Care Nursery had 92% and 100% compliance respectively. Completed electronic discharge summaries are immediately accessible by a patient's GP.

State-wide actions

Baylen's findings were reviewed by the Prevention and Response to Violence and Neglect Serious Incident Review Subcommittee. The subcommittee noted that a number of the recommendations could be considered to have state-wide application, with further discussion on 27 October 2023 with representatives from the Ministry of Health Prevention and Response to Violence and Neglect Unit, the Chief Paediatrician and Clinical Excellence Commission Patient Safety Directorate.

In addition, the Ministry of Health is currently progressing systems-level activities to help address the child protection concerns raised by Baylen's tragic death.

This includes establishing state-wide 'Child and Adolescent Safety Paediatrician' positions as part of a $53M on-going funding package to enhance the medical and forensic workforce announced on 19 September 2023. These roles will complement existing local responses, enhance the provision of clinical care state-wide and importantly provide paediatric child protection medical leadership and capability uplift across the broader local workforce.

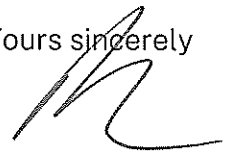
The Ministry of Health is also implementing the Safety and Support project under the Domestic, Family and Sexual Violence National Partnership Agreement, which will deliver a state-wide paediatric medical and forensic training and clinical placement program led by child protection paediatric specialists. The program will seek to enhance current paediatric medical and forensic capability and will include a focus on supporting regional and rural clinicians. This program will be delivered from 2023 to 2025 and will be integral to supporting the appropriate identification, response and referral of child protection matters.

The Ministry of Health is currently developing NSW specific, evidence-based clinical guidelines to improve responses to children experiencing physical abuse and neglect. This will help ensure children and young people receive consistent, quality psychosocial, medical and forensic responses within the NSW Health system. The draft guidelines include specific guidance that consultation with Child Abuse & Sexual Assault Clinical Advice Line (a 24/7 medical and forensic telephone advice line staffed by child protection paediatric specialists) or with your tertiary CPUs/Child Protection team is strongly advisable in all cases where there is the slightest suspicion that an infant or child has sustained a head injury from abuse. The guidelines also advise that children with suspected abusive head trauma should be transferred to a tertiary paediatric hospital for a comprehensive child protection forensic medical assessment.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely



Ryan Park MP
Minister for Health
Minister for Regional Health
Minister for the Illawarra and the South Coast
CC: NSW Coroner's Court
Encl. Coroner's report – *Inquest into the death of Baylen Pendergast*