COMMITTEE ON CHILDREN AND YOUNG PEOPLE

REVIEW OF THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM LEGISLATION

AN EXAMINATION OF A REPORT FOR THE MINISTER FOR COMMUNITY SERVICES

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David P. Campbell M.P., Member for Keira
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This report, the eighteenth by the Committee on Children and Young People, examines the findings and recommendations of a report of the review of the legislation governing the New South Wales Child Death Review Team published by the Commission for Children and Young People:

> Calvert, G. & Yu, J. (2002). Review of legislation governing the NSW Child Death Review Team – Part 7A, Children (Care and Protection) Act 1987 (NSW). Surry Hills, NSW: Commission for Children and Young People.

The report was tabled in the Legislative Assembly on 4 June 2002 by the former Minister for Community Services, the Hon. Faye Lo Po' MP.

Under s.28 (1)(c) of the *Commission for Children and Young People Act 1998*, the Committee on Children and Young People is required to examine reports of the Commission for Children and Young People, and to report any matter arising from such reports to both houses of Parliament.

The Child Death Review Team was established in 1995 with the specific aim of using the facts surrounding the deaths of children to inform policy and procedure so as to prevent future child deaths. With the establishment of the New South Wales Commission for Children and Young People in June 1999, the Commissioner became the Convenor of the Team. The Commission provides research, policy, secretariat and administrative support to the Team and also conducts community education in relation to the Team's work.

The New South Wales government has already taken action in relation to the findings and recommendations of the review. On 1 December 2002, the Community Services Commission amalgamated with the New South Wales Ombudsman to create the Community Services Division. Under the *Community Services Legislation Amendment Act 2002* (NSW), this new division has responsibility for reviewing the deaths of certain specified groups of vulnerable children, including those whose death was due to abuse, neglect or occurred in suspicious circumstances, and to make recommendations. The Child Death Review Team will retain its key functions of maintaining the child death register and conducting research to prevent child deaths.

Section 108 of the *Children (Care and Protection) Act 1987* (NSW) ('the Act') requires the Minister for Community Services to conduct a review of Part 7A of the Act which governs the Child Death Review Team to determine;

- whether the policy objectives of Part 7A remain valid
- whether the terms of Part 7A remain appropriate for securing these objectives.[1]

[1] Part 7A was re-enacted as Part 11 of the new *Children and Young Persons (Care and Protection) Act 1998* (NSW), which is yet to be proclaimed.

The review was to commence five years after Part 7A commenced and a report of the review was to be tabled in Parliament within 12 months (i.e., by June 2002).

The report reviewing the first five years of the legislation makes 11 recommendations covering the following areas;

- review of the legislation again after five years
- setting out the policy objectives of the legislation
- location of the legislative provisions that govern the Child Death Review Team
- functions of the child death review team
- reporting obligations
- access to information concerning children who have died
- confidential information
- composition of the Child Death Review Team
- operational provisions
- guidelines
- regulations

The Committee's examination of the report of the review of the legislation governing the New South Wales Child Death Review Team commenced with public announcements and a call for submissions commenting on the report and its conclusions. The Committee received three primary submissions and one supplementary submission regarding the report. Public hearings into the findings and recommendations of the report were held at Parliament House Sydney on 20 September 2002 and 27 September 2002. Full transcripts of the hearings are included in this report, as is the full text of one submission received (from the Community Services Commission) that addressed the recommendations specifically.

The Committee welcomes the recommendations of the report of the review of the legislation governing the New South Wales Child Death Review Team. The Committee is of the view that these recommendations will strengthen the capacity of the NSW Child Death Review Team to achieve its important role of preventing or reducing child deaths in NSW.

Acknowledgements

I thank my fellow Members of the Committee on Children and Young People for their contribution to this inquiry.

I am also grateful for the assistance of the secretariat to the Committee on Children and Young People, Mr Ian Faulks, the Committee Manager, and the secretariat staff, Mrs Cheryl Samuels, Ms Jodie Young and Ms Susan Tanzer.

I commend this report to Parliament.

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A report required under the Commission for Children and Young People Act 1998 s.28 (1)(c) relating to the statutory function of the Parliamentary Joint Committee to examine each annual or other report of the Commission for Children and Young People Act and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report.

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THE REVIEW OF THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM LEGISLATION – A REPORT FOR THE MINISTER FOR COMMUNITY SERVICES

Introduction

1.1. Section 108 of the *Children (Care and Protection) Act 1987* requires that the Minster for Community Services review Part 7A of the Act which governs the New South Wales Child Death Review Team (the Team) to determine:

- Whether the policy objectives of Part 7A remain valid;
- Whether the terms of Part 7A remain appropriate for securing these objectives.

While Part 7A was re-enacted as Part 11 of the new *Children and Young Persons (Care and Protection Act 1998*, Part 11 has not yet been proclaimed, pending the Minister for Community Services' review.

1.2 The former Minister for Community Services, the Hon. Faye Lo Po' MP, requested Ms Gillian Calvert, Commissioner for Children and Young People, and Dr John Yu, Chair of the Commissioner's Expert Advisory Panel, to conduct the review of the legislation governing the New South Wales Child Death Review Team. The aim of the review was to see whether the legislation's policy objectives remain valid and the terms are still appropriate to secure these objectives five years after the legislation came into operation.

1.3 The former Minister for Community Services tabled the report of the review in the New South Wales Legislative Assembly in early June 2002.

1.4 The New South Wales government has already taken action in relation to the findings and recommendations of the review. Under the *Community Services Legislation Amendment Act 2002*, the new Community Services Division of the Ombudsman is given responsibility for reviewing the deaths of certain specified groups of vulnerable children, including those whose death was due to abuse, neglect or occurred in suspicious circumstances and would make recommendations about how to prevent child deaths as a result. The Child Death Review Team retains its key functions of maintaining the child death register and conducting research to prevent child death from all causes.

1.5 The report of the review of the legislation governing the New South Wales Child Death Review Team contains eleven recommendations. The following paragraphs present each recommendation in turn, and summarise the intent of the recommendation.

RECOMMENDATION 1 – REVIEW OF THE LEGISLATION AGAIN AFTER FIVE YEARS

The legislative provisions governing the NSW Child Death Review Team should be reviewed five years after the date on which legislative amendments commence in response to this review or, if no changes are made, five years from the date this report is tabled in Parliament. The legislated aim of the review should be to determine whether the policy objectives of the legislative provisions remain valid and the terms remain valid for securing those objectives.

1.6 If implemented, the proposed recommendations change the way that the Child Death Review Team operates. The review of the legislation governing the New South Wales Child Death Review Team argues that it is therefore important to review the implementation of these changes five years after the commencement of the new legislative provisions. This is supported by the Community Services Commission as it would present an opportunity to review any duplication in function or practice of the Child Death Review Team and the Community Services Division of the Ombudsman.

RECOMMENDATION 2 – SETTING OUT THE POLICY OBJECTIVES OF THE LEGISLATION

The broad policy objective of Part 7A, to prevent or reduce the deaths of children in New South Wales, should continue. The legislation governing the Child Death Review Team should include an objects clause that provides clear guidance on its policy objectives:

'The object of this Part is to prevent or reduce the deaths of children in NSW and promote their safety, welfare and well-being through relevant research and the making of recommendations."

1.7 According to the review of the legislation governing the New South Wales Child Death Review Team, the policy objectives for having a child death review system are not clearly set out in legislation. There is no specific objects clause for Part 7A or general objectives clause for the Act as a whole. The review of the legislation governing the New South Wales Child Death Review Team argues that the enactment of an objects clause would provide clear guidance on what the Government's objectives were for having a child death review system. The Community Services Commission believes that it would be appropriate to broaden

the focus on the Child Death Review Team's policy objectives to create opportunities for more in-depth work on deaths from causes not covered by the Community Services Division of the Ombudsman and would be particularly supportive of research that has a focus on the most vulnerable children (e.g., children with disabilities) and the impact of social disadvantage on children's safety and well being.

Broadening the focus of the policy objectives would also enable the Child Death Review Team to conduct research that aims to prevent or reduce deaths of children in New South Wales from all causes, if the proposal to have the Community Services Division of the Ombudsman review deaths from child abuse or neglect does not proceed.

RECOMMENDATION 3 – LOCATION OF THE LEGISLATIVE PROVISIONS THAT GOVERN THE CHILD DEATH REVIEW TEAM

The legislative provisions governing the NSW Child Death Review Team should become a separate part of the *Commission for Children and Young People Act 1998* (NSW). It should be a new function of the Commission to support the work of the Child Death Review Team in accordance with this new Part.

1.8 The review of the legislation governing the New South Wales Child Death Review Team argues that there is strong support for moving provision to the *Commission for Children and Young People Act 1998* because:

- the Commission for Children and Young People provides policy, research and secretariat support to the Child Death Review Team;
- the Commissioner for Children and Young People is the Convenor of the Child Death Review Team;
- the Commission for Children and Young People is the advocate for children, independent of Government, that reports direct to Parliament;
- the principles and functions of the *Commission for Children and Young People Act 1998* fit with those of the Child Death Review Team
- the Child Death Review Team's accountability would be enhanced by its work being subject to monitoring and review by the Committee on Children and Young People.

The Community Services Commission agrees that the *Commission for Children and Young People Act 1998* would be the appropriate place for the legislative basis of the Child Death Review Team.

RECOMMENDATION 4 – FUNCTIONS OF THE CHILD DEATH REVIEW TEAM

The Child Death Review Team's work should be guided by the following revised functions:

- Maintaining a register of child deaths occurring in New South Wales after 1 June 1996, classifying such deaths according to cause, demographic criteria or other relevant factors and analysing this data to identify patterns and trends relating to these deaths
- Undertaking research which aims to help prevent or reduce the likelihood of child deaths, either alone or in co-operation with others
- Formulating recommendations arising from the Child Death Review Team's work on the register of child deaths and research as to policies and practices to be implemented by government and non-government agencies and the community to prevent or reduce the likelihood of child deaths.

The legislation should require that in every research report the Child Death Review Team tables in Parliament it should set out the reasons on which it based its decision to undertake the particular project, including:

- The extent to which the deaths in question appear to be preventable
- The circumstances surrounding the deaths
- Whether it is more appropriate for other bodies to conduct the research
- Other matters identified by the Child Death Review Team as relevant.

1.9 The current legislation defines the Child Death Review Team's main function as developing recommendations about policies and practices that government, private agencies and the community can implement to prevent or reduce child deaths. Consultations undertaken during the course of the review of the legislation governing the New South Wales Child Death Review Team strongly supported the continued function of the Child Death Review Team in maintaining a register of child deaths and reporting on the register on an annual basis. There was also strong support for the Child Death Review Team being allowed the opportunity to study serious non-fatal injuries as well as death from the same cause (e.g., near drowning, burns, poisoning, falls, motor vehicle crashes, and injuries from being shaken). The Community Services Commission also supports this recommendation, on the basis that it would enable the Child Death Review Team to undertake collaborative research to provide important information for advocacy on issues such as children's use of public space, environmental hazards, etc.. The Community Services Commission also believes that a focus on vulnerable or disadvantaged children would be the appropriate use of the resources allocated to the Child Death Review Team.

RECOMMENDATION 5 – REPORTING OBLIGATIONS
The Child Death Review Team should be required to report on [any] aspect of deaths from abuse, neglect or that occur in suspicious circumstances every three years [if the Community Services Commission/Ombudsman amalgamation proposal does not go ahead].

The Child Death Review Team should be required to report annually within the period of 4 months after 30 June in each year:

- about deaths registered during the previous calendar year
- giving a description of activities during the year in relation to each of the key functions
- giving details of the extent to which its previous recommendations have been accepted and commenting on the extent to which those recommendations have been implemented in practice
- if information has been authorised by the Convenor for release for the purpose of joint research, or research to be conducted by others to help prevent or reduce the likelihood of deaths of children in New South Wales
- giving reasons if the Team has not presented to Parliament a special research report:
  - every three years [if the Community Services Commission/Ombudsman amalgamation proposal is adopted], or
  - on child deaths from causes other than child abuse or neglect, during the three years between each report on child abuse or neglect [if the Community Services Commission/Ombudsman amalgamation proposal is not adopted]

The Child Death Review Team must present this information as a Child Death Review Team annual report, or combined with the annual report of the Commission for Children and Young People, or in a special report (or as part of a special report).

1.10 The proposed change would enable the Child Death Review Team to report directly to the Parliament rather than providing a draft report to the Minister for Community Services for comment prior to tabling of a final report in the Parliament. The need for independence from the Government was raised by the Opposition in the second reading debate of the Children (Care and Protection) Amendment Bill 1995. The review of the legislation governing the New South Wales Child Death Review Team argues that the current reporting obligations of the Child Death Review Team set very strict timeframes for the provision of an annual report to the Parliament but are unclear as to what the report to Parliament should contain, other than recommendations and what period must be covered by the report. To date, this has been interpreted as requiring a report based on a financial year. The Child Death Review Team argues, however, that it is difficult getting hold of necessary records, for example from the Coroner, and then analysing and reporting on them during a given financial year. Consequently deaths registered within the financial year that it being reported on are not always recorded in the register of deaths, because a final determination has not been made by the Coroner. The Review argues, therefore, that the Child Death Review Team should adopt the Australian Bureau of Statistics model that publishes annual data on child deaths based on coronial and death certificate data registered in one calendar year but reported on in late the following year. The Community Services Commission points out that the proclamation of the *Community Services Amendment Act 2002* later this year will mean that the first component of this recommendation will not be necessary, however, it will be necessary for the Child Death Review Team to review certain

categories of child deaths that occur prior to the proclamation. Following proclamation, the Community Services Division of the Ombudsman will report on reviewable child deaths annual in an Annual Report to Parliament and through any necessary special reports by the Ombudsman.

RECOMMENDATION 6 – ACCESS TO INFORMATION CONCERNING CHILDREN WHO HAVE DIED

The current provision that requires others to provide the Child Death Review Team with access to information they hold about a child who has died should be revised to provide that:

- The Director-General, the Department Head, Chief Executive Officer or senior member of any Department of the Government, statutory body or local authority, the Commissioner of Police and the State Coroner
- A private practitioner or head of an agency delivering health services to children (such as doctors, psychologists and psychiatrists, physiotherapists, nurses, dentists, radiologists and private hospitals
- A person or head of a non-government agency (such as family support services, children's services residential out-of-home care and disability services and foster carers}
- A Principal of a non-government school within the meaning of the *Education Act 1900 (NSW)*

are under a duty to provide the Child Death Review Team with full and unrestricted access t records that are under the person's control, or whose production the person may, in an official capacity, reasonably require. These records are those from which the Team reasonably requires access for the purpose of exercising its functions.

Access to which the Child Death Review Team is entitled under the paragraph above includes the right to inspect and, on request, to be provided with copies of, any such records and to inspect any non-documentary evidence associated with them

A provision of any Act or law that restricts or denies access to records does not prevent a person subject to these provisions complying or affect the person's duty to comply.

1.11 The current legislation provides the Child Death Review Team with full and unrestricted access to records under the control of Government departments, statutory bodies or local authorities. The review of the legislation governing the New South Wales Child Death Review Team argues, however, that key data is held by individuals and organisations outside of government and that inadequate records can frustrate the Team's full consideration of circumstances surrounding child deaths and the development of responsive recommendations. The proposed recommendation received overwhelming support in consultations, although there was some difference of opinion as to whether the non-government sector should provide child death related records voluntarily or under legislation. The Community Services Commission supports the recommended legislative change to enable access to information from a broader group of agencies, including direct access to service providers involved in children's lives. The ability of the Child Death Review Team to review circumstances where children were seriously injured would provide an important base for recommendations regarding injury prevention. The Community Services Commission points out that the Disability Death Review Team has used

protocols and agreements around exchange of information to access information regarding the deaths of certain groups of people with disabilities since its inception in 1998. Access to documents and information from government and non-government accommodation service provides regarding the quality of life of individuals and the broader circumstances surrounding their deaths has allowed the gathering of a holistic view about systemic or service provision changes that may prevent other fatalities arising out of similar circumstances. The Community Services Commission believes that it is appropriate that failure to comply with the proposed new information sharing provisions should not be an offence and agrees with the recommendation that difficulties around the exchange of information, or incomplete information sets for particular reviews should be mentioned in an annual or special report to Parliament.

RECOMMENDATION 7 – CONFIDENTIAL INFORMATION

The current confidentiality provision should be revised to provide that a person who discloses any information obtained in connection with the Child Death Review Team or the exercise of the child death functions is guilty of an offence unless the disclosure:

- is made in good faith for the poses of exercising the child death functions, or
- is authorised by the Convenor for the purpose of joint research or research to be conducted by others to help prevent or reduce the deaths of children in NSW, or
- is made by the Convenor for the purpose of:
  - Referring information about a possible criminal offence to the Police
  - Reporting that a child may be a risk of harm to the Department of Community Services
  - Providing new information to the State coroner or other possible interpretations or known facts that may support a case being reopened

  or,
- is made by the Minister after a draft report is sent to him or her for comment and in the process of seeking the advice of other relevant Ministers and heads of government agencies. During this advice giving stage, relevant Ministers and heads of government agencies can discuss the content of the draft report with their nominee on the Team, the Convenor and other relevant people within their office or agency.

Members of the Child Death Review Team and any person engaged to assist the Team exercise its child death functions are not required, by reasons of being in such a position, to:

- produce or permit access to any court (to be defined as including any tribunal or person having power to require the production of documents or the answering of questions) any document or other thing that has come into the person's possession, custody or control or
- reveal to any court any information that has come to the person's notice.

Where a member of the Child Death Review Team or any officer or person engaged to assist the Team exercise its child death functions reveals information acquired as a result of performing child death functions to an authority or person (this includes a person or employee under the control of that authority or person) that authority or person is subject to the same obligations and liabilities in respect of that information as if they were a member of the Team or any person engaged to assist the Team and enjoys the same rights and privileges. Failure to comply with these obligations and liabilities constitutes an offence.

A person who dishonestly obtains or attempts to obtain confidential information relating to the exercise of the child death functions is guilty of an offence.

An offence should be defined as one attracting 50 penalty units or imprisonment for 12 months, or both.

The Child Death Review Team should continue to be exempt from the *Freedom of Information Act 1989 (NSW).*

1.12 The review of the legislation governing the New South Wales Child Death Review Team argues that the current confidentiality provisions are unnecessarily restrictive and the Child Death Review Team does not now do a number of things

that would clearly assist its overall aim of preventing and reducing child deaths, for example

- representatives of government agencies who are Child Death Review Team members do not now discuss the finding and recommendations of draft reports with the colleagues, the head of their agency or respective Ministers before publication, even though such discussion could enrich the responsiveness of recommendations
- identifying or non-identifying data is not discussed in steering committees of joint research projects (for example, in the Child Death Review Team's current joint project on suicide and risk taking)
- The Child Death Review Team does not release identifying or non-identifying data to other research bodies, even for the purpose of further research on matters that have been the subject of recommendations in a prior Team report.

The review of the legislation governing the New South Wales Child Death Review Team considers that there should be exceptions made to allow the release of confidential information to others in certain well-defined circumstances. The review of the legislation governing the New South Wales Child Death Review Team also took the view that the prohibition on disclosing information obtained in connection with the child death functions of the Child Death Review Team should apply not only to Team members and relevant Commission staff but also individuals engaged by the Convenor to take part in special research projects and members of joint research projects. The review of the legislation governing the New South Wales Child Death Review Team also considers that it is appropriate to include a new offence that applies to anyone who dishonestly obtains or attempts to obtain confidential information relating to the Child Death Review Team or the exercise of its functions, in addition to the existing offence that currently applies for inappropriate disclosure of confidential information. The Community Services Commission supports this recommendation on the grounds that the confidentiality provisions should not limit the ongoing work of the Child Death Review Team in developing effective recommendations and undertaking research. Further, the Community Services Commission believes that the work of the Child Death Review Team must be transparent and not unduly secretive in its conduct, or order to maintain the trust and confidence of the community. This view was supported by the Opposition in the second reading debate of the *Children (Care And Protection) Amendment Bill 1995.* The Community Services Commission also believes that it is reasonable for the legislation to enable the Child Death Review Team and staff of the Commission for Children and Young People to be able to share information with research partners, where that information is directly relevant to the conduct of the research. The legislative change would also assist the development of information exchange strategies between the Child Death Review Team and the Community Services Division of the Ombudsman about individual reviews, systemic issues and any collaborative research undertaken between the two organisations.

RECOMMENDATION 8 – CHILD DEATH REVIEW TEAM COMPOSITION

The provision governing membership should be revised to say that the Child Death Review Team is established as a body corporate and should consist of people appointed by the Minister. The Commission for Children and Young People should be the Convenor of the Child Death Review Team. The Child Death Review Team members should include:

- Nominees of the relevant Minister from the Department of Community Services, NSW Health, New South Wales Police Service, the Department of Education and Training, the Attorney General's Department, the Department of Ageing, Disability and Home Care, and the Office of the State Coroner
- People who are, in the opinion of the Minister, and approved on the recommendation of the Convenor, independent experts in health care, research methodology, child development, and child protection
- Other people who are, in the opinion of the Minister, and approved on the recommendation of the Convenor, valuable as Child Death Review Team members because of their qualifications or experience
- Not members of the Legislative Council or the Legislative Assembly
- Not less than 14 members and the Convenor at any one time with a maximum of 20 and equal number of government representatives and independent experts.

For the purpose of any work to be done by the Child Death Review Team that involves consideration of the deaths of Aboriginal children, the Minister must appoint two persons who are Aboriginal (within the meaning of the *Aboriginal Land Rights Act 1983 (NSW)* as members of the Team.

For the purpose of providing particular expertise for research projects to be undertaken by the Child Death Review Team the Convenor can engage individuals with relevant qualifications or expertise, with their term limited to the particular project and subject to the same provisions as Team members regarding confidentiality and the exemption applying to the Team under the *Freedom of Information Act 1987 (NSW).*

1.13 During the consultation process for the review of the legislation governing the New South Wales Child Death Review Team, the view was often put that the expertise provided by the Child Death Review Team's existing composition worked well and there was support for the legislation requiring that there be an equal number of Government and independent members to guard against the Child Death Review Team becoming overly bureaucratic. It was noted, however, that there is now no nominee from the Department of Ageing, Disability and Home Care, representing the interests of children and young people with a disability, a view that is strongly supported by the Community Services Commission. An issue was raised during consultations was whether, given the Child Death Review Team's proposed new broader research agenda, the type of experts on the Team should be broadened from the current focus on child care and protection aspects of paediatrics, law, social work or psychology. There was general consensus that it would appropriate for the Minister to appoint experts in: health care, child development, research methodology, and child protection. There was universal support in consultations for giving the Convenor power to engage people to sit on steering committees to provide necessary expertise depending on the skills required for a particular project. The Review argues that allowing the Convenor to approve the engagement of people with

particular expertise is quicker and more efficient than requiring Ministerial approval and would allow the Child Death Review Team to bring in expertise if and when required. The review of the legislation governing the New South Wales Child Death Review Team takes the view that these individuals should not be Child Death Review Team members but have their term limited to a particular project and that they should be bound to comply with the confidentiality provisions and should not be subject to requests under the *Freedom of Information Act 1987* for information they hold as a result of their work for the Child Death Review Team.

RECOMMENDATION 9 – OPERATIONAL PROVISIONS

The current Schedule 2A covering how the Child Death Review Team must operate should be revised so that:

- The Deputy Convenor cannot be removed by the Child Death Review Team 'at any time' and the position's term is limited to two years, with the possibility of re-election
- The remuneration provision provides that a Child Death Review Team member, or individual engaged by the Convenor to work on a particular research project, other than an employee of a Department of the Government, the Police Service or a statutory body, is entitled to such allowances as the Minister approves
- The Child Death Review Team should meet as often as business requires, but at least four times a year.

Deputy Convenor

1.14 One issue that arose during the review of the legislation governing the New South Wales Child Death Review Team as requiring attention was the Deputy Convenor's term and how he or she can be removed from office. The Child Death Review Team currently elects the Deputy Convenor, however, there is no limit on his or her term. The Child Death Review Team can now remove the Deputy Director at any time, which the Review considers to be undemocratic and recommends the term should be two years, with the possibility of re-election. The review of the legislation governing the New South Wales Child Death Review Team believes that the existing provisions allowing the Minister to remove a Child Death Review Team member for various reasons, for example incapacity, incompetence, or misbehaviour are adequate to allow for removal.

Remuneration of Team members and other individuals engaged for particular purposes

1.15 The review of the legislation governing the New South Wales Child Death Review Team recommends that the remuneration provisions should be made consistent with those for expert members in the *Commission for Children and Young People Act 1988.*

How often the Child Death Review Team must meet

1.16 There are significant peak and troughs in the Child Death Review Team's workload as a result of the reporting requirements. The review of the legislation governing the New South Wales Child Death Review Team states, therefore, that it is a waste of public money to require the Team to meet every two months even when there is no significant work to consider. The review recommended, therefore, that the provision be modified to require that the Child Death Review Team meet as often as business requires, but at least four times a year.

RECOMMENDATION 10 – GUIDELINES

The Child Death Review Team should continue to maintain policies and practices to protect individual's privacy and confidentiality, however the legislative requirement for Ministerial guidelines to cover operational matters should not be replicated in the revised legislation.

1.17 The current legislation allows the Minister to draw up guidelines on how the Child Death Review Team should operate. The matters they must address include how to:

- Secure confidential information
- Protect individuals' privacy in reports, information published by the Child Death Review Team and in other aspects of the Team's activities.

The review of the legislation governing the New South Wales Child Death Review Team notes that such guidelines have not been approved but there are clear policies and practices that govern how, for example, the Child Death Review Team deals with confidential information. The review argues that, as part of good practice, the Child Death Review Team should continue to give priority to maintaining clear policies and practices on confidentiality and privacy these should not necessarily be required by legislation.

RECOMMENDATION 11 – REGULATIONS

The provision in the *Commission for Children and Young People Act 1998 (NSW)* that allows for the Governor to make regulations necessary to give effect to the Act should replace the current provisions allowing regulations to be made about certain specified matters.

1.18 There is now provision in Part 7A to make regulations that prescribe:

- deaths in additional circumstances about which the Child Death Review Team can do detailed care reviews

- additional factors that would be criteria for classifying child deaths to be entered in the register
- the holder of an office who in addition to other people named (e.g., the Police Commissioner) must provide the Child Death Review Team with access to records
- the circumstances, other than the exercise of Child Death Review Team functions, which form an exception to the ban on disclosing confidential information
- additional matters to be covered by operational guidelines.

The review of the legislation governing the New South Wales Child Death Review Team notes that the only regulation actually made under Part 7A prescribes the date after which child deaths can be entered in the register of child deaths (1 January 1996). As the child death register has already been operating since 1996, continuing the requirement for a regulation that prescribes this date is unnecessary and diverts resources because it must be regularly reviewed under the *Subordinate Legislation Act 1989*. There is a general section in the *Commission for Children and Young People Act 1998* that allows for regulations to be made. The review believes that this provision is adequate to make such regulations as required to allow for the effective and appropriate operation of the Child Death Review Team.

2

THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE'S EXAMINATION OF THE REVIEW OF THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM LEGISLATION

Introduction

2.1. One of the functions of the Committee on Children and Young People is to examine each annual or other report of the Commission for Children and Young People. The Committee, at an appropriate time after the release of a report, commences a public consultative process to assess the response of the general community and other any particular relevant individuals, organisations or agencies to the findings and recommendations arising from the report. The Committee places advertisements in the major Sydney metropolitan dailies, contacts individuals, organisations or agencies who have a specific interest or responsibility associated with the matters examined in the report, and after a period of time to receive submissions may conduct a public hearing to take further testimony before reporting to both Houses of Parliament on any matter appearing in, or arising out of, the report.

2.2. The review of the New South Wales Child Death Review Team legislation was released by the then Minister for Community services, the Hon. Faye Lo Po' MP, in mid-June 2002. The Committee on Children and Young People advertised the inquiry in August 2002, and conducted two public hearings in September 2002.

Submissions received

2.3. The Committee received four submissions that addressed, sometimes generally, issues raised in the report of the review of legislation governing the Child Death Review Team:

- RLCD 001 Dr Carol O'Donnell, School of Behavioural and Community Health Sciences, University of Sydney
  Further submission RLCD 001.1: Dr Carol O'Donnell, School of Behavioural and Community Health Sciences, University of Sydney
- RLCD 002 Mrs P. Wagstaff
- RLCD 003 Mr Robert Fitzgerald, Commissioner for Community Services

- RLCD 004 Ms Kim Cull, on behalf of the Childrens Legal Issues Committee, Law Society of New South Wales

2.4 The submission from the Commission for Community Services commented specifically on the recommendations made in the report into the review of legislation governing the Child Death Review Team. Recommendations 1 - 8 are supported by the Community Services Commission in their future role as the Community Services Division of the NSW Ombudsman. Recommendations 9 - 11 were not addressed by the Community Services Commission in their submission.

2.5 The submission from the Childrens Legal Issues Committee, Law Society of New South Wales, commented specifically on each of the recommendations made in the report into the review of legislation governing the Child Death Review Team. Recommendations 1 – 6, and 8-11 are supported by the Childrens Legal Issues Committee. The Childrens Legal Issues Committee raised concerns with Recommendation 7, arguing that there may be an adverse impact on the independence of the Child Death Review Team if the draft reports are forwarded to relevant Ministers and heads of government agencies. The Law Society's view is that it is more appropriate for the report to be available for discussion after its finalisation so that there can be no question of its independence, that is, responses to the report need to be given after its finalisation.

The testimony of Ms Calvert, Commissioner for Children and Young People, and Dr Yu, Chair, Expert Advisory Committee, Commission for Children and Young People

2.6 On Friday 20 September 2002, the Committee heard the testimony of Ms Gillian Calvert**,** Commissioner for Children and Young People, and Dr John Yu, Chair, Expert Advisory Committee, Commission for Children and Young People, who conducted the review of the Child Death Review Team legislation. The transcript of their testimony follows; a copy of the PowerPoint presentation used by the Commissioner and Dr Yu to illustrate their comments is included at the end of the transcript record.

CHAIR: I open the public hearings of the Committee on Children and Young People into the findings and recommendations of the report of the review of legislation governing the Child Death Review Team.

One of the functions of the Committee on Children and Young People is to examine each annual or other report of the Commission for Children and Young People and conduct a public hearing and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report.

The review of legislation governing the New South Wales Child Death Review Team was conducted for the Minister for Community Services by Ms Gillian Calvert, Commissioner for Children and Young People, and Dr John Yu AC. The review was released on 4 June 2002 and is a significant report which, it is believed, will

strengthen the capacity of the Child Death Review Team to achieve its important aim of preventing or reducing child deaths in New South Wales.

Section 108 of the Children (Care and Protection) Act 1987 requires that the Minister for Community Services review Part 7A of the Act which governs the New South Wales Child Death Review Team to determine:

- whether the policy objectives of Part 7A remain valid and
- whether the terms of Part 7A remain appropriate for securing these objectives.

In accordance with the Act, the review was undertaken five years after the commencement of Part 7A. It is a timely review because of the proposal under the Community Services Legislation Amendment Act 2002 to strengthen the capacity of the New South Wales Ombudsman to monitor the effectiveness of child protection service systems. Under this proposal, the Ombudsman would be given responsibility for reviewing the deaths of certain specified groups of vulnerable children, including those whose death was due to abuse, neglect or occurred in suspicious circumstances. The Child Death Review Team would retain its key functions of maintaining the child death register and conducting research to prevent child deaths from all causes. The Act has passed the Parliament and is awaiting proclamation.

The review makes eleven recommendations that, if implemented, would see some changes to the way the New South Wales Child Death Review Team operates. These recommendations covered the following areas:

- Recommendation 1 - Review of the legislation again after five years
- Recommendation 2 - Setting out the policy objectives of the legislation
- Recommendation 3 - Location of the legislative provisions that govern the Child Death Review Team
- Recommendation 4 - Functions of the Child Death Review Team
- Recommendation 5 - Reporting obligations
- Recommendation 6 - Access to information concerning children who have died
- Recommendation 7 - Confidential information
- Recommendation 8 - Composition of the Child Death Review Team
- Recommendation 9 - Operational provisions
- Recommendation 10 - Guidelines
- Recommendation 11 - Regulations

The Committee received four submissions that addressed these recommendations.

The Committee will report its findings and recommendations arising from its deliberations to Parliament before the completion of the current session, as, of course, we are moving towards the general State election in March 2003.

The Committee on Children and Young People welcomes Gillian Calvert and Dr John Yu to the table, who will testify on matters relating to the findings and recommendations of the review of legislation governing the New South Wales Child Death Review Team. Ms Calvert and Dr Yu, we thank you for your appearance here

today… Would you now like to make an opening statement before the commencement of the question?

Ms CALVERT: Dr Yu and I welcome this opportunity to discuss our report on the review of legislation governing the Child Death Review Team. We view this process as providing a useful forum for additional public input and scrutiny of the review's recommendations. We thought we would start by outlining the review process. The Commission and Dr Yu were asked by the former Minister for Community Services to conduct the review. The aim was to see whether the legislation's policy objectives remain valid and the terms are still appropriate to secure these objectives five years after the legislation came into operation. The review was co-chaired by Dr Yu, who is a well-respected paediatrician, Chancellor of University of New South Wales, former chief executive officer of the children's hospital at Westmead and former Australian of the Year. I publicly thank him for the wealth of expertise he brought to the review process.

Dr Yu and I held targeted face-to-face consultations with more than 30 key individuals and organisations based on a short consultation paper that identified central issues for discussion. Those consulted included past and present members of the team, heads of relevant government agencies, professional associations of doctors, nurses and paediatricians, peak non-government organisations, the Council of Social Service of New South Wales, Privacy New South Wales, Kidsafe, injury and research experts and representatives of non-government schools. Our report was tabled in Parliament by the Minister for Community Services on 4 June 2002. It contains 11 recommendations for change that will provide the Child Death Review Team with a good legislative base from which to conduct its work. Once tabled, we distributed the final report to more than 180 interested individuals and organisations. I am happy to say that the report was received positively and without criticism. The proposals put by the review to those we consulted were on the whole very well received. During consultations many expressed support for the team and appreciation of its past work. The depth and cross-section of expertise on the Child Death Review Team was particularly praised.

The Child Death Review Team's contribution was seen as partly attributable to its holistic approach to examining child deaths and unique access to data from various sources. Its work was considered valuable for identifying areas of concern for policy makers in the community, some of which would not have been recognised otherwise. Indeed, tangible change has occurred as a result of the team's work. For example, the Motor Accidents Authority has undertaken research in the area of toddlers killed by being run over in the driveway of the family home as a result of the team's finding that this is a significant cause of death for young children. Injury prevention standards are being improved; for example, the Swimming Pools Act is being reviewed as a result of child drowning findings, and training initiatives are being implemented regarding domestic violence, neglect of children and drug and alcohol issues.

I will briefly outline some of the review's key recommendations. The central recommendation is to give the Child Death Review Team a broader and more flexible research focus to allow it to look at child deaths from all causes – a change widely supported in the consultation. This will allow us to improve the safety and wellbeing

of all children in New South Wales. Many in consultations made the point that children die for a whole range of reasons, which may be just as problematic as death from child abuse or neglect, and that it is important to develop prevention strategies for these kinds of deaths as well as deaths from child abuse and neglect.

Some people we consulted noted that the Child Death Review Team is the only body in New South Wales that has access to data about child deaths from all causes, and it has presented a unique opportunity that should not be missed to examine all types of deaths. The Child Death Review Team has already begun, in the last few years, to focus on deaths from causes other than abuse and neglect with research projects under way into suicide and risk-taking behaviours, and sudden unexpected infant deaths whilst sleeping. As the Ombudsman will soon be responsible for conducting annual in-depth reviews of all child abuse deaths, with the recent passage of the Community Services Legislation Amendment Bill, the Child Death Review Team will now devote its time to pursue such projects in future.

Some examples of research that could be conducted include studying a particular cause and a rate of death in a population of children, for example, Aboriginal children or children under one year of age. We could also study the impact of the geographical location on death rates, or we could look at socioeconomic status and its relationship with certain types of child deaths. The suggested changes will enable the team to look at a large number of deaths over a longer period and give it a more useful basis on which to propose prevention strategies for a range of child deaths. The review report also makes a number of other key recommendations. We suggest change in the composition of the Child Death Review Team to reflect this broader research focus on providing a capacity to co-opt specialist expertise for the life of a particular research project.

We also recommend requiring that the non-government sector provide a record to help build a more complete picture of why children die. This will enable the Child Death Review Team to collect records about children who die from places like non-government schools, doctors and psychologists in private practice, and family support services. The current legislation provides for the collection of records from government agencies only. But non-government and private agencies often have valuable information that can help provide a more comprehensive picture about why children die, and the more comprehensive the picture the more likely it is that the Child Death Review Team will be able to make better recommendations to prevent child deaths.

We also proposed that the Child Death Review Team should be more accountable in publicly explaining why it is pursuing a particular research gender. We have also recommended a strengthening of the indicators of the Child Death Review Team by moving its legislation from the care and protection legislation to the Act governing the Commission for Children and Young People. This proposal responds to support showing consultations for strengthening the independence of the team even more, as the Commission is an advocate for children independent of government that reports directly to Parliament.

We believe that limited exceptions should be made to the strict confidentiality protections that currently govern the Child Death Review Team, for example, to

report criminal matters revealed through the Child Death Review Team's consideration of case files, and to conduct joint research.

We also consider that legislation should allow consultation at a draft report stage only between the Minister, other relevant Ministers and the department heads to check that recommendations will obtain the results they aim to achieve.

The report also discusses innovations that do not require legislative change, but that Dr Yu and I believe could enhance the work of the Child Death Review Team. The review recommends that the Child Death Review Team should be free to study serious non-fatal injuries as well as child deaths from the same cause, for example, near drowning, burns, poisoning, falls and motor vehicle accidents, as patterns of physical injury may be an equally strong indicator as a need to change policies and practices. We also consider that it would be helpful to be able to interview families and relevant service providers, with their consent, where this would aid the task of developing responsive prevention strategies.

We were pleased to note the endorsement of the recommendations by Mr Robert Fitzgerald, the Community Services Commissioner, who will soon assume responsibility for the review of the death resulting from abuse and neglect as part of his new role in heading the Community Services Division of the Ombudsman's office. In summary, Dr Yu and I commend the report's recommendations to the Committee, as we believe they will strengthen the capacity of the Child Death Review Team to achieve its important aim of preventing or reducing child deaths in New South Wales. We look forward to positive outcomes as a result of their implementation.

CHAIR: I invite Dr Yu to make a comment.

Dr YU: I, clearly, endorse everything that that the Commissioner has said. What we are trying to do is to ensure that we take the next step in protecting kids, and that is looking at all situations and all causes of childhood death, but in particular looking at the circumstances that might result in damage to children, even though that might fall short of death. I very much hope that the Committee will consider our recommendations, and give them its support.

Ms BEAMER: The object of Recommendation 2 is to prevent or reduce deaths of children, and give yourself a policy objective. Would that be further strengthened by including serious injury as a policy objective?

Ms CALVERT: We had a conversation about how much we put serious injury into the legislation. We decided not to because we felt the focus should remain on child death review, but we wanted to acknowledge that there may be some value in being able to combine the child death data and information with the serious injury data. But if you add a serious injury we are opening up another whole field of research and study, and broadening it so that we would lose our focus on deaths. The other thing is that a number of agencies already exist that look at injury prevention, and we would not want to duplicate their work, whereas the Child Death Review Team is the only body that looks at all child deaths.

CHAIR: Perhaps we should go through each recommendation at a time. There may be some questions from around the table on a given recommendation, or Ms Calvert or Dr Yu might want to say something to it. If not, we will move on to the next recommendation. We can move on from Recommendation 1. There has been some discussion on Recommendation 2. Recommendation 3 is a fairly fundamental change to the whole thing.

Ms CALVERT: It is fundamental, but it flows on from the broadening out of the research function of the Child Death Review Team. Because the Child Death Review Team no longer has the focus on death due to child abuse and neglect, it made sense to take it out of that piece of legislation and to put it into a piece of legislation that dealt with the whole of children, and that legislation is the Commission for Children and Young People legislation. It was, in a sense, consistent with the prior decision that the Child Death Review Team should focus on all child deaths.

CHAIR: As I understand it, this recommendation has been accepted. Have any of the recommendations been implemented? You might take that as a standing question for each one.

Ms CALVERT: The logical step, now that the report has been tabled, is for Cabinet to consider the report. I understand that is going to occur. What is accepted will then move forward in the legislative program.

CHAIR: Were there any cons brought up in the discussions leading to Recommendation 3 of the report? One always looks at the pros and cons of taking a decision. What sorts of things might have been considered negatives of implementing this recommendation?

Dr YU: I do not think there were any negatives. Many people felt that one of the big advantages of moving the legislation to the Commission's legislation is that that would remove some of the potential conflict that might occur if it remained within Community Services.

Ms CALVERT: Or indeed in any line agency. If we were to move it to Health, the same issue arose of a conflict of interest. If we were to move it to the Attorney General, the same issue arose. But moving it to the Commission's legislation, as Dr Yu said, strengthens the Commission's independence. It also strengthens accountability because of oversighting by the Parliamentary Committee. That makes the whole process much more transparent because the Committee is obligated to examine any report that the Commissioner publishes or tables. A number of advantages were seen to arise in moving to the Commission's legislation.

CHAIR: We move to Recommendation 4.

Ms CALVERT: This follows on from the decision to broaden the research function of the Child Death Review Team. There was clear and unequivocal support for the maintenance of a register. It is the only place in which all child deaths in New South Wales are recorded, and it allows us access to trend data. As the Committee knows, I am concerned to be able to track trends and outcomes for children, and deaths is one important part of that. Clearly, if we are to maintain a register, we need

research into the causes of death, and therefore we need the function of conducting research. The key is that that research is done either alone or in co-operation with others, allowing the possibility of some joint research, then formulating recommendations and monitoring the implementation of those recommendations.

Because, in a sense, the Child Death Review Team is independent, we recommended increased accountability for the setting of the research agenda. We suggest that the legislation should require that every report set out the reasons for conducting research and why it may be more appropriate for other bodies to conduct research, and so on. That picks up on our previous point that locating responsibility in the Commission's legislation improves accountability and transparency of decision-making by the Child Death Review Team.

CHAIR: We move to Recommendation 5.

Ms BEAMER: The first part of the recommendation is that the Child Death Review Team "should be required to report on an aspect of deaths from abuse and neglect that occur in suspicious circumstances every three years [if the Community Service Commission/Ombudsman amalgamation proposal does not go ahead]." What difference does it make if the amalgamation does not go ahead?

Ms CALVERT: If it did not go ahead, we would have to report on the review of child abuse and neglect deaths every three years. Now that it has gone ahead, we do not have to think about reviewing child abuse and neglect deaths. However, we still wanted to require the Child Death Review Team —again for accountability reasons— to have product and output. So we have recommended that the Child Death Review Team table a report every three years.

Ms BEAMER: The amalgamation proposal having gone ahead, can the part of the recommendation in parenthesis be excluded?

Ms CALVERT: It does not need to be there.

Ms BEAMER: Should it read, "The team should be required to report on any aspect ...", not "an" aspect?

Ms CALVERT: It probably does not matter whether it is "an" or "any".

Ms BEAMER: I do not understand what is meant by "giving reasons if the team has not presented to Parliament a special report". It starts off, "The Child Death Review Team should be required to report annually, within a period of four months after June 30 each year." It then says "if the team has not presented to Parliament a special report every three years". Does that mean if the Child Death Review Team has not reported in the past three years?

Ms CALVERT: Yes, if it has not presented a report every three years.

Ms BEAMER: It should give reasons why it has not done so?

Ms CALVERT: Yes.

Ms BEAMER: Is that if the Child Death Review Team has not reported within the previous three years?

Ms CALVERT: Yes. The register will be reported on annually, so there will be an annual report on the functions and the register. Then there will be special reports, at least every three years.

Ms BEAMER: And, again, the amalgamation proviso is irrelevant?

Ms CALVERT: Yes, now that the decision has been made to transfer those functions. The reason for the three-year requirement is to ensure that the Child Death Review Team did not go off on a frolic—to require that there be output and product.

Ms BEAMER: I do not have a problem with that. I just wanted to clarify what is meant by the wording.

Ms CALVERT: I am sure Parliamentary Counsel will sort that out.

CHAIR: If there are no further questions on Recommendation 5, we will move to Recommendation 6.

Ms CALVERT: I have covered this in my opening address. It is really about obtaining access to a wider range of information.

Ms BEAMER: Do you have power to subpoena information?

Ms CALVERT: Yes, to direct them to provide the information. Currently, we have power in relation to government agencies. That power would be expanded to include non-government agencies. When we met with the non-government agencies they were keen to have that provision in legislation because it provided them with clarity on what they should and should not do.

CHAIR: If there is nothing further in relation to Recommendation 6, we will move to Recommendation 7.

Ms CALVERT: We wanted to clarify the confidentiality provisions in the legislation, and in particular we wanted to give the Convenor the capacity to report issues concerning whether a child was at risk. It may be that in reviewing a case one becomes aware of a child who is still at risk and wants to report that to the Department of Community Services. Or a view might be formed as to some criminal behaviour that should be reported to the police. We wanted to give the Convenor that power. We did not want it to reside with every member of the Child Death Review Team. We wanted some structured way for that to happen. It also meant that at least two members of the Child Death Review Team would be discussing the matter—the person who identified the concern and the person with whom it was discussed, the Convenor. That ensures a check process. That is one part of the confidentiality clarification.

The other is that we wanted to be able to give the Minister a clear ability to consult with other Ministers and their departmental heads so that the recommendations could be reality-tested, if you like, before we finalise them. Both Dr Yu and I felt that it should not occur until the Child Death Review Team had got to the point where it had a draft report that it was satisfied with because we wanted to minimise the possibility of political interference in the Child Death Review Team's deliberations and considerations. Then, of course, there are consequences for the Child Death Review Team if it in fact breaches that confidentiality. That is very important because the Child Death Review Team members and their staff have access to very sensitive information. Both Dr Yu and I thought there must be very strict controls around people who have access to that.

The other clarity around the confidentiality was the ability of the Convenor to be able to release information for a joint research project. For example, when we found the information about driveway deaths of toddlers and recommended the Motor Accidents Authority review those deaths in detail and find some way forward, we were unable to let the Motor Accidents Authority know which children we were talking about because of the confidentiality procedure requirements. This would allow the Convenor to give that information for the purposes of further research. At the same time it requires that procedure to be reported to Parliament, so there is a Parliamentary oversight and transparency and accountability in the operations of the Child Death Review Team.

Ms BEAMER: And the Motor Accidents Authority is also subject to confidentiality requirements?

Ms CALVERT: Yes, it would transfer to the Motor Accidents Authority.

CHAIR: Recommendation 8.

Ms CALVERT: That speaks for itself, as we have changed the function and so on of the Child Death Review Team. I would draw your attention to the capacity of the Convenor to appoint people for specialist research projects. The Child Death Review Team members themselves will be appointed through the normal Cabinet process, which is what happens. But where the Child Death Review Team wants to set up a sub-committee for a specialist research project, the Convenor would have the capacity to appoint members to that sub-committee only without having to go through the Cabinet process. That is for ease of administration reasons. But they would be bound up by the same confidentiality requirements and so on as any full member of the Child Death Review Team.

CHAIR: Recommendation 9.

Ms CALVERT: These are administrative issues. At the moment the Deputy-Convenor's removal appears to be quite arbitrary. We wanted to clarify the term of that person's appointment or election and the grounds under which he or she could be removed. We also wanted to clarify the requirements of the meeting. At the moment the legislation sets out that the Child Death Review Team meet every two months. That seems to be administratively burdensome. There are times when the Child Death Review Team meets every two weeks as opposed to every two months,

but it may not want to meet for another three months because of the particular way in which the work ebbs and flows. Again, it requires them to meet at least four times per year, for accountability purposes.

CHAIR: Recommendation 10.

Ms CALVERT: Currently, there is a requirement for some guidelines. However, we have suggested they not be replicated. We prefer to clarify it through legislation, which we have done in an earlier recommendation.

CHAIR: Recommendation 11.

Ms CALVERT: It is a machinery recommendation giving us the power to make regulations.

Ms ANDREWS: Would you discuss the interface between the roles of the Child Death Review Team and the Community Services Commission?

Ms CALVERT: In the future or now?

Ms ANDREWS: Now.

Ms CALVERT: The Child Death Review Team cannot really interface with anybody because of its confidentiality provisions. It interfaces with Parliament, and that is really it. However, the Community Services Commission currently has the Disability Death Review Team and it does notify the Child Death Review Team of any deaths of children with a disability that it becomes aware of. It is very difficult through the Births, Deaths and Marriages information to identify which children have disabilities. We have tried to solve that problem and it is very hard to do so. We try to find as many alternative ways of identifying kids with disabilities as we can, and the Disability Death Review Team is one way that we can do that.

The Hon. DON HARWIN: Commissioner, how does the proposed practice compare with interstate practice and best practice elsewhere?

Ms CALVERT: New South Wales leads Australia in relation to child death review team legislation. We were the first new State to have specific legislation. The only other State that currently has legislation is Victoria and it is restricted in a sense to reviewing the reviews that have been conducted by the child welfare agency. They do not have that broad function, nor do they maintain a register. They review the internal reviews that the child welfare agency has done. In relation to international child death review teams, New South Wales again is seen as a very strong model. Some of the features that have been highlighted as being very good are the power to access information and to direct agencies to give us information.

Each of the States in America now has a child death review team, but their scope, mandate and powers are enormously varied. We have met with the American group who oversight all of the State child death review teams in America. He felt that our legislation was very strong and he certainly was impressed by the calibre of the reports that the team was releasing. What I am saying is New South Wales can be

proud of its legislation. We can be even more proud if Dr Yu's and my recommendations are enacted upon.

Ms ANDREWS: Commissioner, further to what you said about the interface between the Child Death Review Team and the Community Service Commission, do you believe an improvement can be made in the future as to the interaction?

Ms CALVERT: I think the improvement has been made by locating the review of disability deaths and the review of child deaths due to child abuse and neglect in the Community Services Division of the Ombudsman. One of the reasons for moving the child abuse and neglect functions over to the Ombudsman was to enable it to interface more with some of the disability deaths and also give it an increased capacity to look at service effectiveness—because they can combine data and information from deaths and can also combine it from the reviews of children and from complaints made by individuals. The interface has been strengthened by the move over to the Ombudsman.

CHAIR: It is pleasing to see the continuous improvements being made to this process. I thank both witnesses for your time and for the report.

The testimony of the Community Services Commission

2.7 The Committee held a further public hearing on 27 September 2002, where the Community Services Commissioner, Mr Robert Fitzgerald, and Ms Christine Flynn, an Acting Senior Project Officer with the Community Services Commission, testified on the issues raised in the review of the New South Wales Child Death Review Team legislation. As noted earlier, the text of the Community Services Commission's submission is included as Appendix 1.

CHAIR: Commissioner, would you now like to make an opening statement or talk to the submission that you have made?

Mr FITZGERALD: Very briefly, in relation to the review of the Child Death Review Team legislation, our submission clearly indicates favourable support for most of the recommendations contained in that review report. As you would be aware, as from the date of proclamation of the community services amending legislation, which is currently due for 1 December, much of the current child death review work in relation to what has become colloquially known as children "known to DoCS" [i.e., known to the Department of Community Services] will in fact pass to the Ombudsman. I can report to the Committee that plans are well advanced for the Ombudsman through the community services division, plans are well on track for that changeover to take place, so effectively from 1 December 2002 deaths that occur of what have become known as reviewable children will be handled by the community services division within the Ombudsman's office.

The only comment that I would make in relation to the Child Death Review Team report is in relation to the confidential information. One of the issues that the Committee needs to consider carefully is the extent to which confidentiality of information is appropriate without allowing it to detract from the necessary exchange of information between agencies and relevant parties in order to improve service by agencies in relation to children, but also to be fully conversant with the issues that are being raised, so the only point that we have made in our submission dated 11 September is that confidentiality needs to be balanced against, in many senses, the common court or the public interest and the Committee does need to consider carefully the extent of confidentiality provisions that can arise in this area.

At the end of the day, the only way that we can prevent preventable child deaths is by a much more robust approach between agencies, both Government and non-Government agencies, and the only way that can be achieved is if there can be an open dialogue around the issues that are pertinent. The first is one of the issues that we have made. As I have indicated, in respect of most of the other recommendations, we are supportive of those and our comments have been made accordingly.

That is all we have really to say on that subject.

CHAIR: I wonder, Commissioner, if you might just expand a little on how you see the interface under this new arrangement between the Child Death Review Team and the Community Services Commissioner?

Mr FITZGERALD: I will just give a brief outline. Under the new legislation, which we believe will be proclaimed on 1 December 2002 or thereabouts, the first element is the Community Services Division will be established within the office of the Ombudsman. That division is charged with carrying out the functions of the new amalgamated legislation. Part of the functions is in relation to the systemic review of children who now fall within what we call a reviewable deaths category, and I think you are familiar with what that will involve.

The procedures will be that the Births, Deaths and Marriages Registery will advise the Ombudsman's Office of all deaths of all children. The coroner will also advise the Ombudsman's Office of all deaths that have been reported to him under the amended legislation. The Ombudsman's Office will then screen all of those deaths, that is between 700 to 800, by examining the information systems of the Department of Community Services to determine whether or not they are children within the reviewable category. They include children that have been reported at risk of harm within the last three years, a child whose sibling may have been reported within the last three years, a child who is currently in out-of-home care, a child who dies whilst in any juvenile justice detention centre or any restraint facility such as a police office, and a number of other categories.

That screening will then identify the group of children that are within the review category. All of the information in relation to the 700 or 800 children will then be forwarded across to the Child Death Review Team within the Commission for Children and Young People. Of the children that are within the review category, then a second screening will be done to determine whether or not those children need to be fully reviewed. So a child, for example, who is in foster care, who dies of natural causes or dies, say for example from a motor vehicle accident, it is likely that that death would not be further reviewed. Nevertheless, a child who might be in foster care, where there have been suspicions of abuse, neglect, ill treatment or other causes that are unknown, then that death would be subject to review.

The reviews will be conducted by the staff of the Ombudsman's Office together with members drawn from an expert panel, and a register of those reviewable deaths will be maintained and an annual report will be prepared in relation to those reviewable child deaths. That information also is fed to the Child Death Review Team within the Commission for Children and Young People who will maintain a register of the 700 to 800 children who die annually in the State, but they will not review, or they will not re-review, any of those deaths that have been reviewed by the Ombudsman's Office.

If I can shorthand all of that, effectively what the legislation creates is a child protection review function, that is children who have been in any way associated with the child protection system, plus others, as a subset of the main group. Those deaths are only reviewed by the Ombudsman's Office, but that information forms a subset of the total child death reviews of the Children's Commission. So that information goes across. The interface is that the information comes into the

Ombudsman, moves across to the Child Death Review Team. The Child Death Review Team does not re-review any of the deaths that have been reviewed by the Ombudsman's Office, but they will report in brief as part of their overall register.

The Government's decision in relation to that relates to a couple of issues which I need to briefly articulate. The first is that the coroner's office will have his resources increased, a new deputy coroner is to be appointed and additional investigative staff are also to be appointed. All of the children within the reviewable child death category, which is now substantially expanded, must be reported to the coroner. It is anticipated that the coroner will take a much more pro-active level of involvement in those deaths. The coroner, as is currently the case, will concern himself with the cause of death, but that is insufficient in relation to child deaths. The need is to look systemically at the patterns and trends and, I suppose, to identify issues that can lead to service improvement.

The view of the Government was that, in fact, all of that in relation to children who had been associated with the child protection system, together with people with disabilities in care, should be dealt with in the one body, that body being the Ombudsman. All generic deaths, that is deaths of children that have not been associated with the child protection area, should continue to be dealt with by the Commissioner for Children and Young People through the Child Death Review Team. So, effectively, what you have in the Ombudsman's Office after proclamation is the systemic review of the deaths of people with disabilities in care and children and young people who have been associated with the child protection system or other causes of death, and that is where significant public policy needs to be directed. General deaths of children, if I can use that term, or generic deaths of children, will continue to be dealt with by the Child Death Review Team.

I do not know if that helps or hinders in the understanding of what is to take place. To go right to the heart of it, the co-operation between the two will be incredibly important. The Child Death Review Team will continue to maintain a full register of all deaths. Therefore, the information that is collected by the Ombudsman needs to be able to be input into that easily. The Child Death Review Team will continue to have a research function in relation to general issues. We see a great deal of co-operation between the work of the Ombudsman's Office and the work of the Child Death Review Team, and the Act allows for very significant information exchange to take place. We also hope and expect that the Child Death Review Team will be able to feed information to the Ombudsman to help inform its work as well.

The last part of all that is: What will be produced at the end of each year? There will continue to be an annual report produced by the Child Death Review Team, by the Commissioner for Children and Young People. That will deal with the 700 to 800 deaths of children. It will only briefly deal with the children who have been associated with the child protection system. There will be a second and separate report produced by the Ombudsman which will only deal with those children that it has reviewed, and if I can call that the child protection reviewable deaths area. So, in fact, there will be two reports annually produced dealing with child deaths. We hope that that dovetails rather than confuses, but that is the position. Just to complete the picture, there will be a third annual report produced and that is in relation to people

with disabilities, both children and adults, who die whilst in care in New South Wales, and in care means in residential care. In New South Wales there are 5100 people with disabilities in residential care and we currently review approximately 70 deaths a year.

CHAIR: Is it possible for, say, a young person with a disability to end up as a statistic in the three reports?

Mr FITZGERALD: Yes, absolutely. Yes, a child with a disability who is in a residential service, and there are approximately 250 such children who are currently living in residential services in New South Wales, would appear in three reports. In the Child Death Review Team's report, they may appear just as a statistic. In the Ombudsman's report, if the child falls into one of the reviewable categories and they are likely to fall into the category of in out-of-home care, that child's death may have been reviewed. As a person with a disability, they may also end up in the disability death review report. Because the last two are in the same office, that is the Ombudsman's Office, it is not anticipated that we would be doing a double review, but a child with a disability could end up potentially in three reports, yes, that is correct.

CHAIR: What I am concerned about is that we do not end up tripling the number of individuals.

Mr FITZGERALD: No.

CHAIR: Or manipulating the statistics to triple the number of individuals.

Mr FITZGERALD: The Child Death Review Team report, as I say, will be a comprehensive report in relation to the death of all children, the 700 to 800 deaths per year, and that would be the report you would look at to find the totality, and, of course, they would be then split up. No, I think we need to avoid that at all costs. We do not want to count the child three times. An alternative circumstance could be that a child with a disability who was reported to the Department of Community Services, who then ended up in a disability service and then subsequently died, will definitely end up in the three reports. So it is possible.

Ms FLYNN: One of the shortcomings of the previous Child Death Review Team annual reports has been the difficulty of establishing whether a child has a disability or not, and there have been discussions around how they can identify the disability. There is obviously some lack of identification going onto the databases or on the material that is provided to the Child Death Review Team. In fact, we might pick up more children with disabilities, or those numbers might appear greater by the effectiveness of the two other angles on the reporting structure.

CHAIR: It is fairly important and appropriate, for kids in care in the future, to clearly define the different categories and that sort of thing, but it is of no value to kids, in my view, if we then manipulate the figures.

Mr FITZGERALD: Yes.

CHAIR: I am not saying that agencies would, but others might manipulate the figures and make a bigger problem than may exist. That is a concern I had in asking that earlier question.

Mr FITZGERALD: I think it will be critically important that the Child Death Review Team within the Commission for Children and Young People ensures that their annual report clearly identifies by category and naturally indicates that the reviews have been conducted by the Ombudsman's Office, either as part of the child death review area or as part of the disability death review area, and we would expect a close relationship so that we do not end up with that potential confusion.

The Hon. JAN BURNSWOODS: I have questions on two areas. One is about the coroner's role. There will be a new deputy coroner appointed who will have responsibility in this area.

Mr FITZGERALD: Yes, that is correct.

The Hon. JAN BURNSWOODS: In the past it has sometimes been said that there are a lot of agencies that have not really learned thoroughly the lessons that everyone should have learned over the last decade of child protection issues and it has sometimes been suggested that the coroner's office is one of them. What sort of extra training, what sort of staffing will go there?

The other side of it too is that it has been suggested that that can mean that a child who may well have been abused or neglected, but perhaps not come from the families that are the usual suspects, may be missed by the coroner and their office because they are not as aware as they might be of some of the signs to look for. I just wondered if you could comment on their role in this quite complicated sort of jigsaw.

Mr FITZGERALD: Thanks very much for that question. A couple of comments: The deputy coroner will not be specifically allocated to this area. The new deputy coroner will be an additional resource, but the legislation does not propose that there will be a separate deputy coroner just for this area and that, I think, is significant because it makes very important the questions you have now raised.

I think it is absolutely critical if this new regime is to work that the coroner's office be considerably more proactive in relation to the deaths of children and I think you have identified, very appropriately, the need for extensive and increased training in this area. If that does not happen then I think, even with the additional resources, there is a real potential for the system to be overloaded generally and what we would see is what we have seen in the past and that is a lack of a concentrated effort within the coroner's office in relation to these deaths, so I think training, together with the additional resources, together with an ongoing commitment to awareness raising both within its own staff and generally will be important within the coroner's office. It is a critical link in this process. The safeguard here is that, because the Ombudsman's office will be doing systemic reviews and systemic reviews come from doing individual reviews, so you pick it up, there is another way by which the issues can be raised which would not exist if it was simply the coroners, so I think we do

have a safety net, but I agree absolutely that the work and the expertise and the commitment of the coroner's office will be critical in this area. The resources alone will not just achieve that. At this stage I have to also say that the coroner's office, and the coroner in particular, have been working with us and others to achieve implementation of this and have shown a commitment to the new regime, and I have to be confident that that will be the reality once it has been proclaimed, but your questions are absolutely pertinent given that there will not be a separate division within the coroner's office dealing with these issues.

The Hon. JAN BURNSWOODS: Does it also mean that the people who see the child, particularly see the dead child, a bit earlier, like police or ambulance officers or GPs or doctors in emergency services in hospital, also need a bit more training and awareness raising so that they in turn alert the coroner?

Mr FITZGERALD: Yes. Well, one of the issues in relation to this matter is that the category of reportable deaths under the new regime has been increased, so already we are having discussions with the police force in relation to that. The police force will need to be trained in relation to simply what children and what people with disabilities are included as mandatorily reportable to the coroner, so that is the first thing. The second issue is that we have to get to a situation where the police ask the right questions. For example, a child that has been reported to the Department of Community Services is not visibly identifiable as a child reported to Department of Community Services if they are currently living at home. In other words, the child dies and, unless somebody actually says that the child was reported to Department of Community Services in the last two to three years, it will be unknown. It is highly unlikely that the parents of the child will volunteer that information. What would be important is that the police attending and/or the GPs that attend ask some of those questions. If they do not ask, we still pick it up in another safety net because the births, deaths and marriages will send all the names to the Ombudsman's office; we will then do a screening against the Department of Community Services' information systems and we may pick that group up again, so there are some fail-safes in this, but again your question is very appropriate: It will be necessary for both police and GPs to be alerted to the extended category and to get them to try to ask the right questions, but there is a fail-safe in that or a safety net which we need to pick up. The other implication is true that people and police and others are inclined to look at socioeconomic circumstance and sometimes attribute the likelihood of misadventure to some categories rather than to others. Nevertheless, we have to rely on their skills and hope that over time, as these child death review reports start to become not only more frequent but are actually starting to be used, that will start to change.

One of the things that I would hope is that when the Ombudsman takes over responsibility for this we will be having a much more extensive community education program around this. If I can just explain, in the disability death reviews which we currently do we now run six or seven workshops around disability deaths throughout New South Wales. Yesterday I was conducting one at the central coast, in Wyong. We would expect to do the same with child deaths because one of the problems at the moment is that the reports are issued, there is a reliance on the agencies to act, but what we know is that you often need to be going to the frontline workers and constantly talking about the issues, talking about practice improvement. We would see the same thing in relation to child protection. They are not controversial, what

they are is about actually trying to bring those reports to life, and in the disability death area we have now been doing that for three to four years and I have to say that that sort of community education has been instrumental in getting service improvement whereas the release of the report often does not achieve that in and of itself, so we would be certainly trying to include police and GPs in that, although you would be well aware of how difficult that is.

Ms FLYNN: I think a point to remember is that the ultimate aim, I guess, is to understand why certain deaths occur, but also to look at ways to prevent those deaths from occurring, so with the Disability Death Review Team it is not just talking about what the function is and how we review and what happens with a review or what we find in a review, it is about looking for those sorts of elements that then can inform a service in how to avoid, so the feeding practices or the nutrition policies or the immunisation practices, et cetera, in some residential services, for example, so I am sure that trends will be found in relation to child deaths in the reviewable category that we can use to then inform people about their practice so that they can work to prevent those deaths in as many cases as possible.

APPENDIX 1

THE COMMUNITY SERVICE COMMISSION SUBMISSION CONCERNING THE REVIEW OF THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM LEGISLATION

The Community Services Commission is the independent government watchdog for consumers of community services in New South Wales. The Commission was established under the *Community Services (Complaints, Reviews and Monitoring) Act* 1993. The aim of the Commission is to improve the quality of community services that are provided or funded through the Department of Community Services or the Department of Ageing, Disability and Home Care.

RECOMMENDATION 1 – REVIEW OF THE LEGISLATION AGAIN AFTER FIVE YEARS

If implemented, the proposed recommendations change the way that the Child Death Review Team operates. The Review argues that it is therefore important to review the implementation of these changes five years after the commencement of the new legislative provisions. This is supported by the Community Services Commission as it would present an opportunity to review any duplication in function or practice of the Child Death Review Team and the Community Services Division of the Ombudsman.

RECOMMENDATION 2 – SETTING OUT THE POLICY OBJECTIVES OF THE LEGISLATION

The Community Services Commission believes that it would be appropriate to broaden the focus on the Child Death Review Team's policy objectives to create opportunities for more in-depth work on deaths from causes not covered by the Community Services Division of the Ombudsman and would be particularly supportive of research that has a focus on the most vulnerable children (e.g., children with disabilities) and the impact of social disadvantage on children's safety and well being.

Broadening the focus of the policy objectives would also enable the Child Death Review Team to conduct research that aims to prevent or reduce deaths of children in New South Wales from all causes, if the proposal to have the Community Services Division of the Ombudsman review deaths from child abuse or neglect does not proceed.

RECOMMENDATION 3 – LOCATION OF THE LEGISLATIVE PROVISIONS THAT GOVERN THE CHILD DEATH REVIEW TEAM

The Community Services Commission agrees that the *Commission for Children and Young People Act* would be the appropriate place for the legislative basis of the Child Death Review Team.

RECOMMENDATION 4 – FUNCTIONS OF THE CHILD DEATH REVIEW TEAM

The Community Services Commission also supports this recommendation, on the basis that it would enable the Child Death Review Team to undertake collaborative research to provide important information for advocacy on issues such as children's use of public space, environmental hazards, etc.

The Community Services Commission also believes that a focus on vulnerable or disadvantaged children would be the appropriate use of the resources allocated to the Child Death Review Team.

RECOMMENDATION 5 – REPORTING OBLIGATIONS

The Community Services Commission points out that the proclamation of the Community Services Amendment Act 2002 later this year will mean that the first component of this recommendation will not be necessary, however, it will be necessary for the Team to review certain categories of child deaths that occur prior to the proclamation. Following proclamation, the Community Services Division of the Ombudsman will report on reviewable child deaths annual in an Annual Report to Parliament and through any necessary special reports by the Ombudsman.

RECOMMENDATION 6 – ACCESS TO INFORMATION CONCERNING CHILDREN WHO HAVE DIED

The Community Services Commission supports the recommended legislative change to enable access to information from a broader group of agencies, including direct access to service providers involved in children's lives. The ability of the Team to review circumstances where children were seriously injured would provide an important base for recommendations regarding injury prevention. The Community Services Commission points out that the Disability Death Review Team has used protocols and agreements around exchange of information to access information regarding the deaths of certain groups of people with disabilities since its inception in 1998. Access to documents and information from government and non-government accommodation service provides regarding the quality of life of individuals and the broader circumstances surrounding their deaths has allowed the gathering of a holistic view about systemic or service provision changes that may prevent other fatalities arising out of similar circumstances. The Community Services Commission believes that it is appropriate that failure to comply with the proposed new information sharing provisions should not be an offence and agrees with the recommendation that difficulties around the exchange of information, or incomplete information sets for particular reviews should be mentioned in an annual or special report to Parliament.

RECOMMENDATION 7 – CONFIDENTIAL INFORMATION

The Community Services Commission supports this recommendation on the grounds that the confidentiality provisions should not limit the ongoing work of the Child Death Review Team in developing effective recommendations and undertaking research. Further, the Community Services Commission believes that the work of the Child Death Review Team must be transparent and not unduly secretive in its conduct, or order to maintain the trust and confidence of the community. This view was supported by the Opposition in the second reading debate of the *Children (Care And Protection) Amendment Bill 1995.*

The Community Services Commission also believes that it is reasonable for the legislation to enable the Child Death Review Team and staff of the Commission for Children and Young People to be able to share information with research partners, where that information is directly relevant to the conduct of the research. The legislative change would also assist the development of information exchange strategies between the Child Death Review Team and the Community Services Division of the Ombudsman about individual reviews, systemic issues and any collaborative research undertaken between the two organisations.

RECOMMENDATION 8 – CHILD DEATH REVIEW TEAM COMPOSITION

During the Review consultation process, the view was often put that the expertise provided by the Child Death Review Team's existing composition worked well and there was support for the legislation requiring that there be an equal number of Government and independent members to guard against the Team becoming overly bureaucratic. It was noted, however, that there is now no nominee from the Department of Ageing, Disability and Home Care, representing the interests of children and young people with a disability, a view that is strongly supported by the Community Services Commission.

APPENDIX 2

THE SUBMISSION OF THE CHILDREN'S LEGAL ISSUES COMMITTEE, LAW SOCIETY OF NEW SOUTH WALES, CONCERNING THE REVIEW OF THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM LEGISLATION

The Children's Legal Issues Committee, Law Society Of New South Wales, provided a submission in response to the Committee's request for comment regarding the review of the legislation governing the New South Wales Child Death Review Team conducted by the Commissioner for Children and Young People, Ms Gillian Calvert, and Dr John Yu.

The Children's Legal Issues Committee noted that the statutory provision for the Child Death Review Team rested in Children (Care and Protection) Act 1987 (NSW), Part 7A.

Recommendation 1: Review of the legislation again after five years

The Children's Legal Issues Committee supports review of the legislation five years after the date on which legislative amendments commence in response to the review, or if no changes are made, five years from the date the report of the NSW Commission for Children and Young People is tabled in Parliament. The Committee agrees that the aim of the review should be to determine whether legislative policy objectives and the terms for securing them remain valid.

Recommendation 2: Setting out the policy objectives of the legislation

The Children's Legal Issues Committee supports the continuation of the broad policy objective of Part 7A and agrees that an objects clause (as outlined in the recommendation) which clearly guides the Team's policy objectives should be included.

Recommendation 3: Location of the legislative provisions that govern the Team

The recommendation to make the legislative provisions governing the Team a separate part the Commission for Children and Young People Act 1998 (NSW) is supported. The Children's Legal Issues Committee agrees that the Commission should support the work of the Team in accordance with this new Part.

Recommendation 4: Functions of the Team

The Children's Legal Issues Committee supports the recommendation to move the investigative functions in child deaths as a result of abuse and neglect to the Ombudsman / Children's Services Commissioner.

Recommendation 5: Reporting Obligations

If the proposal for amalgamation of the roles of Community Services Commission and Ombudsman does not proceed, the recommendation for the Child Death Review Team to report every three years on an aspect of deaths from abuse or neglect or deaths that occur in suspicious circumstances is supported. The Children's Legal Issues Committee agrees that the Team should be required to report annually by 31 October and that reports should include:

- the register of child deaths about deaths registered during the previous calendar year;
- a description of the Team's activities in relation to each of its key functions;
- details of the extent to which previous recommendations have been accepted including comment on the extent of practical implementation.
- the results of any research by others or joint research projects into the prevention or reduction of the likelihood of child death in NSW which is conducted following the release of information authorised by the Convenor;
- reasons should be provided where no special research report has been presented to Parliament:
  - every three years (if the proposed amalgamation of the Community Services Commission/Ombudsman is adopted) or
  - on child deaths from causes other than child abuse or neglect, during the three years between each report on child abuse or neglect (if the proposed amalgamation of the Community Services Commission/Ombudsman is not adopted).

The Committee has no objection to the report being combined with the annual report of the Commission for Children and Young People, in a special report, or as part of a special report.

Recommendation 6: Access to information concerning children who have died

The recommendation to revise the current provision to require nominated third parties to provide information they hold and give unrestricted access to records about the death of a child to the Team is supported.

Recommendation 7: Confidential Information

The Children's Legal Issues Committee questions the impact on the independence of the team if the draft reports are forwarded to relevant Ministers and heads of government agencies. The Society's view is that it is more appropriate for the report to be available for discussion after its finalisation so that there can be no question of its independence. Responses to the report need to be given after its finalisation.

Recommendation 8: Team composition

Provided that deaths of children known to the Department of Community Services are investigated by the Ombudsman in the first instance, the Children's Legal Issues Committee supports the composition of the Team to undertake further research into the prevention of child death.

Recommendation 9: **Operational Provisions**

The Children's Legal Issues Committee supports revision of Schedule 2A so that the Deputy Convenor's position cannot be removed by the team "at any time" and limiting the position term to two years with the possibility of re-election. The Committee agrees that a Team member or individual engaged by the Convenor to work on a particular research project other than an employee of a government department, the Police Service or a statutory body should be entitled to such allowances as the Minister approves. The recommendation that the Team meet as often as business requires, but at least four times each year, is supported.

Recommendation 10: Guidelines

The Children's Legal Issues Committee agrees that the Team should continue to maintain policies and practices to protect individuals' privacy and confidentiality. The recommendation that revised legislation should not replicate Ministerial guidelines to cover operational matters is supported.

Recommendation 11: Regulations

The Children's Legal Issues Committee agrees that there should be provision for the Governor to make regulations necessary to give effect to the Act.

EXTRACTS FROM THE MINUTES OF THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE REGARDING THE REVIEW OF THE NEW SOUTH WALES CHILD DEATH REVIEW TEAM LEGISLATION

No. 21

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 30 AUGUST 2002
AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Primrose	Mr Campbell
Ms Burnswoods	Ms Andrews
	Mr Smith
	Ms Beamer

The Chair, Mr Campbell, presiding.

Also in attendance: Mr Faulks, Committee Manager.

1. Apologies

Apologies were received from Mr Cull, Mr Tsang, Mr Harwin, Mr Corbett and Mrs Hopwood.

2. Previous Minutes

On the motion of Ms Beamer, seconded by Mr Primrose, the minutes of meeting No. 20, having been distributed previously, were accepted unanimously as being a true and accurate record.

….

5. Report of the Commission for Children and Young People of a review of legislation governing the NSW Child Death Review Team

The Chair reported that the following report was tabled in the Legislative Assembly on 4 June 2002 by the Hon. Faye Lo Po' MP, Minister for Community Services:

> Calvert, G. & Yu, J. (2002). Review of legislation governing the NSW Child Death Review Team – Part 7A, Children (Care and Protection) Act 1987 (NSW). Surry Hills, NSW: Commission for Children and Young People.

Under Part 6 and Schedule 1 of the *Commission for Children and Young People Act 1998*, the Committee on Children and Young People is required, in part, to report upon any matter appertaining to the Commission or connected with the exercise of its functions (s.28(1)(b)) and to examine each annual report or other report of the Commission and report on any matter appearing in or arising from any such report (s.28(1)(c)).

The Chair indicated that he had decided to advertise for submissions relating to the Calvert and Yu (2002) report immediately, given the constraint of the approaching end of the Parliamentary term, and the need to allow an appropriate time for the preparation of submissions from relevant parties and the general community. The advertisement of the inquiry was published on Saturday 10 August 2002, with submissions requested by Monday 9 September 2002.

On the motion of Mr Primrose, seconded Ms Beamer:

> That pursuant to the *Commission for Children and Young People Act 1998* s.28(1), the Committee conduct an inquiry into the report of the review of legislation governing the NSW Child Death Review Team – Part 7A, Children (Care and Protection) Act 1987 (NSW).

Passed unanimously.

The Chair proposed that the public hearing to examine this report would be scheduled for Friday 20 September 2002.

….

10. General business

….

There being no further business, the Committee adjourned at 10:10 a.m.

Chair **Manager**

No. 22

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 13 SEPTEMBER 2002 AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
Mr Tsang	Ms Andrews

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Election of Acting Chair

The Manager advised that the Chair was assisting the Premier in Wollongong, and would not join the Committee until later in the morning.

On the Motion of Mr Tsang, seconded, Ms Burnswoods:

That Ms Beamer be Acting Chair until the arrival of the Chair.

Passed unanimously.

Ms Beamer, Acting Chair, presiding.

2. Apologies

Apologies were received from Mr Primrose, Mr Corbett, Mrs Hopwood, Mr Cull and Mr Smith.

3. Previous Minutes

On the motion of Ms Beamer, seconded by Ms Andrews, the minutes of meeting No. 21, having been distributed previously, were accepted unanimously as being a true and accurate record.

….

6. Chair's report

….

Inquiry into the report of the Commission for Children and Young People of a review of legislation governing the NSW Child Death Review Team
The Chair indicated that three submissions had been received relating to the Calvert and Yu (2002) report.

….

7. General business

There being no further business, the Committee adjourned at 4:50 p.m..

Acting Chair

Chair **Manager**

Amended No. 23

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 20 SEPTEMBER 2002 AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
Mr Primrose	Mrs Hopwood
	Ms Andrews

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Apologies

Apologies were received from Mr Cull, Mr Smith, Mr Tsang and Mr Corbett.

2. Previous Minutes

On the motion of Ms Beamer, seconded by Mr Campbell, the minutes of meeting No. 22, having been distributed previously, were accepted unanimously as being a true and accurate record.

….

4. Inquiry into the report of the review of legislation governing the Child Death Review Team

Ms Gillian Calvert, Commissioner for Children and Young People
Dr John Yu, Chair, Commissioner's Expert Panel,

were called and sworn.

The witnesses acknowledged receipt of a summons issued by the Chair under the

Parliamentary Evidence Act 1901.

The witnesses were examined by the Chair and Members of the Committee.

Evidence completed, the witnesses withdrew.

….

6. General business

There being no further business, the Committee adjourned at 3:30 p.m..

Chair **Manager**

No. 24

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

10:00 A.M., FRIDAY 27 SEPTEMBER 2002 AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
	Mrs Hopwood
	Mr Smith
	Mr Cull

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Apologies

Apologies were received from Mr Primrose, Ms Andrews, Mr Tsang and Mr Corbett.

2. Previous Minutes

On the motion of Mr Harwin, seconded by Mr Smith, the minutes of meeting No. 23, having been distributed previously, were amended and accepted unanimously as being a true and accurate record.

….

5. Inquiry into the report of the review of legislation governing the Child Death Review Team

The public were admitted.

Mr Robert Fitzgerald, Community Services Commissioner
Ms Christine Flynn, Community Services Commission

were called and sworn.

The witnesses acknowledged receipt of a summons issued by the Chair under the Parliamentary Evidence Act 1901.

The witnesses were examined by the Chair and Members of the Committee.

Evidence completed, the witnesses withdrew.

….

6. General business

There being no further business, the Committee adjourned at 4:05 p.m..

Chair **Manager**

No. 26

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PROCEEDINGS

9:30 A.M., THURSDAY 14 NOVEMBER 2002 AT PARLIAMENT HOUSE, SYDNEY

MEMBERS PRESENT

Legislative Council	*Legislative Assembly*
Mr Harwin	Mr Campbell
Ms Burnswoods	Ms Beamer
Mr Primrose	Mrs Hopwood
	Mr Smith
	Ms Andrews

Also in attendance: Mr Faulks, Committee Manager, Ms Samuels, Project Officer, Ms Young, Committee Officer, and Ms Tanzer, Assistant Committee Officer.

1. Apologies

Apologies were received from Mr Corbett and Mr Cull.

2. Previous Minutes

On the motion of Ms Beamer, seconded Mr Primrose, the minutes of meetings No. 24 and No. 25, having been distributed previously, were amended and accepted unanimously as being a true and accurate record.

….

4. Chair's report

The Hon. Henry Tsang MLC
The Chair noted that with his appointment on 11 July 2002 as Parliamentary Secretary to the Premier on Investment, Mr Tsang was ineligible to be a Member of the Committee. The Commission for Children and Young People Act 1998 s.29 (3) precludes a Member who has been appointed as a Parliamentary Secretary from being a Member of the Committee on Children and Young People:

29 Membership of Committee

…

(3) A person is not eligible for appointment as a member of the Parliamentary Joint Committee if the person is a Minister of the Crown or a Parliamentary Secretary.

The Committee is awaiting the appointment of Mr Tsang's replacement.

….

7. Chair's draft report: Review of the New South Wales Child Death Review Team legislation: An examination of a report for the Minister for Community Services

The Chair presented the draft report: "Review of the New South Wales Child Death Review Team legislation: An examination of a report for the Minister for Community Services".

The draft report was accepted as having been read.

The draft report was examined by the Chair and Members of the Committee:

Chapter 1: read and agreed to.
Chapter 2: read and agreed to
Appendix 1: read and agreed to
Appendix 2: read and agreed to

On the motion of Ms Beamer, seconded Ms Burnswoods:

> That the draft report: "Review of the New South Wales Child Death Review Team legislation: An examination of a report for the Minister for Community Services", be read and agreed to.

Passed unanimously.

On the motion of Ms Beamer, seconded Ms Burnswoods:

> That the draft report: "Review of the New South Wales Child Death Review Team legislation: An examination of a report for the Minister for Community Services" be accepted as a report of the Committee on Children and Young People, that the report be further revised at the discretion of the Chair, and that it be signed by the Chair and presented to the House.

Passed unanimously.

On the motion of Ms Beamer, seconded Ms Burnswoods:

> That the Chair and Manager be permitted to correct any stylistic, typographical and grammatical errors in the report.

Passed unanimously.

8. General business

There being no further business, the Committee adjourned at 10:00 a.m..

Chair **Manager**

REPORTS OF THE COMMITTEE ON CHILDREN AND YOUNG PEOPLE

The first steps ... Review of the first annual report of the Commission for Children and Young People, for the 1999-2000 financial year. (Report 1/52, May 2001).

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