PARLIAMENT OF NEW SOUTH WALES

Committee on Children and Young People

Review of Child Death Review Team Reports: 2007 Annual Report and Trends in Child Deaths in New South Wales 1996-2005

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Table of contents

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Terms of Reference

The Committee on Children and Young People is constituted under Part 6 of the Commission for Children and Young People Act 1998. The functions of the Committee under the Commission for Children and Young People Act are set out in section 28 of the Act as follows:

(1) The Parliamentary Joint Committee has the following functions under this Act:

(a) to monitor and review the exercise by the Commission of its functions,

(b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of its functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,

(c) to examine each annual or other report of the Commission and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,

(d) to examine trends and changes in services and issues affecting children, and report to both Houses of Parliament any changes that the Joint Committee thinks desirable to the functions and procedures of the Commission,

(e) to inquire into any question in connection with the Committee's functions which is referred to it by both Houses of Parliament, and report to both Houses on that question.

(2) Nothing in this Part authorises the Parliamentary Joint Committee to investigate a matter relating to particular conduct.

(3) The Commission may, as soon as practicable after a report of the Parliamentary Joint Committee has been tabled in a House of Parliament, make and furnish to the Presiding Officer of that House a report in response to the report of the Committee. Section 26 applies to such a report.

(4) A reference in this section to the Commission includes a reference to the Child Death Review Team.

Chair's Foreword

It gives me great pleasure to present this report of the Joint Parliamentary Committee on Children and Young People, the first in my role as Chair. In doing so, the Committee fulfills its statutory duties under s 28 of the *Commission for Children and Young People Act 1998* to examine each annual or other report of the Child Death Review Team and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report.

At the outset, I would like to acknowledge the notable contribution to the work of the Committee made by the previous Chair, Hon Carmel Tebbutt MP, and Deputy Chair, Dr Andrew McDonald MP. Due to the provisions of the Act, Ms Tebbutt's return to the Ministry as Deputy Premier, and Dr McDonald's appointment as Parliamentary Secretary for Health, meant that they could no longer continue as Members of the Committee. I know I speak for all Committee Members when I express my gratitude for their dedication and collegial approach to Committee work.

The purpose of the Child Death Review Team is to prevent or reduce the number of deaths in New South Wales of children and young people aged 0 - 17 years. In its 12th Annual Report, the Team provided information about the 601 children and young people who died in 2007, where those deaths were also registered in the State. The Committee notes that an important development during this period was the participation of the Team in meetings of the Australian and New Zealand Child Death Review Teams, working on the development of a classification framework for system failures in child deaths and a data dictionary to guide the collection and reporting of child deaths.

The 2007 Annual Report continues the Team's examination of a discrete set of causes of death, based on the International Classification of Disease classifications reported in the Team's *Trends in Child Deaths in New South Wales 1996–2005*. This latter report details the findings of the Team's examination of the 6,879 children and young people whose deaths were registered in NSW over the period 1996 to 2005. The Committee has also examined this significant report, with a particular focus on trends relating to Sudden Unexplained Death in Infancy, and youth suicide.

I would like to take this opportunity to thank Dr John Howard, Senior Lecturer National Drug and Alcohol Research Centre, University of NSW, and Professor Heather Jeffery, Chair of International Maternal and Child Health, University of Sydney, for their invaluable assistance to the Committee in considering the results of the Team's research. I note in particular Professor Jeffery's evidence to the Committee that best practice guidelines that are well implemented save lives when targeted appropriately,[1] and I would urge all agencies and individuals involved in protecting the health and welfare of children and young people to examine the Team's findings to ensure that preventable deaths are in fact prevented.
In December 2007, the Special Commission of Inquiry into Child Protection Services in NSW was established under Justice James Wood. One of the Inquiry's recommendations in December 2008 was that the *Commission for Children and Young People Act 1998* should be amended to make the NSW Ombudsman the Convenor of the Child Death Review Team, and the Commissioner for Children and Young People a member of that Team rather than its Convenor. The secretariat and research functions associated with the Team would

[1] Professor Heather Jeffery, Transcript of Evidence, 15 April 2009, p 20.

also be transferred from the Commission for Children and Young People to the NSW Ombudsman.

Justice Wood's recommendations have been put into effect by the *Children Legislation Amendment (Wood Inquiry Recommendations) Bill 2009.* However, as that Bill does not specifically amend the Act to remove the Team from the Committee's remit, it is presently unclear as to whether the Committee for Children and Young people will continue to have an oversight role in respect of the Child Death Review Team.

Nonetheless, this is the last occasion on which the Commissioner for Children and Young People will present a report of the Child Death Review Team. I would like to thank outgoing Commissioner, Ms Gillian Calvert, for the highly professional manner in which she has led the Team since its inception in this undoubtedly difficult field of research.

Robert Coombs MP
Chair

Chapter One - Questions Answered Before Hearing

Responses from the Commissioner on the *2007 Annual Report of the Child Death Review Team* and on *Trends in Child Deaths in NSW 1996-2005*

Nationally comparable data

Question 1
Did the Australian and New Zealand Child Death Review Teams [ANZCDRT] meet during 2008? If so, what progress has been made on developing a national classification framework for system failures in child deaths and a data dictionary to guide the collection and reporting child deaths? [Annual Report p. 2] If not, why did ANZCDRT not meet?

Response:
The Australian and New Zealand Child Death Review Teams met in December 2008. At that meeting the New Zealand representative advised they will report on progress on the national classification framework for system failures in child deaths at the next annual meeting. The ANZCDRT has been unsuccessful in securing funding for the data dictionary and consequently this has delayed its development.

Matters arising out of the Committee's Review of the Child Death Review Team Report on Suicide and Risk-taking

Question 2

In November 2004, the Committee examined you on the Child Death Review Team (CDRT) Report on *Suicide and risk-taking deaths of children and young people*. At that time it was mentioned that the Government would be reviewing the NSW Suicide Prevention Strategy to reflect the findings of that study.

Did this review take place, and, if so, what changes have occurred to the Strategy over the intervening period? Have related strategies, such as drug education and road safety been linked to the revised Strategy?

Response:
NSW Health undertook a Review of the NSW Suicide Prevention Strategy between 2004 and 2007. NSW Health reported in the *Second Yearly Progress Report on the Interagency Action Plan for Better Mental Health* that this Review concluded that the Strategy's strategic directions remain current and appropriate.

One of the priorities for focused action is children and young people and some of the initiatives being developed directly address the findings from the *Suicide and risk-taking deaths of children and young people* report including increasing clinical staff capacity to recognise and manage children who are at risk of suicide and developing a youth mental health service model aimed at providing services that are child friendly. Strategies related to drug education and road safety have not been linked to the NSW Suicide Prevention Strategy.

Question 3
It was also noted at that hearing that school-based programs such as School-Link and MindMatters, and programs addressing suicide prevention initiatives for Aboriginal And Torres Strait Islander (ATSI) communities were being evaluated. What was the outcome of these evaluations?

Response:
One of the commitments of the *Interagency Action Plan for Better Mental Health* is to "Expand the School-Link initiative to increase the knowledge of teaching staff and health workers about how to respond to the mental health of students".

The Department of Education and Training have advised that School-Link has several phases and each phase is evaluated as it is implemented. In its *Second Yearly Progress Report on the Interagency Action Plan for Better Mental Health NSW Health* (2008), they report a positive outcome for the last phase (phase 4) which focused on training around co-existing mental disorder and problematic substance use in adolescents.

Another commitment of the *Interagency Action Plan for Better Mental Health* is to "Implement evidence-based whole of school approaches in all schools which aim to prevent mental health problems developing, and support students with mental health problems".

The continuation of MindMatters is part of this commitment. The evaluation of MindMatters is managed by the MindMatters Evaluation Committee and results are available in a series of reports www.mindmatters.edu.au/about/evaluation/evaluation_-_landing.html.

The evaluation shows that 87 per cent of secondary schools had taken part in the professional development activities, that students felt more confident about their ability to deal with mental health issues and were more comfortable talking about them and that teachers were more confident to support and understand the needs of students, and to identify those who may need additional support.

The Commission is unaware of any evaluations that have been conducted on programs addressing suicide prevention in Aboriginal and Torres Strait Islander (ATSI) communities.

Question 4
Has there been a formal evaluation of the guidelines for media professionals in relation to enhancing local community capacity to prevent and respond to increases in suicide?

Response:
The guidelines for Australian media professional have been reviewed twice since 1999 to reflect new statistics and research. The most recent version was published in 2007. The effectiveness of the guidelines has not been formally evaluated.

Question 5
In terms of the impact of family dysfunction, it was noted in the Commission's written response to Questions on Notice for the 2004 meeting that the Department of Community Services was undertaking a major reform program for improving identification of and responses to children that were at high risk of potential suicide due to family dysfunction. Has this reform program concluded, and what changes have occurred to the service system? [Committee's Report, pp. 15-16]

Response:
I am advised by the Department of Community Services that last year they completed a review of their work with 14 young people who died by suicide and 13 young people who died in the context of risk taking during the period 2004 to 2006. This Review made a number of recommendations that aim to support and promote more effective and targeted work with vulnerable young people, and improve staff understanding of factors contributing to suicide and risk-taking behaviours of young people.

The Department advises that the recommendations are in the process of being implemented.

Sudden Unexpected Death in Infancy (SUDI)

Question 6

The CDRT Annual Report 2007 notes that the Standardised Autopsy Protocol for Sudden Unexpected Death of an Infant (NSW) or the Australasian SIDS protocol was noted in 41 of the 58 autopsies that were available at the time of reporting [p. xiv]. What do you consider have been the results of the use of these protocols?

Response:
In 2006, a trial *Standardised Autopsy Protocol for Sudden Unexpected Death of an Infant (NSW)* was implemented for use. In the 2007 Annual Report the CDRT reported on the use of this protocol.

The final protocol was adopted for use in June 2008. It is too early to know the outcome of the use of the protocol but we anticipate that fewer cases will be incorrectly labelled as SIDS and homicides and perpetrators will be better identified.

Question 7
The CDRT Annual Report 2007 notes that the number of infants that died suddenly and unexpectedly in 2007 was the highest in seven years and substantially higher than for 2006 [p. xiv]. Do you consider that this was due to the broader definition of SUDI, or were there other factors contributing to this increase?

Response:
In order to know if the broader definition was solely responsible for the increase in the number of deaths, the Team would need to review all infant deaths in the years prior to 2007 to see how many infants died suddenly and unexpectedly that would have been included in the broader definition. The Team has not undertaken such a review. Other factors could have contributed to the increase, including placing an infant for sleep on their side or stomach, a risk factor where we have noticed a proportional increase.

Swimming pool deaths

Question 8
The Trends Report recommended that local authorities be required to inspect all swimming pools notified within their area and monitor compliance with the relevant legislation.

Has any progress been made on this recommendation?

Response:
The Commission wrote to the Department of Local Government in September 2008 about the recommendation and was advised that it is being considered as part of the review of the *Swimming Pools Act 1992*. This Act has been under review since July 2005 and no date has been set for the review to be finalised.

The Commission phoned the Department of Local Government in December 2008 and again in early March 2009 to seek further information on progress of the review. The Department advised in March 2009 that the review is ongoing, with no final date set and that it is considering the CDRT's recommendation in its review.

The Commissioner has written to the Director-General of the Department of Local Government seeking a meeting about implementing this recommendation.

Question 9
The CDRT Annual Report notes that twelve children and young people drowned in private swimming pools, the highest directly standardised mortality seen since the CDRT began reporting [p. x]. Kidsafe Australia is currently running a water safety campaign which includes references to "fence the pool, shut the gate", and the Department of Local Government's website contains a brochure which sets out the swimming pool laws, particularly as they apply to home owners and tenants.

Do you consider it might be appropriate for a stronger publicity campaign - along the lines of those used in road safety campaigns - targeted at parents and carers?

Response:
Research from VicHealth (1998) has identified the biggest barriers to getting people to comply with pool fencing legislation is lack of owner knowledge or confusion over requirements; pool owner attitude; and the cost of fencing. Based on this research, a strong and broad ranging publicity campaign like those used in road safety campaigns is unlikely to be the most effective way of reaching pool owners and changing these issues.

Question 10
The *Swimming Pools Act 1992* places the responsibility for promoting awareness of the requirements under the Act in relation to swimming pools onto local authorities.

To your knowledge, is there any mechanism to monitor local authority compliance with the Act in terms of promoting awareness? Given the large number of local authorities, do you consider that a more coordinated, State-wide approach to promoting awareness by the Department of Local Government might be more effective?

Response:
The Commission is not aware of any mechanism to monitor local authorities' efforts to promote awareness. We are not aware of any evidence that a State-wide coordinated approach would be any more effective than actions taken by individual local authorities.

Toddlers in residential driveways

Question 11
According to the Trends Report, 46.4 per cent of pedestrian deaths occurred in residential driveways, but no trend analysis was undertaken for the deaths of children that occurred in the context of inadequate supervision [pp. 113-4].

Given that inadequate supervision would seem to be the major cause of these accidents, why did the CDRT decide not to undertake a trend analysis?

Response:
The information in the *Trends in Child Deaths in NSW 1996-2005,* on deaths that occurred in the context of inadequate supervision was exploratory and so did not provide any analysis of trends. The Team did analyse trends in supervision deaths and reported in the *2007 Annual Report* that there was no difference in the likelihood of death related to supervision between the periods 1996-2001 and 2002-2007. The Team will continue to analyse trends in deaths that occur in the context of inadequate supervision.

Monitoring

Question 12
The Trends report contains a number of recommendations requiring action by other agencies. What was the response of those agencies to the recommendations?

Response:
In relation to swimming pools, the Department of Local Government is currently reviewing the *Swimming Pool Act 1992* and considering the recommendation as part of that review. This Act has been under review since July 2005 and no date has been set for the review to be finalised. The Commissioner has written to the Director-General of the Department of Local Government seeking a meeting about implementing this recommendation (Rec. 3).

The Motor Accidents Authority (MAA) Board has identified the reduction of driver deaths of under 16 year olds as a priority for its next few years and has incorporated it into the MAA's Road Safety Plan (Rec. 4). Officers from the Commission and the MAA's Injury Prevention Policy Officer meet bi-monthly to discuss this and other issues.

The Commissioner has written to the Registrar, Births, Deaths and Marriages and the Attorney-General to follow up on actions the Registry is taking to monitor the identification of Aboriginal children (Rec. 7).

Preliminary advice from NSW Health indicates they support the recommendation to convey in all education messages concerning children with epilepsy the importance of safe swimming (Rec. 5). They also support developing a plan to improve the quality of the medical certificates of cause of death for children and young people (Rec. 8).

Discussions are underway with NSW Health about developing prevention strategies that eliminate current inequities relating to meningococcal infection (Rec. 1) and pneumonia (Rec. 2), and developing a definition of chronic conditions (Rec. 9) as alternative approaches may deliver a better outcome.

Question 13
What arrangements does the CDRT or the Commission have in place generally to monitor the acceptance and implementation, or the reasons for non-acceptance of recommendations made by the CDRT?

Response:
The Convenor writes to the CEO of relevant agencies following the tabling of an Annual Report or a Special Report, to highlight relevant recommendations and the information that

underpins those recommendations. The Convenor writes again the following year, seeking comment on their progress in implementing them. This progress and the Team's view on this is then reported in the next Annual Report.

In addition to this formal monitoring and reporting, the Commission internally monitors progress on a quarterly basis, and where appropriate, takes action to support the implementation.

The Commission actively responds to and creates opportunities for implementation. This might include strategies such as:

- Building support for the recommendations through writing or meeting with government departments, Ministers, relevant community groups or professional associations to advocate, support or advise on implementation. This includes speeches, conference presentations and media comment.
- Commenting on drafts of guidelines and policy directions, for example, the Commission is assisting Attorney Generals Department develop the questions for trialling the P79a form as recommended in the *2007 Annual Report*.
- Educating professional groups regarding the findings and recommendations of specific reports to assist in cultural and practice changes for example, the Commissioner presented on the *Sudden Unexpected Death in Infancy: the NSW Experience* to the Royal Prince Alfred Hospital Grand Rounds
- Participating in committees that are overseeing the implementation of the recommendations for example, the Commission supported the implementation of the recommendations regarding driveway reversal deaths by sitting on the MAA committee that implemented that recommendation from the *1998-1999 Annual Report*.
- Promoting the recommendations and issues through general committees where the Commission is represented, for example, a range of issues identified in the *Suicide and risk-taking deaths of children and young people* are promoted through the Commission's membership on the Mental Health Senior Officers Group
- Using its general advocacy work to create opportunities to include and promote the Team's findings and recommendations on other agendas for example, advocating for sustained nurse home visiting through its joint submission to Justice Wood's Special Commission of Inquiry into Child Protection.

Limitation of current analysis options

Question 14

The Trends Report notes that there are fundamental problems for the analysis of mortality data where deaths are rare, or the numbers of deaths are small because commonly used statistical approaches are largely inadequate. As a result of this, the Commission, on behalf of the Team, will lead an investigation of currently available methods that may be more sensitive in the determination of differences between time periods or subpopulations.

Can you elaborate on this planned investigation for the Committee? Has it commenced?

Response:
The Commission has tested alternative ways of analysing mortality data with promising results. This confirms there are other statistical methods that could for example, analyse the data at smaller geographical areas. These methods are not widely used in Australia although they are used internationally. The Commission is currently exploring partnerships with institutions and groups who have sufficient authority to support this approach before it is recommended to the Team for adoption.

Socio-economic background

Question 15
The Trends Report notes that the typical pattern is that mortality rates decline as relative socio-economic advantage increases, except for deaths by suicide and deaths related to asthma, epilepsy and cerebral palsy.[2] Is the CDRT aware of any explanation as to why there is an increase in deaths from asthma in relatively high socio-economic areas but a decrease in low and middle areas?

Response:
The finding of an increase in deaths from asthma in high socio-economic areas but a decrease in low and middle areas is similar to that reported in 2007 by Shankardass and colleagues in their study looking at the increase in asthma prevalence in high socio-economic areas.

The finding of most relevance to the CDRT in understanding this finding is that children in lower socio-economic areas may have higher protective exposures to endotoxin in early life (the hygiene hypothesis) and other bacterial compounds.

Question 16
A report by Canadian and American Researchers at the University of British Columbia has found that socially disadvantaged children suffered more severe symptoms of asthma than affluent ones and suggested that disadvantaged children felt more threatened by stresses in their lives, which had an effect on their body chemistry.[3]

Has the CDRT concluded that stress is one of the contributing factors to asthma, and if so, what kind of effect does it have? Are you aware of any other studies on the different causes of stress suffered by children in low, middle or high socio-economic areas?

Response:
The Team has not looked at stress as a contributing factor in asthma deaths - it is difficult, if not impossible to identify this once the child is deceased. The study reported in the *Sydney Morning Herald* would need to be confirmed in larger studies before any real conclusions can be drawn.

There is not a lot of research about the specific causes of stress in children from different socio-economic backgrounds. There is evidence however that the relationship between stress levels and socio-economic background may not be a simple one. For example, a

[2] In relatively low socio-economic areas there was a 94 per cent decline in the likelihood of an asthma-related death, in middle socio-economic areas there was a 70 per cent decline, while in relatively high socio-economic areas there was a 12 per cent increase: Trends Report Trends Vol. 1, xxvii & Vol. 2, p 224.
[3] See *Sydney Morning Herald*, 11 November 2008, "Poverty and poor health in gene link".

Canadian study reported in 2000 that cortisol (a stress hormone) is significantly higher in children with lower socio-economic status compared with higher socio-economic status and it was also significantly correlated with his or her mother's extent of depressive symptoms.

Question 17
The Trends Report notes that there appears to be continuing - and in some cases, growing - inequities in health outcomes with reference to Aboriginal identity, socio-economic disadvantage and geographic remoteness [Vol. 1 p xxxi]. Does the CDRT have any plans to undertake more in-depth research on the manner in which these inequities contributed to the deaths of children and young people, and the implications for the provision of health and other services?

Response:
The *Trends in Child Deaths in NSW 1996-2005* was analysed at a State-wide level therefore it cannot demonstrate that Aboriginal identity, socio-economic disadvantage or geographic remoteness causes inequity in death. It does show there is an association between Aboriginality and death.

In order to determine whether and how the inequities contributed to children's death would require a critical path analysis of the life of every Aboriginal child who died, and possibly the mothers for infants, which was then aggregated and analysed. This is a large research project over a number of years which the Team is not at this stage planning to undertake. In the meantime there is a large body of existing knowledge on health inequities that can and does inform the development of health and other services.

Responses from Dr John Howard to the Committee's Questions

The following written responses were provided by Dr John Howard, Senior Lecturer, National Drug and Alcohol Research Centre, University of New South Wales. Dr Howard is a member of the Child Death Review Team. He provided expert analysis of mental health issues for children and young people who died by suicide.

Question 1
An ongoing issue for the CDRT has been the limited information available on the mental health state of the children and young people who die by suicide. The Trends Report recommended that the existing information requirements of the Police Report of Death to Coroner be reviewed in consultation with NSW Health and that the review aim to align the information collected with current knowledge about what is important for understanding these suicide deaths.

Are you aware as to whether any progress has been made on the recommendations? If implemented and how effective do you think it might be, and how might the CDRT be able to use this information in the future?

Response:
I have not been involved in this review and am not aware if it has occurred and, if so, what the findings and recommendations are. I have been provided with a copy of the Report of Death to the Coroner form P79A, and make some comments on this form in my response to your Question 2 below.

Question 2
Can you explain to the Committee what type of information is important for understanding these deaths?

Response:
I have reviewed the Report of Death to the Coroner form (P79A) of NSW Police. I believe the form attempts to be comprehensive. It obviously requires extensive (necessary) police activity to complete. I believe that Section 12, Suspected Suicide should include Acute Mental Distress (or similar phrasing) and School or Employment Crisis/Severe Distress (or similar phrasing). I also speculate that it might be possible to include some questions related to mental health that police could ask of various key informants (eg family members, teachers, peers). These may not be included in the actual form, but could guide investigating police. They could be quite useful in detecting undiagnosed mental illness if routinely asked. For example "Has there been any noticeable change in the way *X* has been dealing with day to day stress?"; "Did they appear to be more nervous?"; "Did they say things that made you think they were feeling hopeless?"; "Did they appear to be more fidgety or restless and could not sit still?"; "Was it like everything was an effort for them?"; "Did they seem so sad that nothing much could cheer them up?"; "Did they appear to feel worthless?". These questions are adapted from those contained in a widely used short screening instrument used to screen for those with possible mental health concerns.

Other areas worth commenting on could be concerns re sexuality, increased time on the Internet, interest in celebrity suicides or accidental/violent death, increased interest in/membership of particular subcultures that appear to hold more bleak views of life and

existence, or which have a strong interest in death, self-mutilation, esoteric practices, and so on.

Question 3
In November 2004, the Committee examined the Commissioner on the CDRT Report on *Suicide and risk-taking deaths of children and young people*, at which time the Commissioner noted that the Government would be reviewing the NSW Suicide Prevention Strategy to reflect the findings of that study.

Has this review taken place, and, if so, what changes have occurred to the Strategy over the intervening period? Do you consider that linking related strategies, such as drug education and road safety, would enhance the effectiveness of the Suicide Prevention Strategy?

Response:
I understand that NSW Health undertook a Review of the NSW Suicide Prevention Strategy which concluded that the Strategy's strategic directions remain current and appropriate. I believe that there is no ***one*** way of helping young people, prevention is definitely the best and there are many prevention strategies around. I do not have an opinion on where these strategies should be located but rather efforts should be linked and coordinated. Certainly, strategies to reduce problematic drug use and increase road safety are important. What is known in the "drugs area" is that interventions provided across the years (and, in schools, relevant K-12 curricula) where young people are assisted to build the skills to lead positive and satisfying lives. This includes attention to *enhancing protective factors* and attempting to *minimise the impact of risk factors*. Over-emphasis on *the drug/drugs* does not bring about much protection in and of itself.

In relation to driving, there is evidence that "risk takers"/sensation seekers/impulsive young people are at greater risk of accidents, and also of drug use. Such young people may not necessarily respond to driving, and drink/drug driving awareness strategies that focus on rational decision making. They may require different strategies to engage them. Increasingly young people use the *web* to seek and obtain assistance. Sites such as Reach Out (www.reachout.com.au) provide an essential service to young people and should be supported.

I have noticed some, albeit fairly small, increase in clinical staff capacity to recognise and manage children who are at risk of suicide and changes to mental health services for young people including integrated health services for young people with mental health problems in youth friendly settings. I expect this could give young people better access to mental health services, drug and alcohol services, GPs and other services.

While the Commonwealth's *Headspace* initiative is welcomed, and has raised awareness of issues and of the need to provide comprehensive, integrated, easy access services, the initiative did not really provide for the necessary clinical scale up. This means that few experienced Child and Adolescent psychiatrists remain in public access settings, and, if in a private setting, very few will entertain "bulk billing". The impact of this is that it can be difficult to get an urgent psychiatric assessment of a suicidal young person, and in particular, young people presenting with acute psychotic conditions. It is well known that those diagnosed with schizophrenia, in particular, have a much higher than average chance of dying by suicide. When, if urgent psychiatric intervention is essential, the "Liaison Psychiatry" service available may be being provided by a Psychiatrist or Registrar with limited child and

adolescent experience. This situation is obviously much more critical in rural and remote areas.

To allow the NSW Suicide Prevention Strategy to have a larger impact in preventing death by suicide, especially where a young person is presenting with distressing and/or acute mental health concerns, more needs to be in place. I believe NSW Health could explore models for developing and adequately funding readily available experienced child and adolescent psychiatry services. While specialist nurses would be central to such services, especially in an Emergency Department (ED) triage process, a psychiatrist is essential for diagnosis, medication and, if needed, involuntary containment. Possibly engaging with experienced private practitioners who are appropriately remunerated to be available in public settings on a roster basis could assist.

Question 4
It was also noted at that hearing that school-based programs such as School-Link and MindMatters, and programs addressing suicide prevention initiatives for Aboriginal And Torres Strait Islander (ATSI) communities were being evaluated.

Are you aware as to whether these evaluations have take place and could you elaborate for the Committee on the content, and measured effectiveness of such programs?

Response:
I am not directly involved in the School-Link and MindMatters programs. I understand that as each new component of School-Link is introduced it is evaluated. I understand that other material to be present to the Committee will outline the content of such programs.

Question 5
Are you aware as to whether there has been a formal evaluation of the guidelines for media professionals in relation to enhancing local community capacity to prevent and respond to increases in suicide? If so, what recommendations have come out of the evaluation?

Response:
I do not know if there has been any evaluation of the impact of the guidelines. I understand the guidelines for Australian media professionals have been reviewed twice since 1999 with the most recent version published in 2007. I do not know of any evaluation of the impact of the guidelines.

Question 6
With respect to the impact of family dysfunction upon youth suicide, in its Review of the 2004 CDRT Report, the Committee was advised that the Department of Community Services was undertaking a major reform program for improving identification of and responses to children that were at high risk of potential suicide due to family dysfunction. Has this reform program concluded, and what changes have occurred to the service system as a result?

Response:
I have not been involved in this review but understand the Department of Community Services have completed a review of 27 young people who died by suicide or risk taking. I do know that the results have not yet been implemented.

Question 7
The Committee notes that, unlike most causes of child deaths, the rate of deaths by suicide in New South Wales actually increases for higher socio-economic areas? Could you advise the Committee as to whether there is any evidence to explain this anomaly?

Response:
There were increases in both the middle and high groups for suicide deaths. I think it is important to keep this finding in the spirit it is provided – it is interesting that we found this but the finding in is not statistically significant for either group. I wouldn't be inclined at this stage to describe the finding as an anomaly but rather something to keep our eye on.

Responses from Professor Heather Jeffery to the Committee's Questions

Professor Heather Jeffery, Chair of International Maternal and Child Health, School of Public Health, University of Sydney undertook identification of Sudden and Unexpected Deaths in Infancy for the Trends in Child Deaths in NSW 1995-2006 Report and the 2007 Annual Report. Professor Jeffery provided the following written responses.

Question 1
The Committee notes that the Standardised Autopsy protocol for Sudden Unexpected Death of an Infant (NSW) or the Australasian SIDS protocol was noted in 41 of the 58 autopsies available at the time of the CDRT's last Annual Report. What if any do you consider to be the impact of the use of the protocol?

Response:
The aim of standardising an autopsy is to:

- Ensure the autopsy is thorough and explained causes of death are not missed as this may have an important bearing on counselling of the parents and future children, as well as the resolution of the bereavement process;
- Ensure that deaths that are unexplained have adequate and sufficient information for them to be classified as SIDS according to the accepted San Diego definition (to impart a degree of certainty that the death is truly SIDS and not in a "grey area" due to inadequate investigation)
- Assist future prevention and research. Accurate information needs to be available on which to direct targeted prevention.

Recent literature (Weber M.A. et al, ADC 2008) would suggest that cause of death at autopsy is significantly improved if a recommended autopsy protocol by paediatric pathologists using a range of ancillary investigations (eg radiology, toxicology, microbiology) is implemented. The authors found in 546 SUDI cases in the U.K. in which 37 per cent were explained and 63 per cent unexplained. We need such current "gold standard" expectations of an optimal autopsy service for SUDI cases.

In March 2006 a trial protocol, the Standardised Autopsy protocol for Sudden Unexpected Death of an Infant (NSW) was introduced at all three forensic units in New South Wales that manage SUDI's and implemented as policy from August 2008. The evidence so far suggests that the explained deaths have increased over the last five years. In 2007, of the 67 SUDI deaths in New South Wales, 37 per cent were explained and 63 per cent unexplained (see Table 1).

Table 1. Proportion of explained to unexplained SUDI deaths 2003-07
(from CDRT Annual Reports)

Year	SUDI's	Number unavailable at time of reporting	EXPLAINED DEATHS * n (%)	UNEXPLAINED DEATHS SIDS + Undetermined
2003	43	17	28 (65%)	5 + 10 (35%)
2004	43	9	9 (26%)	13 + 12 (74%)
2005	49	5	7 (16%)	33 + 4 (86%)
2006	54	7	12 (25%)	25 + 10 (75%)
2007	67	4	25 (37%)	35 + 3 (63%)

March 2006 Introduction of Standardised Autopsy protocol for Sudden Unexpected Death of an Infant (NSW)

The increase in explained deaths over the last five years suggests that the autopsy protocol and more complete reporting may have contributed to the increased identification of cause of death. The 2003 figure showing 65 per cent explained deaths is likely spurious as nearly one third, 17 of 60 SUDI (28 per cent) deaths were unavailable for classification.

However a systematic, best practice approach is needed for the whole investigatory process when SUDI occurs as defined previously (Jeffery H.E., Literature Review for CDRT 2002). Autopsy is only one part of a continuum in a diagnostic process that requires standards for all parts including the history, examination of the death scene, examination at autopsy, ancillary investigations and multi-disciplinary case discussion to assign cause of death.

Best practice guidelines for the investigation of SUDI's have been developed in the U.K. and in the U.S. concerning:

- Collection of information from all relevant sources as soon as possible after death, ideally within 24 to 48 hours, by a trained health professional and police investigators.
- Standards for death scene investigation.
- Standards for post-mortem protocols, ideally undertaken by a paediatric pathologist or in conjunction with a designated forensic pathologist.
- Specialised investigations with the conditions that provide optimal yield and include radiology, metabolic and toxicological tests.
- Multi-disciplinary case discussion to assign the most likely cause of death and contributory factors.
- Certification of the cause of death.

A recent study (Arnestad M. et al, *Forensic Science International* 2002) found that review of the circumstances (42 per cent), followed by macroscopic and microscopic (histological) examination (44 per cent and 40 per cent, respectively) were the three most important autopsy investigations for the detection of identifiable causes of death. In two thirds of the

cases more than two investigative components were required at autopsy to determine cause of death.

The protocol released on 22 December 2008 by the NSW Health, entitled "Death – Management of SUDI" (PD2008_070), addresses some of this process. However it is yet to be implemented by the systematic education of all stakeholders engaged in the process. Importantly, experience has shown that protocols when developed on best available evidence require auditing to ensure quality and the whole multi-disciplinary process managed in order to sustain the needed behavioural change for best practice to occur. This has yet to be achieved for the autopsy protocol and for the management of the more complex SUDI protocol.

Question 2
The CDRT Annual Report 2007 states that the number of infants who died suddenly and unexpectedly in 2007 was the highest in seven years, and substantially higher than for 2006. Do you consider that this was due to the broader definition of SUDI, or were there other factors contributing to this increase?

Response:
SUDI numbered 67 in 2007 of which six died while "awake", that is 61 infants died during apparent sleep, the definition used for SUDI in previous years. When recalculated as 61 deaths this resulted in a rate similar to previous years of 66.46 Crude Mortality Rate.

However it is notable that SUDI has not really declined in the last 7 years with 50 to 60 infants dying each year in New South Wales, and over 90 per cent demonstrating the presence of at least one risk factor, that indicates nearly all these deaths are potentially preventable.

Question 3
The Trend Reports notes that infants living in relatively high socio-economic areas were 44 per cent less likely to die suddenly and unexpectedly than were those living in relatively low socio-economic areas. Can you explain to the committee what factors might contribute to the higher rate among children in low socio-economic areas?

Response
Previous CDRT reports and in particular the analysis in the CDRT research monograph entitled "SUDI the NSW Experience" demonstrate a consistently increased risk of SUDI in

- Indigenous infants (six fold);
- Excessive number of preterm infants amongst SUDI deaths (29 per cent in 2007 report compared with a background rate of 7-8 per cent);
- Excessive number of deaths in remote as opposed to urban communities and
- Unsafe sleeping practices that place infants at risk (side or front sleeping, smoking during pregnancy) associated with a lower level of maternal and paternal education which needs to be addressed with appropriate educational strategies.

Each of these risk factors is known to be closely associated with lower socio-economic status. Data from Western Australia indicate that the elevated risk of SUDI in Indigenous infants can be attributed to known risk factors including unsafe sleeping practices, and

smoking. The information in the CDRT reports provides evidence on how to target safe sleeping messages for parents and health providers.

Chapter Two - Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

REVIEW OF THE 2007-08 ANNUAL REPORT OF THE COMMISSION FOR CHILDREN AND YOUNG PEOPLE AND THE 2007 ANNUAL REPORT OF THE CHILD DEATH REVIEW TEAM

REVIEW OF CHILD DEATH REVIEW TEAM REPORT: TRENDS IN CHILD DEATHS IN NEW SOUTH WALES 1996-2005

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At Sydney on Wednesday 15 April 2009

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The Committee met at 10.45 a.m.

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PRESENT

Mr R. D. Coombs (Chair)

Legislative Council	**Legislative Assembly**
The Hon. C. E. Cusack	Ms M. T. Andrews
The Hon. K. F. Griffin	Mr S. R. Cansdell
Reverend the Hon. F. J. Nile	Mr R. A. Furolo

CHAIR: I now declare open the public hearing in relation to the Review of the 2007-08 Annual Report of the Commission for Children and Young People, the 2007 Annual Report of the Child Death Review Team and the Child Death Review Team report: Trends in Child Deaths in New South Wales 1996-2005. The Committee welcomes the Commissioner, Ms Gillian Calvert, and Professor Heather Jeffery, Chair of International Maternal and Child Health, University of Sydney. Thank you very much for joining us today. It is a function of the Committee on Children and Young People to examine each Annual Report of the Commission and report to Parliament in accordance with part 6 section 28 (1) (c) of the Commission for Children and Young People Act 1998. I note that the first part of today's hearing will relate to the reports of the Child Death Review Team.

HEATHER ELIZABETH JEFFERY, Professor, International Maternal and Child Health, School of Public Health, University of Sydney, and

GILLIAN ELIZABETH CALVERT, Commissioner for Children and Young People, level 2, 407 Elizabeth Street, Surry Hills, affirmed and examined:

CHAIR: The Commissioner will be very familiar with the Committee's procedure. Professor Jeffery, I am advised that you have been issued with a copy of the Committee's terms of reference and also a brochure entitled "Information for witnesses appearing before Parliamentary Committees". Is that correct?

Professor JEFFERY: That is correct.

CHAIR: The Committee has received a detailed response from the Commission to its questions on notice relating to the 2007-08 Annual Report, the 2007 Annual Report of the Child Death Review Team and the Child Death Review Team's report: Trends in Child Deaths in New South Wales 1996-2005. Commissioner, do you wish this response to form part of your evidence today and be made public?

Ms CALVERT: Yes.

CHAIR: Professor Jeffery, you have also provided a response to the Committee's questions on the 2007 Annual Report of the Child Death Review Team and the Child Death Review Team's report: Trends in Child Deaths in New South Wales 1996-2005. Do you wish this response to form part of your evidence today and be made public?

Professor JEFFERY: Yes, thanks.

CHAIR: Does either of you want to make any comment before we start with questions?

Ms CALVERT: I would like to make an opening statement. I have to say that it is with mixed emotions that I appear before you today as the New South Wales Commissioner for Children and Young People and the convenor of the New South Wales Child Death Review Team. There is some sadness in undertaking what is likely to be my final appearance before the Committee. However, it is also with great pride when I look back at what the Commission has achieved for children and young people in New South Wales over the past 10 years. In particular, I have appreciated the role of the Parliamentary Joint Committee in the Commissioner's work and value the positive relationship that I think we share.

The Committee and the Commission have always had a productive relationship, which I believe comes from our common and genuine desire to improve the lives of our younger citizens, and providing this level of representation for children and young people has resulted in significant benefits in their lives. But the changes we make for our kids also bring great benefits to the broader community and help make our society a stronger and healthier place for all our members across all our generations. I think the Parliamentary Joint Committee's own commitment to children and young people and its efforts to help bring kids' issues into Parliament is a key element to this process, and being provided with this level of direct political representation sends a strong message that children and young people are valued as citizens and should be consulted about the decisions that will affect them. It means that the public do not see Committee Members as being faceless and invisible but as people who are taking on an important and purposeful role in representing children as citizens in our democracy.

I have seen the Parliamentary Joint Committee grow over the last 10 years and become more confident about bringing kids into the consultation process—for example, as a result of your work such as your current Inquiry into Children and Young People Aged 9 to 14 Years. Our approach to kids' participation in New South Wales is leading the way both nationally and internationally, and other States, the Commonwealth Government and many countries are now adopting the participation practices that we developed and fine-tuned in New South Wales. It was with great pleasure that I attended the Commonwealth Government's 2020 Summit in Canberra last year and saw this take place at the national level. The event was preceded by the Youth 2020 Summit where, for the first time, young people were invited to make significant contribution at that level. I think these opportunities help to promote community understanding that children and young people need to be acknowledged and encouraged to participate as full community members of a truly democratic society. When the community sees this process happen in positive and meaningful ways, such as through Parliamentary Joint Committees, it recognises and values the mechanisms that enable this to happen.

I hope that the Committee Members continue to consolidate this best practice approach with the next Commissioner. The new Commissioner is fortunate indeed to inherit a Committee that combines stability from its long-term members with the freshness of those with new ideas. In particular, I would like to acknowledge and personally thank long-term Committee Members Marie Andrews, Steve Cansdell, Catherine Cusack, Reverend Nile and Kayee Griffin for their support and commitment to the Commission's work over many years, their willingness to stay with the Committee and to provide it with the continuity and commitment that has enabled it to make an important contribution to Parliament. I would also like to acknowledge the contributions of the Committee's Chairs—David Campbell, who gave us a good early start with the commitment to bipartisanship support to work with the Commission in promoting children's wellbeing; Barbara Perry, who brought a commitment to the built environment that is reflected in our work over the past five years; and Carmel Tebbutt, who brought a strong commitment to children's wellbeing, powerfully demonstrated by her bringing children directly into the work of the Committee when they appeared before the Committee's current Inquiry. I am confident that the new Commissioner and the new Chair, Robert Coombs, will continue this tradition of fostering a strong and productive relationship for the benefit of children.

The Commission has always welcomed the scrutiny of the Parliamentary Joint Committee. It is a valued mechanism that we use to hold ourselves accountable for the decisions that we make and the work we have done in the last 10 years to bring about positive changes for children and young people. Over the past decade, with all the decisions we have made, the Commission has been guided by the governing principles contained in our legislation. In our work with others, the Commission promotes the spirit of that legislation to encourage the ethos that any decisions concerning children and young people should be made with children and young people in mind. The recent decision to move the Child Death Review Team was therefore disappointing.

In the last 10 years the work of the Team and the support of the Commission has produced good outcomes. Together the Team and the Commission formed a valuable partnership across the continuum of New South Wales children's lives from birth through to death. The Commission has been able to take the Team's recommendations and work with community groups, government agencies and others to bring about change for children and young people where it was needed. I think this is well demonstrated with the release of the Team's groundbreaking report covering the 10-year period from 1996 to 2005. The Commission draws on the Team's research to inform and help opinion leaders, organisations and the wider community to take action to support children and young people's overall development and wellbeing. It is a holistic and integrated approach to our work and to children's wellbeing that follows similar principles being implemented in the United Kingdom. The recent decision signifies a worrying shift in thinking away from that whole-of-child approach to children's issues. The decision in my view does not keep the wellbeing of all children in the front of our minds as seen by the fact that this Joint Parliamentary Committee on children will no longer oversight the Child Death Review Team. Despite this setback for children, I am sure the Commission will continue to perform and build upon its role as the peak advocate for all children in New South Wales.

There is still great pride when I look back at what the Commission and those who have worked with us have achieved over the last 10 years to improve children's lives. In that time I have seen a greater acceptance that children are capable of giving meaning to their world and actions, and therefore the right of kids to have a say in decisions that affect them. Kids are increasingly understood to be active and are increasingly given a seat at the table. I have also seen a greater appreciation of the importance of the early years for children. Accompanying this has been an increasing emphasis on promoting wellbeing to improve the quality of children's lives and to prevent problems in later life from intervening earlier. There is also greater understanding of the importance of relationships to children and the need for us as a country to support families and workers to enable and maintain those relationships as illustrated through solid community support through the introduction of paid parental leave. There have been particular areas where we are keeping children in mind where previously we had not—the work we have done and are doing, for example, on the built environment and on children in work. Importantly, we have seen an acceptance of the need for people in organisations who work with children to take action to reduce harm to them, either through the 2 million checks we have done or through our Child-safe - Child-friendly Program's emphasis on reducing risks in organisations. These are all changes in areas that children have told us in so many of our consultations, our research work and our listening, are the things that make them grow and develop, that promote their wellbeing and are important to them.

I said before that there is great pride when I look back at what the Commission has achieved over the last 10 years. It has been an honour and a privilege to have been the first

Commissioner for Children and Young People in New South Wales, but I do not see this point as the end of the journey but rather an opportunity for the Commission to look to the future with a feeling of renewal and a new sense of purpose in what it can still achieve. I hope you share with me that great excitement and anticipation about the future of both the Commission and the Parliamentary Joint Committee and that together the Commission and the Parliamentary Joint Committee continue to improve the lives of children and young people in New South Wales.

The Hon. KAYEE GRIFFIN: Thank you for those words, and for the support you have given children and young people in New South Wales over the period that you have served as Commissioner. We will miss you.

Ms CALVERT: Thank you.

The Hon. KAYEE GRIFFIN: In your response to the Committee's questions on the 2007 Annual Report you note that strategies relating to drug education and road safety have not been linked to the New South Wales Suicide Prevention Strategy. Do you consider there might be any benefits in having such a linkage?

Ms CALVERT: If we are going to first of all focus on the Child Death Review Team and then talk about the other one, could you bear with me for a moment, and would you mind restating the question?

The Hon. KAYEE GRIFFIN: Yes, it was in relation to your response regarding strategies in relation to drug education and road safety and your comment that they have not been linked to the New South Wales Suicide Prevention Strategy. Do you consider that there might be benefits in having such a linkage?

Ms CALVERT: One of the reasons that we conducted the suicide and risk-taking strategy is that we wanted to look at whether or not there was a relationship between risk taking and suicide. We did find that there was a group of young people who did take risks. I think that in trying to reduce the number of deaths we would be better off looking at it from the point of view of road fatalities rather than trying to look at it as a Suicide Prevention Strategy. There are a number of well researched and evidence-based strategies for reducing the number of deaths from road traffic accidents and I think we are better off keeping it in that sphere rather than seeing it as a suicide prevention activity.

The Hon. KAYEE GRIFFIN: And in relation to drug education as well?

Ms CALVERT: Similarly with drug education, although probably there is a greater crossover with drug education and suicide prevention activity than there is with road traffic accidents and suicide prevention activities.

The Hon. KAYEE GRIFFIN: You note that there has not been any formal evaluation of the guidelines for Australian media professionals in relation to community capacity to prevent and respond to increases in suicide. Are you aware of any anecdotal evidence of their effectiveness or otherwise?

Ms CALVERT: My understanding is that those suicide guidelines have been reviewed twice to reflect new statistics and research, and the most recent version was in 2007. I think a measure of the success of the guidelines is the number of times they have been breached and our understanding is from ACMA, the Australian Communications Media Authority, that there has only been one finding of a breach of safeguards of reporting suicide in the past four years.

The Hon. KAYEE GRIFFIN: My last question relates to the review of the *Swimming Pools Act 1992*, and it would appear to be a lengthy process. You referred in your answers to the questions that the Committee sent you that you were going to meet with the Director-General of the Department of Local Government. Has that occurred and, if so, can you report any outcome in relation to that?

Ms CALVERT: I am meeting with the Acting Director-General next Monday. So that meeting has been arranged and I am happy to report back to the Committee, if that is what the Committee would like.

CHAIR: Before we go to questions for Professor Jeffery, does anybody have any further questions of Commissioner Calvert in relation the Child Death Review Team?

Reverend the Hon. FRED NILE: Just a quick comment only. As you know from the debate, I strongly supported the statement that you just made and hopefully there may be a review in the future.

Mr STEVE CANSDELL: A few people supported your statements, Gillian.

The Hon. CATHERINE CUSACK: Chair, is this the last opportunity to question in relation to the 2007 report?

CHAIR: The Child Death Review Team report, yes, for Commissioner Calvert it is. We can go back after we deal with questions for Professor Jeffery, if you like, to ask some general questions.

Reverend the Hon. FRED NILE: Professor Jeffery, with respect to the 10-year Review could you please explain for the Committee the manner in which the members of the Child Death Review Team undertook the Sudden Unexpected Death in Infancy research?

Professor JEFFERY: I really think I should defer to Gillian for that because I was not directly overseeing the Child Death Review Team; I am not part of that Team.

Ms CALVERT: Professor Jeffery's relationship is what we call an expert adviser, which means that she has access to the data and the information, and when we need expert advice we will bring in our expert adviser. Clearly, because of the range of causes of deaths of children we cannot hold all that knowledge on the Team so we have got this system of expert advisers, and Professor Jeffery is our expert adviser on Sudden Unexpected Death of Infants. Were you wanting to know how we did the Sudden Unexpected Deaths of Infants for the 10-year data study or the 2007 Annual Report, Reverend Nile?

Reverend the Hon. FRED NILE: I think it would be the report.

CHAIR: The 10 years.

Ms CALVERT: We have a register of all the deaths of children in New South Wales where we collect a number of bits of information, and the information we collect is guided by advice from people like Professor Jeffery and also based on our special study on the Sudden Unexpected Deaths of Infants Report, which showed a number of issues. So we now routinely collect that data on all the deaths of children who die from Sudden Unexpected Deaths. We then subjected that data to a range of statistical analyses and that then gave us the information that we needed. So that is how we gather the information and how we then understand the information.

Mr ROBERT FUROLO: Professor, in relation to the Review's findings on Sudden Unexpected Deaths of infants were there any particular trends or anomalies that you encountered that you can comment on?

Professor JEFFERY: I think that this was a landmark publication and I think it needs to be put in context with the previous publication, *Sudden Unexpected Death in Infancy: the New South Wales Experience*, which was a turning point for New South Wales in its approach to prevention of these deaths. The issues that have come out in that publication and in the 10-year Review I think are very important ones in terms of prevention and in terms of process. In terms of prevention, there are some very clear messages arising both from the 10-year Review and also reinforced by the 2007 Annual Report and that is that we are seeing deaths in parts of our population in excess of the background rate, and I am referring here to Indigenous infants where there is a 6.5-fold increase in these infants death. That is one of the highest statistics and one of the largest gaps that we are seeing in infant mortality.

The second is the overrepresentation of preterm babies—that is, babies that are what we call less than 37 weeks of the 40 weeks gestation in humans—they represent 28.6 per cent in the 2007 Review. That is concerning but does help us in terms of where we should be targeting prevention and how we should be targeting prevention. I think the third issue is that surrounding remoteness, the fact that rural remote infants are dying in excess of urban babies—about 2.5 times the urban rate. So we are seeing a gradient from inner urban to outer, to remote. Underlying all of this is the very strong predeterminant, and that is low socio-economic status, poverty. So I think we have got some very clear messages from this very good research and excellent output from the Child Death Review Team on what we should be doing.

In terms of process, I have addressed that to some extent in the questions that you posed to me in writing, but the process of examining the death of an infant who has died a Sudden Unexpected Death is a reasonably complex process because it cuts across different agencies and different disciplines. Australia is not the only country that has had to face that complexity. The United Kingdom has done it and the United States has done it and Canada has done it in different ways. I refer back to this landmark document, which is *Sudden Unexpected Death in Infancy: the New South Wales Experience*. I think this clearly sets out how we in Australia and in New South Wales still need to reach international standards in this process.

Since this was published there has been a lot done to try and achieve that, and I believe that the recent protocol put out by NSW Health on 22 December 2008 certainly has

been hard work in moving towards that across agencies, across disciplines, to try and reach optimal standards. But we still have got a long way to go, and I put that into the background of we still have 50 to 60 deaths suddenly and unexpectedly of these young infants in New South Wales, the large number of which—over 90 per cent of which—have one or more risk factors and therefore are potentially preventable.

Ms MARIE ANDREWS: Professor, I think the Commissioner might have already answered part of this question. The Committee would like to know how much you and your colleagues had to do with the overall preparation of the report and did you work independently according to area of expertise?

Professor JEFFERY: I have worked with the Commission, and in particular I have worked with both my colleagues here. They have posed questions to me, I have also examined with other experts the difficult issues of defining Sudden Unexpected Death and we have had a very nice two-way debate and conversation about these issues over now a long period of time.

Ms CALVERT: I would like to say Professor Jeffery is very much involved in this special report of Sudden Unexpected Deaths of Infants, and has continued to be involved, and that provided the basis of what we have carried on through the 10-year data study and the Annual Reports. So it has been over about five or six years.

Professor JEFFERY: Since 2002.

Mr STEVE CANSDELL: Professor, are you aware of any similar long-term studies of child deaths and if so have they reached similar findings to the Child Death Review Team research?

Professor JEFFERY: Yes, there are a number of longitudinal studies in the literature, particularly from the southern part of the United Kingdom, what is called the Avon district, under Professor Peter Fleming and colleagues, and also now a number of publications from the United States and Canada generally on both population-based and State-based outcomes of Sudden Unexpected Death in Infancy, and I think low socio-economic status is the biggest antecedent determinant and underlies all of them. Of course, the issues associated with that mean the groups who are most vulnerable here do differ depending on the country. For example, black infants in the United States are particularly vulnerable and share a 2.5 to 3 times increased risk of death.

The issues that underlie the neonatal aspects of prematurity are also a common thread, and particularly so in the United Kingdom, the data from the United Kingdom. I guess, thirdly, the practices that underlie the risk, that is, of generally unsafe sleeping, are common across all countries, and that is really the most outstanding thing, that you can look at the proximate risk factors then go back to further antecedent causes and further back and yes they share a very common thread.

Mr STEVE CANSDELL: Those figures with the negroes in the United States would be very similar to Indigenous Australians, would they not?

Professor JEFFERY: Our rate here in New South Wales is higher: we are talking about a 2.5 to 3 times increased rate of SUDI in the United States but here in New South Wales the Indigenous rate is over 6. This is a very important issue that we need to address.

Mr STEVE CANSDELL: I know that one of your research areas is in methods of translating evidence into clinical and preventative practice. How do you consider that this might be done in respect of the evidence obtained in the course of a 10-year Review?

Professor JEFFERY: I think this very much comes down to implementation of what this 10-year Review is telling us. Gillian might like to comment but I see this as dependent on the responsible agencies for implementation of facts that have been detected here; that is, where there are vulnerable populations and increased risk we have Government, SIDS and Kids Advisory Committee, and community organisations and we need to get the "safe sleep" messages across.

Ms CALVERT: I think it also ties into other strategies that have been implemented. Smoking is another of the risk factors that cross borders in a sense, so reducing smoking around infants and in the household is one strategy. Broad programs that are aimed at reducing smoking, whether through taxes, point of sale strategies or quit lines, all contribute to potentially reducing Sudden Unexpected Deaths in infants because they reduce the general level of smoking in households. Of course, the level of smoking in poor households is much higher than in more wealthy households. Again you can start to see the interaction of various things.

Reverend the Hon. FRED NILE: What machinery is in place to make sure the different departments study that report and apply its findings to their areas—you mentioned smoking. Health, DoCS?

Ms CALVERT: All of the relevant agencies have been sent copies of the three reports that have looked at Sudden Unexpected Deaths in infants over the last three or four years. When *Sudden Unexpected Deaths in Infancy: the New South Wales Experience* was tabled the New South Wales Government undertook to implement the recommendations. They have given that responsibility to the SIDS and Kids Advisory Committee and they are working their way through the recommendations. The Team review progress on the recommendations as part of their annual reporting and report on progress on the implementation of the recommendations.

I think it is important that we now have a standard autopsy protocol in place and required to be used. It is also important that we now have the multi-disciplinary response protocol in place and required to be used, and all the agencies have signed up to that protocol and it is now being implemented. I also know that some of the agencies have done specific things to target Aboriginal communities. For example, the Department of Community Services was giving some of the people it is in contact with, singlets for children in Aboriginal colours saying "This side up" to encourage safe sleeping practices such as placing the baby on its back to sleep. The Team looks at the implementation on an annual basis and reports.

The Hon. CATHERINE CUSACK: I want to ask about asthma deaths. There has been a fairly substantial decline in the number of asthma deaths, which is really

tremendous. Do you have any explanation for that? Secondly, I note the percentage of asthma deaths is increasing in metropolitan areas. Given that the overall death rate, as you commented, is disproportionately higher for non-metropolitan areas, that would suggest there are still a large number of preventable asthma deaths occurring in metropolitan areas. So, why the reduction and what are the issues for metropolitan areas?

Ms CALVERT: I will take part of that on notice because I am not really qualified to talk about why there has been a reduction in asthma deaths. I do know that the number of asthma-related deaths is very small. There were no asthma-related deaths from 2003 to 2005, five in 2006 and three in 2007. With those small numbers it is very difficult to comment generally about anything contributing to those deaths. I will take that on notice and seek the advice of our independent expert on asthma.

The Hon. CATHERINE CUSACK: Can I draw your attention to page 231? It shows the trend has come right down. The reason I am interested is that I know the Department of Health has undertaken a number of interventions and of course we all recall the big drama about childhood asthma. It suggests to me that public health interventions can succeed in reducing the number of deaths. I come from the Northern Rivers area of New South Wales where we have, particularly in my part of the world, the immunisation rates of a Third World nation. I am concerned that if a public health intervention can be successful, as it has been in the case of asthma, maybe there are other preventable deaths that we need to focus on as well, particularly looking at rates of immunisation across the State.

Ms CALVERT: I will comment on the issue of public health measures in relation to asthma. I think it has been a contributor. Changes to procedures and protocols for the treatment of asthma in Emergency Departments are another factor that has probably contributed to the decrease in asthma deaths. I do know that there are differences in the rate of asthma deaths depending on socio-economic status. We have had an increase in the higher socio-economic areas and a decrease in the lower and middle areas. That same pattern has also been reported by others. In relation to immunisation, I know there has been a big effort on the part of various levels of government and the professions to try to increase rates of immunisation. The strategy to pay GPs to undertake immunisation whenever they see children has stopped the decline in immunisation and is beginning to reverse that. We are seeing more children being immunised than we did in the past. Heather might have more information on that.

Professor JEFFERY: We have evidence that best practice guidelines that are well implemented save lives when targeted appropriately, so I think your comment about asthma, for example, is very real as there are very good and clear guidelines that have been well implemented. To come back to Mr Cansdell's question in relation to this, which I think I probably did not answer fully, I believe the first thing is to get the stakeholders together and agree on best practice guidelines. Probably the toughest aspect of this is implementation. A policy alone does not have “teeth” in the health area unless it has not only the power to be implemented, which means the resources, the best evidence in educational and public health means of implementation. We have now an armamentarium of good, high-level evidence where we know that it will work if we can get it into practice.

To come back to Sudden Unexpected Death in Infancy, we really have to get the whole process into practice in terms both of prevention and also, when a child dies, looking at the circumstances of the death and the best practice autopsy and the multi-disciplinary group deciding from the evidence what they believe is the cause of death. Both aspects of

this are really necessary to drive those deaths down. We have 65 infant deaths and you could probably argue that 60 of them, the majority, are preventable. That is too many. I remind you that a country's progress and social fabric are really assessed on its infant mortality rate. The comment that we have done well with the reduction in SIDS is true, but we have not done well enough.

The Hon. CATHERINE CUSACK: I agree. There is no cause for complacency. Do you know what percentage of SIDS deaths were children who had been immunised?

Professor JEFFERY: We do have data and I believe it is in this book. We did look at immunisations, as I recall. Are you asking about the relationship between SIDS and immunisation?

The Hon. CATHERINE CUSACK: I am asking factually because there is a very powerful lobby group in our part of the world that argues that immunisation is a causal factor. If we could be provided with the factual information a number of us would like to publicise it. We have just had a baby die of whooping cough, so that will have to be a new item in your reporting. It is very distressing to see the sort of misinformation that is put about. I am suggesting that maybe the Committee could be of assistance in ensuring some factual information gets to the community. I am also hoping you would be a voice in favour of a stronger campaign to boost our immunisation rates.

Professor JEFFERY: Absolutely. I am very aware of the "black hole" in the Northern areas of New South Wales with regard to immunisation. There is no causal relationship between immunisation and SIDS that has been found to date with several very large studies in North America, the United Kingdom and Europe. We have to remember that the immunisation of a young infant occurs around the maximal time of death from SIDS; that is, between two and four months, and quite rare after six months. This is when babies here have their immunisation schedules. It is natural for the community to jump to look for a cause. This has been very well looked at because immunisation has been such a successful public health strategy. Probably many of us here have not seen a child with whooping cough. I have and it is a terrible death. It brings us back again to all the issues in prevention, which are dependent on human behaviour.

If we talk about asthma, it is at the parental level in the home to follow a particular flow chart. If we talk about immunisation, it is parents and community helping in supporting the schedule. If we talk about Sudden Unexpected Death, it is to always put a baby on the back for sleep, never on the side or the front, and never to smoke around a baby. These are all behavioural issues. Once the particular death rates, whether it is due to asthma or Sudden Unexpected Infant Death, come down and once the deaths from the preventable diseases come down through immunisation, there is the potential for laxity in the community. I think we are seeing that clearly with pertussis—whooping cough. Part of it is the education of adults. How many of you in this room have actually had the adult whooping cough injection so that you are protecting every very young child in the community?

The Hon. CATHERINE CUSACK: I was not aware there was such an injection.

Professor JEFFERY: This is a message that is not out there. Adults do not know that they need to get the adult injection, the single pertussis injection, and in that way you as adults will not get the infection and will not pass it on to young infants who are extremely

vulnerable to death or neurological damage if they get whooping cough. Everywhere we have gaps which have not yet been transferred or implemented. I think this is probably one of them.

The Hon. CATHERINE CUSACK: Every year I ask the same question. In relation to gender, you mention socio-economic factors as the main driver, but in fact gender is an even greater predictor, or the mortality rates are even more disparate in relation to gender. Do you agree?

Professor JEFFERY: With respect to which deaths?

The Hon. CATHERINE CUSACK: Boys and girls?

Professor JEFFERY: Yes.

The Hon. CATHERINE CUSACK: Why has the Commission not looked at gender?

Ms CALVERT: We in fact did look at gender in relation to the 10-year data study. It was one of the demographics we used in our analysis. In some causes of death, it was a significant issue, and in other causes of death it was not a significant issue. For example, if you look at different types of road traffic accidents, then gender starts to emerge as an issue. If you look at page 410 of Volume Two, we look at the differences in mortality rates by sex. You start to see which of the deaths have gender as an issue.

The Hon. CATHERINE CUSACK: When I look at, for example, risk-taking behaviour-

Ms CALVERT: For males and females? Yes, it is very different.

The Hon. CATHERINE CUSACK: It is very different, yet in that chapter of the book it is not discussed at all. Can I also put to you that in relation to risk-taking behaviour, particularly in relation to motor vehicles although I would not like to generalise, maybe there would be fewer female deaths as well as male deaths if we could deal with the male risk-taking behaviour issues. I just feel that on principle I should keep raising this as an issue because it perplexes me why the Commission does not mount something separate in relation to this.

Ms CALVERT: I will take that back to the Team and let them know your views.

The Hon. CATHERINE CUSACK: Thank you.

CHAIR: Thank you very much. I am sure that information will prove to be more than valuable. Commissioner Calvert will remain with us for the next session, but I thank you, Professor Jeffrey, for your attendance today. We wish you well in the future.

Professor JEFFERY: Thank you very much.

(The witnesses withdrew)

Chapter Three - Questions Answered After Hearing

Question 1
There has been a fairly substantial decline in the number of asthma deaths; do you have any explanation for that? The percentage of asthma deaths is increasing in metropolitan areas. What are the issues for metropolitan areas? (Question of Hon Catherine Cusack MLC, Transcript p.13)

Response:
We cannot be sure why asthma-related deaths are declining but we do know that the decline reflects an overall reduction in the prevalence of reported asthma, as well as Emergency Department visits and hospitalisations for asthma in children and young people between 1993 and 2002.

A wide range of factors can trigger airway constriction in people with asthma, including irritants such as environmental tobacco smoke and outdoor air pollutants, and allergens such as house dust mites and pollen. The most common triggers for acute severe episodes of asthma in children are viral infections. As there was no change in the prevalence of viral infections during the period we looked at, nor any of the other triggers mentioned, it is unlikely that this would be an explanation for the decline in asthma-related deaths.

The results of a 2004 study[4] suggest that the improvements that were made over our study period in asthma treatment, management and education are yet to have any impact.

The asthma-related death rate is decreasing in all geographic areas. The decrease is greater outside major cities (56 per cent in major cities compared with 85 per cent in other areas). The increased percentage of deaths in major cities arises from this greater decline in non-metropolitan areas, rather than from any increased rate in the cities.

Answers continued over page.

[4] Belessis, Y., Dixon, S., Thomsen, A., Duffy, B., Rawlinson, W., Henry, R. L., & Morton, J. 2004. Risk factors for an intensive care unit admission in children with asthma. *Paediatric Pulmonology* 2004; 37: 201–209.

Question 2
The Annual Report shows that six consultants were engaged during 2007-08 to provide specialist management advice at a cost of $19,833. In what kind of work were the consultants engaged? How will the advice be utilised by the Commission? (Question of Mr Robert Coombs MP, Transcript p.16)

Response:
The Commission engaged the following consultants in 2007-08:

Consultant	Amount	Nature of the consultancy	Utilising the advice
Paradigm Play	$2,000.00	Facilitating an experts forum on climate change	Used to develop environmental sustainability project
Paradigm Play	$937.00	Expenses associated with the climate change forum	Used to develop environmental sustainability project
University of Sheffield	$476.16	Provision of expert commentary on research paper.	Improved our paper on Children and Poverty
TeKnowledge IT Consulting	$3,500.00	Services associated with the functional requirements and design of eCheck.	Used to guide development of eCheck.
Sage Consulting	$5,120.00	Specialist IT advice on software integration.	Used to improve IT links with Police and CrimTrac for the Working With Children Check.
Carolyn Quinn Consultancy	$7,800.00	Advice on operating Relevant Employment Proceedings for the Working With Children Check	Used to guide improvements in the operations of the Working With Children Check.

Question 3
What can [the Committee] do better to fulfil our statutory role? Do you have any suggestions for us? (Question of Mr Robert Coombs MP, Transcript p. 26)

Response:
As I said at the hearing on 15 April, I believe that the Committee's approach could already be described as "best practice", so I do not have many suggestions for the Committee.

I have appreciated the fact that, in recent years, the Committee has included both newer members with fresh and interesting approaches, and some longer- established members who have had time to absorb and reflect on a great deal of information about children's lives. I hope that this mix of experience will continue.

Perhaps you could continue to explore ways to hear directly from children and young people. This may mean developing ways of operating which are different from the traditional methods used by Parliamentary Committees, as they were developed to take evidence from adults in quite formal ways.

Appendix 1 – Committee Minutes

Minutes of Proceedings of the Committee on Children and Young People (No 17)

Friday 28 November 2008 at 10:00 a.m.
Parliament House

Members Present
Mr Robert Coombs MP (Chair); Hon Kayee Griffin MLC (Deputy Chair); Ms Marie Andrews MP; Mr Geoff Corrigan MP.

In Attendance
Mr Mel Keenan (Committee Manager), Ms Jo Alley (Senior Committee Officer), Ms Cheryl Samuels (Research Officer), Ms Jacqui Isles (Committee Officer)

The Chair opened the meeting at 10.20 a.m.

5. Review of the CDRT Report "Trends in Child Deaths in NSW: 1996-2005"
The Chair referred to the memorandum previously distributed and Members noted the content of the *Trends in Child Deaths* Report.
Moved Mr Geoff Corrigan MP, seconded Ms Marie Andrews MP:

> "That the Committee publicly examine the Commissioner; Dr Jonathan Gillis (Senior Staff Specialist in Intensive Care, The Children's Hospital at Westmead); and Dr John Howard (Senior Lecturer National Drug and Alcohol Research Centre, University of NSW); and
> "That the Secretariat prepare and distribute to Members Questions on Notice to be put to the Commissioner for consideration at the Committee's next meeting".

6. Terms of Reference for the 2007-08 Annual Report of the Commission for Children and Young People and the 2007 Annual Report of the Child Death Review Team
The Chair noted that the Secretariat was preparing Briefing Notes and Questions on Notice for both these Reports.
Moved Mr Geoff Corrigan MP, seconded Hon Kayee Griffin MLC:

> "That in relation to the review of the 2007-08 Annual Report of the Commission for Children and Young People and of the 2007 Annual Report of the Child Death Review Team:
> (a) The Committee's report shall consist of:
> - The questions on notice to the Commissioner;
> - The corrected transcript of the evidence given by the Commissioner during the public hearing;
> - Answers to the questions on notice, not provided during the hearing by the Commissioner but taken on notice;
> - Relevant information (that is not confidential) as provided by the Commissioner in response to matters taken on notice during the hearing.
>
> (b) The report, so comprised, be adopted as the report of the Committee and that it be signed by the Chair and presented to the House, together with the minutes of evidence;

(c) The Chair and Committee Manager be permitted to correct stylistic, typographical and grammatical errors.

The Chair closed the meeting at 10.50 a.m.

Chair

Committee Manager

Minutes of Proceedings of the Committee on Children and Young People (No. 18)

Wednesday 18 February 2009 at 12:00 p.m.
Waratah Room, Parliament House

Members Present
Mr Robert Coombs MP (Chair), Hon Kayee Griffin MLC (Deputy Chair), Mr Steve Cansdell MP, Mr Geoff Corrigan MP, Hon Catherine Cusack MLC, Hon Fred Nile MLC.

In Attendance
Mr Mel Keenan (Committee Manager), Ms Jo Alley, Ms Cheryl Samuels, Ms Jacqui Isles, Mr John Miller.

The Chair opened the meeting at 12.07 p.m.

Apologies
Ms Marie Andrews MP

7. Review of the CDRT Report "Trends in Child Deaths in NSW: 1996-2005"
Moved Hon Fred Nile MLC, seconded Mr Geoff Corrigan MP:

> "That the Committee write to Dr John Howard putting to him questions arising from his involvement with the CDRT in the preparation of its Report *Trends in Child Deaths in NSW: 1996-2005*".

The Chair advised the Committee that the questions and draft letter would be available prior to the Committee's next meeting on 17 March 2009.

The Chair closed the meeting at 12.41 p.m.

Chair

Committee Manager

Minutes of Proceedings of the Committee on Children and Young People (No. 19)

Wednesday 25 February 2009 at 11:00 a.m.
Parkes Room, Parliament House

Members Present
Mr Robert Coombs MP (Chair)
Hon Kayee Griffin MLC (Deputy Chair) Mr Steve Cansdell MP
Rev the Hon Fred Nile MLC

In Attendance
Mr Mel Keenan, Ms Cheryl Samuels, Ms Jacqui Isles and Mr John Miller

The Chair opened the meeting at 11.00 a.m.

Apologies
Apologies were received from Ms Andrews, Mr Corrigan and Ms Cusack.

3. Review of the 2007 Annual Report of the Child Death Review Team and the Child Death Review Team's Report *Trends in Child Deaths in New South Wales 1996–2005*

The Chair asked for any questions or comments on the questions drafted in relation to the CDRT Annual Report and the 10 year *Trends Report* and informed the Committee that a response would be requested from the Commissioner in time for the Committee's meeting on 17 March 2009.

Resolved, on the motion of Rev Nile, seconded by Ms Griffin:

> "That the draft Questions on Notice on the 2007 Annual Report of the Child Death Review Team's 2007 Annual Report and Report *Trends in Child Deaths in New South Wales 1996–2005* be adopted and forwarded to the Commissioner for her response."

Resolved, on the motion of Rev Nile, seconded by Ms Griffin:

> "That the Committee forward to Dr Jonathan Gillis questions relating to SUDI arising from the Report *Trends in Child Deaths in New South Wales 1996–2005*."

The Chair closed the meeting at 12.30 p.m.until 11.00 a.m. Tuesday 17 March 2009.

Chair Committee Manager

Minutes of Proceedings of the Committee On Children And Young People

Tuesday 17 March 2009 at 11.00 a.m. (No 20)
Room 814/815, Parliament House.

Members Present
Mr Robert Coombs MP (Chair)
Hon Kayee Griffin MLC (Deputy Chair) Mr Steve Cansdell MP
Rev the Hon Fred Nile MLC

Ms Andrews joined the meeting at 12.40 p.m.

In Attendance
Mr Mel Keenan, Ms Jo Alley, Ms Cheryl Samuels, Ms Jacqui Isles and Mr John Miller.

The Chair opened the meeting at 11.04 a.m.

3. Review of Reports
The Chair noted the advice from the Commissioner that, instead of Dr Jonathan Gillis, Professor Heather Jeffery, Chair of International Maternal and Child Health at the University of Sydney was the appropriate person to give evidence to the Committee in its review of the CDRT 10 year trends Report. He noted that Professor Jeffery had been contacted by the Secretariat.

Resolved, on the motion of Ms Griffin, seconded by Rev Nile:

"That in relation to the review of the Child Death Review Team Report *Trends in Child Deaths in New South Wales 1996 –2005* the Committee's report shall consist of:

- the questions on notice to the Commissioner;
- the corrected transcript of the evidence given by the Commissioner during the public hearing;
- answers to the questions on notice, not provided during the hearing by the Commissioner but taken on notice; and
- relevant information (that is not confidential) as provided by the Commissioner in response to matters taken on notice during the hearing."

The Chair closed the meeting at 11.13 a.m.

Chair Committee Manager

Minutes of Proceedings of the Committee On Children And Young People

Wednesday 15 April 2009 at 10.00 a.m. (No 21)
Room 814/815, Parliament House.

Members Present

Mr Robert Coombs MP (Chair)
Hon Kayee Griffin MLC (Deputy Chair)
Hon Catherine Cusack MLC
Rev the Hon Fred Nile MLC
Ms Marie Andrews MP
Mr Steve Cansdell MP
Mr Robert Furolo MP

In Attendance

Mr Mel Keenan, Ms Jo Alley, Ms Cheryl Samuels, Ms Jacqui Isles, Mr John Miller, Ms Caesi Egan (work experience student).

The Chair opened the meeting at 10.07 a.m.

4.2 Review of the 2007 Annual Report of the Child Death Review Team and the Child Death Review Team Report: *Trends in Child Deaths in New South Wales 1996-2005*

The following witnesses were affirmed and examined:
Ms Gillian Calvert, Commissioner for Children and Young People;
Professor Heather Jeffery, Chair of International Maternal and Child Health, University of Sydney.

The Chair noted that the Commissioner and Professor Jeffery had each provided detailed responses to the Committee's Questions on Notice relating to the relevant Reports. Ms Calvert and Professor Jeffery agreed that these responses would form part of the evidence which they had given, and be made public.
Evidence concluded, Professor Jeffery withdrew.

The Chair adjourned the hearing at 11.30 a.m.

Resolved, on the motion of Mr Furolo, seconded by Ms Andrews:

> "That the transcript of the witnesses' evidence, after making corrections for recording inaccuracy, and the answers to any questions taken on notice in the course of the hearing, be published on the Committee's website."

The Chair closed the public hearing at 12.50 p.m.

Chair

Committee Manager

Minutes of Proceedings of the Committee On Children And Young People

Tuesday 12 May 2009 at 1.30 p.m. (No 22)
Waratah Room, Parliament House.

Members Present

Mr Robert Coombs MP (Chair)
Hon Kayee Griffin MLC (Deputy Chair)
Mr Robert Furolo MP
Ms Marie Andrews MP
Rev the Hon Fred Nile MLC

In Attendance

Mr Mel Keenan, Ms Jo Alley, Ms Cheryl Samuels, Ms Jacqui Isles, Mr John Miller, Ms Michelle Kroesche (volunteer).

The Chair opened the meeting at 1.31 p.m.

Apologies

Apologies were received from Mr Cansdell and Ms Cusack.

4. Consideration of Chair's Draft - Review of the 2007-08 Annual Report of the Commission for Children and Young People; Review of the 2007 Annual Report of the Child Death Review Team and the Child Death Review Team Report: Trends in Child Deaths in New South Wales 1996-2005

Consideration of Chair's Draft Report

The Committee considered the reports *in globo*.

Adoption of Report

Resolved, on the motion of Mr Furolo, seconded by Reverend Nile:

i) 'That the draft reports be the Reports of the Committee and that they be signed by the Chair and presented to the House'.

ii) 'That the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors'.

Publication of the Report

Resolved, on the motion of Ms Griffin, seconded by Reverend Nile:

'That, once tabled, the Reports be placed on the Committee's website'.

The Chair closed the meeting at 1.50 p.m.

Chair

Committee Manager