Commission for Children and Young People Amendment (Child Death Review Team) Bill.

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COMMISSION FOR CHILDREN AND YOUNG PEOPLE AMENDMENT (CHILD DEATH REVIEW TEAM) BILL

Second Reading

Mr HICKEY (Cessnock—Minister for Mineral Resources), on behalf of Dr Refshauge [8.42 p.m.]: I move:

That this bill be now read a second time.

The bill was introduced in the other place on 25 June 2003 and the second reading speech appears on page 42 of the *Hansard* proof for that day. The bill is in the same form as introduced in the other place and I commend it to the House.

Mr HAZZARD (Wakehurst) [8.42 p.m.]: I lead for the Opposition on the Commission for Children and Young People Amendment (Child Death Review Team) Bill. The history of the Child Death Review Team is interesting, as is much of the legislation and the approaches taken to the investigation of, and responses to, child abuse in New South Wales in recent years. The Child Death Review Team has existed since 1987, when it was established by part 7A of the Children (Care and Protection) Act. It has had some changes along the way. It was co-located with the Child Protection Council until about 1999 when the passage of further legislation put it under the auspices of the Commission for Children and Young People.

Most honourable members will be aware that I was shadow Minister for Community Services for almost three years. During that time I expressed a great deal of criticism and concern about the way in which the Government failed to address properly child abuse and child neglect in New South Wales. I could happily speak on this topic for at least the next two or three hours but I am sure that my colleagues would not be too keen on that. The Minister for Mineral Resources would certainly not be too happy about it, and I do not blame him. However, I am suspicious of any changes that the Government makes with regard to child abuse and the processes surrounding its investigation, not because I believe the Government lacks bona fides in wanting to address this problem but because it simply does not know how to do that. Therefore, it is far more interested in plugging the dyke and spreading some gloss over the surface, which was a major pastime during the regime of the former Minister for Community Services, the Hon. Faye Lo' Po, and the then Director-General of the Department of Community Services [DOCS], Carmel Niland. Without wishing to reflect upon them personally, they made glossing what was happening with regard to child abuse in this State an art form.

According to both the former Minister and the former director-general there were no problems in the Department of Community Services—everything was working wonderfully well. However, the Opposition and the Australian Democrats joined forces in the upper

House to establish a parliamentary inquiry into the Department of Community Services. The Opposition—I also played a role—ensured that the issue had a high public profile during the last few years of the previous Parliament. I keep hearing the words of the former Minister for Community Services, who said that there were about 19 watchdogs oversighting the Department of Community Services and that she would ensure the situation improved. However, her "improvements" were improvements only from the Government's perspective. It is not, and has not been, on the Government's agenda to improve the general approach to child protection in New South Wales. The Government would like to do that but it simply does not know how.

Mr Corrigan: It does. That's what we are doing.

Mr HAZZARD: The new boy on the block says that the Government knows all about it. When he has spent two or three years in this place, sat with families who have lost children and visited Aboriginal communities located only a kilometre from Parliament and heard how the Department of Community Services has let them down day after day he will not sit in this place with the glossiness of a new member of Parliament and stick up for his Government, which is hopeless at doing what is necessary to protect children in New South Wales.

I approach this legislation with suspicion. I remind the House that it is part of the agenda that the Government put before Parliament last year in line with its stated purpose of reducing the number of watchdogs. I cannot work out why the Government would want to reduce the number of watchdogs unless it does not want to be watched. That is a key priority for the Government. I remind honourable members of the debacle of the Community Services Commission, which was created by the Coalition Government in 1993. It was designed as a place for advocacy where specialists could provide proper assistance and support to people who thought they had been let down, or who had been let down, by the child protection system. Both Roger West and Robert Fitzgerald were excellent commissioners. However, approximately 2½ years ago the present Government sought the Crown Solicitor's advice regarding allegations that the Community Services Commission had been acting ultra vires, or acting beyond its powers, in pursuing certain investigative roles.

We tend to forget that a series of reports, which no doubt the honourable member for Camden might like to read, had been highly critical of the Government and the Department of Community Services. The only purpose of the Community Services Commission was to improve the child protection system in New South Wales. It highlighted a series of failures on the part of DOCS and other agencies that worked with it. The public announcement of the receipt of the Crown Solicitor's advice prompted an outcry from the Association of Children's Welfare Agencies, the Council of Social Service of New South Wales, the Opposition and numerous other organisations in the community, who declared the Government's position unacceptable. That certainly indicated mala fides rather than bona fides in relation to the Government's role in child protection. It effectively contained the Children's Services Commission for the next 18 months. In fact, it almost destroyed it.

The legislation was introduced by the Opposition in the upper House and passed almost unanimously, save for the Australian Labor Party, which would have re-implemented the powers of the Community Services Commission. When it was sent to this House it stopped. In fact, the legislation just sat here until the Parliament adjourned and an election was held, and it has now lapsed. If that shows the good intentions of this Government, I fail to see it. When the Community Services Commission was absorbed into the Office of the Ombudsman it presented major challenges for the whole culture of the commission in regard to its advocacy role. I will not bore honourable members with all the details; they can read it in *Hansard.* I have recounted on a number of occasions correspondence from the Ombudsman's office in relation to reviews in regard to child protection matters. Prior to the legislation being passed in this House last year it had a limited role, in regard to government employees who might be involved in child abuse.

Without any reflection on Mr Barbour, the culture within the Ombudsman's office is not one of advocacy but of very strict black letter law review. I wait with great interest to see whether the Community Services Commission will blossom out of the new cloistered environment of the Office of the Ombudsman. I do not think it will. I have not heard a peep from that section of the Ombudsman's office since it effectively merged three or four months ago. There seems to be no urgency, no sense that the problem still exists. We have a new Minister and director-general and somehow the problems are supposed to be solved. They are not solved. Front-line officers of the Department of Community Services [DOCS] are frustrated

because they are still stretched beyond belief and cannot get their job done. They can only intervene in level one child abuse reports. Level two and three reports do not get a response at all.

With the absorption of the Community Services Commission into the Ombudsman's office came an interesting collateral action by People With Disabilities [PWD]. Only two or three months ago the Administrative Decisions Tribunal handed down a decision that it considered that the Crown Solicitor's advice that predicated the absorption of the Community Services Commission into the Ombudsman's offie was ultra vires: it was wrong. But by that stage it was too late because Robert Fitzgerald and what was left of his team were already in the Ombudsman's office. As the Opposition in the upper House indicated, we do not oppose this legislation. But we should not just accept these things, because the history of this Government does not lead us to accept that what it is doing in relation to child protection is bona fide.

I therefore have serious concerns about whether the absorption of the Child Death Review Team into the Ombudsman's office in regard to children who died of abuse or neglect is a worthwhile pursuit or whether it is just one more effort by the Government to minimise scrutiny. I suspect that that is what we are really talking about in regard to this legislation. Sadly, I suspect that there is not a lot of sense in passing this legislation, but it is one more step that this Government wants to take. The Hon. Carmel Tebbutt said, in the Legislative Council:

The bill ensures that the team [Child Death Review Team] will not duplicate the work of the Ombudsman by prohibiting the team from undertaking detailed reviews of deaths that are "reviewable" under part 6 of the Community Services (Complaints, Reviews and Monitoring) Act 1993 unless the reviewable death is incidental to the research sample or population.

I read into that statement that another review will not be possible. If the Ombudsman's office does not get it right, as a result of this legislation and the package of changes in the past six months, investigation of child deaths will be limited. Individuals who lose their children, nieces or nephews, and those who want their children protected but DOCS does not effectively protect them, will have no avenue to go down to obtain assistance. The Child Death Review Team was not, and is not, an advocacy organisation, but at least it had a history of doing some good work. I do not say that the Child Death Review Team was always good. In fact, I criticised it for complying with the Minister's directions. In 1999 the reference to children who had died and were known to DOCS disappeared from the report. There was a great deal of public outcry and, because this Government cannot stand public scrutiny—it is the only thing it responds to—the report that was issued the following year showed the number of children that were known to DOCS in the relevant review period.

Why should we trust this Government on any initiative that removes scrutiny? It seems to be a hallmark of the Carr Government that scrutiny by anybody who has a capacity to know what is going on should be shoved out the door. The Inspector-General of Corrective Services, the only person whose role was to conduct a review on a daily basis, and someone to whom the prisoners could go, has been removed. At a number of meetings I attend I am told about the huge level of concern about DOCS. I hear that children are still dying at the same rate. I hear that Aboriginal children are dying in alarming numbers. I hear that people in Aboriginal communities do not think that the service that is available from DOCS to assist with children who are at the risk of abuse is appropriate. I hear all sorts of strong, colourful, emotive and passionate language about the failings of the Department of Community Services.

What I hear is not much different from what was exposed last year on the *60 Minutes* program or on the *Four Corners* program that was the subject of the Walkley award for its report on DOCS. I hear that the same culture still exists within DOCS. I also hear that reports at the lower levels are still being tampered with so that the Ombudsman and others cannot find out what is going on. I hear that the Government is not honest when it says it is creating 130 new positions, and that only about half of those positions have been filled. In fact, they have been filled by temporary staff who are already doing the job and have been rebadged as permanent workers within DOCS. A few extra places have been filled, but not many. I hear that the Department of Community Services is so desperate that in the western part of State positions have been reserved for Canadians to work as child protection officers.

The Government has told the community it is filling these positions. In the lead-up to the

election it gave the Coalition a serve. It said that we would cut positions. We did not say we would do that; we said we would have a royal commission because we believed the problems in DOCS were systemically and fundamentally wrong. I had very little faith in the outcome of the upper House inquiry, which was chaired by the Hon. Jan Burnswoods, who ensured that some witnesses were not able to give to evidence, and certain witnesses were cut off at appropriate times. The report of the inquiry was better than no report, but it was not a royal commission.

Where do we stand now? Children are still dying. Level 1 reports of child abuse are being investigated most of the time. Level 2 and level 3 reports, the potential calamities of tomorrow, are not being investigated. Will this bill make a difference? The review says it will. The review was undertaken by Gillian Calvert. I do not reflect personally on Gillian Calvert when I say I have some difficulty understanding an arrangement under which a chair of the Child Death Review Team is the same person who heads the commission that auspices the team. Even though Gillian Calvert was a joint chair with Dr John Yu, I find that arrangement strange.

As I do not wish to reflect personally on Gillian Calvert, who is doing as good a job as she can in the circumstances, I would say that the review should have been undertaken by a totally independent panel, which could take whatever public evidence it chose and provide adequate opportunities for the public to make submissions to the panel. The web site says that the team went out and spoke to about 30 selected groups or people. So the team has made its decision based on its meetings with about 30 different meetings, groups or individuals that it talked to. With the greatest of respect, that adds to my suspicion about this legislation and its intention. I hope, for the sake of the children of New South Wales, that this legislation will turn out to be less detrimental than it might appear to be.

The Ombudsman's office has a mighty role in the implementation of this legislation, and it had best make sure it gets it right. I do not have a great deal of faith in the review process in New South Wales. I do not have a great deal of faith in the Coroner's office. Recently, the Coroner took a swipe at me in relation to concerns I ventilated about the death of Tahlia Brockmann and the fact that I referred that matter to his office. The Coroner wants to rethink the way he operates in relation to child deaths. He wants to reflect on the fact that political figures of both political persuasions have an obligation, when constituents approach them, to raise issues publicly and to push for appropriate reviews, especially when families are disturbed about what has gone on. The Coroner should refrain from making political comment in his judgments; he should stick to the law.

If the Ombudsman's office is responsible for a component of the Child Death Review Team that looks into cases of children who die from abuse and neglect, and the Coroner shows a distinct disinterest in getting involved in these sorts of hearings—especially when such matters will become an increasing part of the role of the Coroner's office as a result of last year's review of legislation—then I am concerned. Unless we have a strong Ombudsman's office that is prepared to develop a culture of advocacy similar to that within the Community Services Commission and to let Robert Fitzgerald and his team off the hook, push him out of his office and let the community hear in the next few months some of the concerns he might well have, I will be concerned that this legislation is part of an overall attempt to silence those who would carry the message to the public and to the Government that the child protection system in New South Wales remains a substantial problem. That means that children in New South Wales are not getting the protection that the community and members of Parliament, as individuals rather than members of political organisations, certainly want. If we allow the present system and the cover-up to continue, we will all be implicated in the system that will fail children, at least in the foreseeable future.

Mrs PERRY (Auburn) [9.03 p.m.]: The Commission for Children and Young People Amendment (Child Death Review Team) Bill arises from a review of legislation undertaken by Dr John Yu and the Commission for Children and Young People. The report of that review was examined by the Committee for Children and Young People. My predecessor as chair of the committee is present in the Chamber. That is David Campbell, now the Minister for Regional Development, Minister for the Illawarra, and Minister for Small Business, who tabled the committee's report on 21 November last year, supporting the implementation of the review's recommendations.

By way of a brief history, might I indicate that in 1990 a report by the New South Wales Physical Abuse and Neglect of Children Committee identified the lack of a central review

mechanism in situations where a child suffers serious physical injury or dies. In 1993 a Child Deaths Review Committee of the New South Wales Child Protection Council was established to review a sample of deaths of children up to 14 years of age occurring in New South Wales between 1989 and 1991, identified or suspected as being due to abuse or neglect. It recommended that the New South Wales Government establish a Child Death Review Committee with the aim of learning from the facts about the deaths of children and using those findings to educate workers and to inform policy and procedure across all areas of work to prevent future child deaths.

In 1995 the Government implemented this recommendation by passing, with bipartisan support, legislation establishing the team, a first for Australia and the first team of its kind outside the United States of America. That legislation was the Children (Care and Protection) Amendment Act 1995. The 1993 committee was chaired by Dr Ferry Grunseit, a paediatrician and chair of the Child Protection Council. Dr Grunseit was appointed as an inaugural member of the Child Death Review Team and remains a member to this day. I pay special tribute to Dr Grunseit's enormous contribution to the work of the team, and to child protection generally, over the past two decades. New South Wales is indeed fortunate to have him advocating for children in this State.

For its first 3½ years the team was co-located with the New South Wales Child Protection Council, with its work supported by the New South Wales Department of Community Services. The team was funded from the budgets of various government agencies represented on the team. With the establishment of the New South Wales Commission for Children and Young People in June 1999, its commissioner, Gillian Calvert, became the team's convener. I take the opportunity in this House to place on record the exceptional work that both the commission and its leader, Gillian Calvert, have undertaken since the inception of that commission. This State is indeed lucky to have someone with the knowledge, skills and background of Gillian Calvert representing children's interests and needs. The commission provides research, policy, secretariat and administrative support to the team and conducts community education in relation to the team's work.

Bearing in mind all of that history, it important to say that we do need a Child Death Review Team. I say that for the following reasons. The team makes a positive contribution to reducing the deaths of children and young people in New South Wales. Individuals and organisations consulted as part of the review to which I referred expressed support for the team and appreciation of its work. As the report of the review states:

The Team's work was considered valuable for identifying areas of concern for policy makers and the community, some which would not have been recognised otherwise (eg deaths of toddlers in driveways). The depth and across-section of expertise on the Team was also praised.

That seems to be in stark contrast with some comments that I understood my colleague the honourable member for Wakehurst to make. A further need for the team is that it has unique access to information as well as the expertise to undertake high-quality research that can help prevent deaths of children. The further reason that we need a Child Death Review Team is the examples that such research can provide, including examining a factor associated with a child's death—for example, playground equipment—or an event that occurred in a residence. Those are the reasons for the establishment of a Child Death Review Team and why its work is important. Victoria is the only other Australian State with a Child Deaths Review Committee. The Victorian committee is an independent ministerial advisory body that provides an independent review of all deaths of child protection service clients and advises the Minister of implications from its findings. It also considers case analysis review reports of a particular death or group of deaths conducted with a view to systemic change.

The recent Layton report in South Australia entitled "Our Best Investment: a State Plan to Protect and Advance the Interests of Children" recommended the establishment of such a committee in that State. The report noted that New South Wales has the most comprehensive child death review legislation in Australia—again in stark contrast to some of the comments made by the honourable member for Wakehurst. The Australian Capital Territory and Western Australian governments are currently investigating the possibility of establishing child death review systems. It is important to note that there is no systematic and independent review of child deaths in any of the other jurisdictions. New South Wales is leading the way.

What is the value of the Child Death Review Team? The team, with its broad role of monitoring trends in deaths and undertaking research to prevent child deaths, can provide the community with quality research that is not undertaken by other bodies. The team can adopt a population-based focus and improve the safety and wellbeing of all children in New South Wales. It is worth remembering that the deaths of toddlers in driveways became a public issue primarily because of the work of the team. The team can also undertake a full examination of children's lives and the reasons they died, not just in relation to services that exist for them and their families but in all aspects of the child's environment.

The team has the ability to identify risk factors that are of extreme concern, and suggest ways that government, services, families and communities can help to prevent deaths. Because of the team's wide brief and unique access to information it can undertake a range of valuable research including studying the incidence of death and factors affecting the rate of death in a certain population of children; examining a certain factor associated with child death, like allergic reactions; looking at economic status and its relationship with certain types of child death; and studying the impact of geographical location on death rates. One example is the result of work done by the team.

As this House would know, a report on suicide and risk-taking behaviour was tabled in January. The findings of the report are now being used to form the redevelopment of the New South Wales suicide prevention strategy "We Can All Make A Difference". I cannot think of much more important work. The report identified for the first time a link between HSC-related stress and suicide. I am very pleased to note that the Department of Education and Training is considering this finding and its implications for supporting HSC students, and reducing their stress levels whenever possible.

The report also showed that deaths from suicide and risk-taking behaviour are intimately related, and that our approaches to prevention should probably see these as part of a single continuum, rather than as separate phenomena. We would not have these important findings without the Child Death Review Team. They arise from just one of the team's reports. New South Wales is leading Australia in this area, as acknowledged by the Layton report to which I referred earlier. As Chair of the Committee for Children and Young People I look forward to working with the Commissioner of Children and Young People, Jillian Calvert, who is here tonight, the team and my colleagues who are on the committee in fulfilling the important task set by the bill.

Ms D'AMORE (Drummoyne) [9.13 p.m.]: I support the bill. The Child Death Review Team, from its establishment in 1996, had three distinct functions: maintaining the register of all child deaths in New South Wales and using it to identify trends, undertaking research into deaths from any cause aimed at preventing or reducing deaths, and undertaking detailed reviews of deaths arising from abuse or neglect, or in suspicious or undetermined circumstances. With the passage of the Community Services Legislation Amendment Act 2002 the Ombudsman assumed responsibility for one of these functions, namely, detailed reviews of deaths due to abuse, neglect or in suspicious circumstances. The Ombudsman already has a similar role relating to people with disabilities who died in residential facilities.

The bill ensures that the team will not duplicate the work of the Ombudsman by prohibiting the team from undertaking detailed reviews of deaths that are reviewable under part 6 of the Community Services (Complaints, Reviews and Monitoring) Act 1993 unless the reviewable death is incidental to the research sample or population. For example, the team is required to analyse data from the register of all child deaths and, therefore, may identify trends and patterns of deaths of children from motor vehicle accidents. Some of these children may be in the care of the Department of Community Services and, thus, are reviewable deaths. The fact that they are reviewable deaths is incidental to the team's purpose in researching those deaths. To exclude them would distort the analysis of motor vehicle accidents.

In these circumstances the bill permits the team to include in its research reviewable deaths from motor vehicle accidents. The bill also allows the team to conduct research about reviewable deaths when the Minister has approved the research, after seeking and considering the advice of the Ombudsman. With the Ombudsman's support, the bill makes some further minor changes to the Ombudsman's reporting time frames about reviewable deaths by amending the Community Services (Complaints, Reviews and Monitoring) Act 1993. New South Wales now has the best of both worlds: the Ombudsman, with his considerable powers, oversighting the deaths of very vulnerable children and the Child

Death Review Team researching all deaths of children to help us form a clearer picture of those deaths so that we may prevent them in the future. We should be proud of what we are achieving in New South Wales for children and young people. I commend the bill to the House.

Ms JUDGE (Strathfield) [9.16 p.m.]: Previous speakers in the debate have mentioned the excellent work done by the Child Death Review Team. I am pleased to speak in favour of the bill, which will implement recommendations from the report of the review of legislation governing the New South Wales Child Death Review Team, and work towards reducing child deaths. In an ideal world children would not die by suspicious circumstances or as a result of neglect or, for that matter, at all. Every child is precious. Every child is irreplaceable. I have three daughters, and I cannot for one moment conceive what it would be like for my family if one of my daughters died from natural causes, let alone from something that was not a natural cause.

However, the sad reality and the tragedy is that in our less-than-perfect world the Child Death Review Team works to reduce or to prevent child deaths. The team has undertaken its work by reviewing the records held by State government agencies, such as the Coroner's Office, the police, the Department of Community Services, courts, area health services, the Department of Education and Training, the Registry of Births, Deaths and Marriages and the Department of Juvenile Justice. Although the team has been able to do valuable work, the fact that its access has been limited to records of government agencies means that it has not been able to access information that would have made its research even better.

For example, the team has been able to review school records of students in public schools, but not those of students in private schools. It has looked at records of children who have been patients in public hospitals or who have been seen by an adolescent counsellor employed by an area health service, but not the records of those who have seen a psychiatrist privately. Clearly, this restriction could prevent the team from being able to establish a clear picture and get the full story from a particular cause and, therefore, has the potential to skew the research results.

This problem was identified in the report of the review of the legislation governing the Child Death Review Team. This bill fixes this shortcoming and extends the team's access to records in relation to child deaths to private health agencies and practitioners, non-government schools, and people or agencies that provide services such as family support, child care and education, residential out-of-home care, disability services or foster care. The professionals, practitioners and non-government representatives who were consulted during the review supported this, and the Privacy Commission raised no objection. The people who were consulted said that there is a strong public interest in obtaining a more complete and accurate picture of why children die, which justified the extension of the team's access to non-government records.

We need to do everything we can to ensure that children are protected 24 hours a day—every second of every minute of every hour. We also need to ensure that when death occurs, as sadly and tragically it occasionally does, the Child Death Review Team has adequate powers to properly investigate. We do not want the team to be a toothless tiger. This bill is not about placing added administrative burdens on non-government organisations to maintain any particular records. They can continue keeping exactly the same records they keep now. The only requirement is that, if the organisation possesses any records about a child and the team requests a copy, that organisation will be obliged to provide a copy.

As requests will be limited to records of children who have died and who are the subject of a particular research project, this type of request would be made rarely to any one organisation. The bill does not create an offence of failure to comply with such a request, but the team's convener has the capacity to draw Parliament's attention to failures by agencies to comply. In matters dealing with the death of a child, it is of course of critical importance that privacy is maintained and that personal details about the deceased child and his or her family are not made public. As has been observed by other honourable members in their contributions to this debate, the Child Death Review Team has operated since 1996 in accordance with legislation that includes rigorous privacy rules and that restricts access to the information. This bill maintains that regime when information gathered by the team is subject to stringent confidentiality safeguards and will not be able to be revealed to a court or released under the Freedom of Information Act 1989.

The bill extends these provisions to individuals engaged by the convener to take part in research projects and to members of joint research projects. However, the bill also sets out the circumstances in which this confidentiality provision does not apply, such as using the information for research that is aimed to help prevent or reduce the deaths of children in New South Wales. Because of the team's unique access to a wide range of information, the team might form a view about the circumstances of a child's death that other organisations, without all the information and pieces of the puzzle, may not have formed. For that reason, the bill allows the team's convener to report possible criminal matters to the police, to report that a child may be at risk of harm to the Department of Community Services and to report information to the State Coroner and Ombudsman that supports their functions. Only the team's convener will have that power. He or she must report annually to Parliament, if the power has been used.

This is an important bill because it builds our knowledge about the deaths of children and, in turn, that information and knowledge helps us to prevent deaths from occurring in the future. I am proud of the New South Wales State Government because this is the second time today I have had the privilege and pleasure of speaking in the House on legislation that focuses on looking after and protecting our young people, our youth, our future. I commend the bill to the House.

Ms BURNEY (Canterbury) [9.23 p.m.]: The safety and wellbeing of children is probably one of the greatest responsibilities that is incumbent upon us as individuals, families, societies and a government. Throughout both my professional and personal experiences, I have come into contact with children and their families that have not, will not or could not provide this safety and wellbeing. Such contact shakes one's belief in human nature, challenges one's sense of decency and leaves one shaken at how such dreadful things—such as the death of a child—can take place in what we call a civil society. Acts of cruelty and neglect towards vulnerable children sometimes are unfathomable and sometimes they are not, but it happens. And that is the reality: it does happen. That is why our conversations and decisions relating to the Commission for Children and Young People (Child Death Review Team) Bill are so important. It is an emotional topic, but it is a topic that we are addressing as a Government. Unlike the honourable member for Wakehurst, I welcome the bill. There is nothing cynical about the bill.

The bill will support and strengthen the work of the Child Death Review Team in researching and monitoring deaths of all children in New South Wales. Tonight I will focus my comments on one group of children who stand to benefit most from reductions in the number of preventable deaths: Aboriginal children. To date, the work of the team has demonstrated that the disadvantages experienced by Aboriginal children in our society extend to their being significantly more likely to die, and to die at younger ages, than is the case for other children in New South Wales. I draw the attention of the House to media reports on this topic. Because of the work that we need to get through tonight I will not mention in detail press reports in my possession. The front page of the *Australian* of 12 June reported on Professor Michael Dodson's address to the National Press Club in Canberra. He spoke about the incredible level of violence, the devastating effects of violence in Aboriginal communities and how much that is affecting Aboriginal children. The editorial of the *Australian* on the same day, headed "Violence and black children", stated:

Dr Dodson's speech made harrowing listening. He spoke of patterns of violence so entrenched in Aboriginal communities that child victims of violence become perpetrators themselves before they reach adulthood. He said Aboriginal women experience violence at a rate that is 45 times that of non-Aboriginal women... While Aboriginal people are, as Prime Minister John Howard has acknowledged, the most systematically disadvantaged group in the community, Aboriginal children are the most vulnerable members of that group.

It is harrowing reading, but it is one of the reasons why this bill is so important. Levels of family violence in the Koori community have reached epidemic proportions and have reached crisis point. As I have said, that is why this bill is so significant. Indigenous children currently make up 3.5 per cent of the population younger than 18 years of age in New South Wales. The team's most recent annual report showed that, overall in New South Wales, 37 children died out of every 100,000 children who were younger than 18 years of age. However, among Aboriginal children 80 children out of every 100,000 children died. The discrepancy is obvious. Aboriginal children's death rate is more than twice the overall rate of deaths. For every young Aboriginal child, the situation is even worse. For all children who died in New South Wales, just over half of the deaths occurred before the child's first

birthday. I ask all honourable members to listen to what I am about to say: Unfortunately, 71 per cent of Aboriginal child deaths occur before the child's first birthday. That is an absolutely unthinkable situation, but it is true.

The team has also shown that Aboriginal young people are more than twice as likely as are other young people to die from suicide or risk-taking behaviour, and those deaths account for 7.5 per cent of New South Wales deaths. The same proportion applies to Aboriginal young people who die as a result of assaults, and those deaths account for 8.3 per cent of New South Wales deaths. Anything that we can do to reduce the rate of Aboriginal child deaths is worth supporting. I point out to all honourable members that the statistics I have cited represent real children in real families. I recall once again Mick Dodson's words when he was the Social Justice Commissioner, "We die silently, under these statistics." This bill will enable the Child Death Review Team to continue and extend its work in conducting, publishing and disseminating quality research that is aimed at informing the entire community about the nature of child deaths, factors contributing to deaths and ways in which our laws, policies, services and practices can be changed to reduce the number of deaths.

The bill requires that two members of the team be Aboriginal, to assist the team in understanding the context of the death of Aboriginal children. I acknowledge and thank the members of the Aboriginal community who have served as members of the team to date: Pam Greer, Melva Kennedy and Alice Silva—three indigenous women who are senior in the cultural sense in the Aboriginal community. I know the women personally and I have spoken with them about these issues and about the demons created by the death of children—demons we must all face, not just the Aboriginal community. The three senior women are widely known and respected in the community, particularly in the Aboriginal community, for their expertise in and commitment to caring for children and families.

Reading about the deaths of children from one's community is a very painful and confronting experience. It is even more confronting in the indigenous community, because we know each other and each other's families—they are not just statistics but real children and real families. The three women's extensive knowledge of the Aboriginal peoples within this State has helped the team in many ways, including identifying some deceased children as Aboriginal when neither the child's death certificate nor the police reports reflected the child's cultural background. This goes to the heart of identity, to the heart of Aboriginal people's reality. I cannot imagine what it would be like for the families if the children were not identified as Aboriginal. Aboriginality is not just about the colour of one's skin or the shape of one's nose; it is about a sense of place, connection to country, connection to family.

I thank Melva, Pam and Alice for their work on behalf of Aboriginal children in New South Wales. I repeat the words of the honourable member for Auburn: I place on record, as she did, the respect that I have for the Commission for Children and Young People. I can say that because in a previous life I worked closely with the commission. Its leadership through Gillian Calvert is exemplary—no-one in this Chamber or in this State need worry about her leadership. The bill will help us all improve our knowledge about the systems for protecting children in this State. I started my speech by saying that there is nothing more important than protecting those rights and those children's lives. I am pleased to support the bill.

Mr HICKEY (Cessnock—Minister for Mineral Resources), on behalf of Dr Refshauge [9.32 p.m.], in reply: I thank all honourable members for their contributions to this debate. As honourable members in both Houses have acknowledged, the Child Death Review Team has made a significant contribution to reducing the deaths of children and young people in New South Wales. The provisions in this bill will enable the team to continue this valuable work. The bill stems from the review of legislation governing the New South Wales Child Death Review Team, the report of which was released in May 2002. The report made 11 recommendations and dealt with issues including the management of confidential information, the appropriate functions for the team and its composition. The Government is grateful for the work conducted in that review by Dr John Yu and the Commission for Children and Young People. As is stated in the foreword to the report, the recommendations of the reviewers will "strengthen the capacity of the NSW Child Death Review Team to achieve its important aim of preventing or reducing child deaths in NSW". That aim is shared by all of us. I commend the bill to the House.

Motion agreed to.

Bill read a second time and passed through remaining stages.

Subjects: Child Abuse; Children; Ombudsman; Government Departments: New South Wales: Community Services.
Speakers: Hickey, Mr; Hazzard, Mr; Perry, Mrs; D'Amore, Ms; Judge, Ms; Burney, Ms.
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