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

**Second Reading**

**The Hon CARMEL TEBBUTT** (Minister for Community Services, Minister for Ageing, Minister for Disability Services, and Minister for Youth) [4.15 p.m.]: I move:

That this bill be now read a second time.

The Carr Government established the Child Death Review Team in 1996 when, with bipartisan support, part 7A of the Children (Care and Protection) Act 1987 was passed. It was a first for Australia and the first team of its kind established outside the United States of America. Since then, the team has released five annual reports and two special reports entitled "Fatal assault of children and young people" and "Suicide and risk-taking deaths of children and young people". These reports have been extremely valuable in guiding policy development and practice in New South Wales.

I place on record our appreciation of those who have contributed to the team's achievements. They include the team's inaugural convenor, Dr Kim Oates, who is the chief executive officer of Westmead Children's Hospital; the current convenor, Gillian Calvert, who is the New South Wales Commissioner for Children and Young People; the deputy convenor, Dr Judy Cashmore; and the team members and staff over the past five years who have all contributed to the team's success. I seek leave to incorporate a list of their names in *Hansard.*

**Leave granted.**

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Ms Sandie Bredemeyer
Ms Gillian Calvert
Dr Ian Cameron
Dr Judy Cashmore
Dr Michael Fairley
Ms Anne Farah-Hill
Dr John Feneley
Ms Helen Freeland
Dr Jonathon Gillis
Ms Anne Maree Gleeson
Ms Pam Greer
Dr Ferry Grunseit
Mr Phillip Hart
Supt John Heslop
Assoc Prof John Hilton
Mr James Hirshman
Prof Judith Irwin
Ms Melva Kennedy
Ms Helen Kerr-Roubicek
Dr David Lillystone
Dr Dianne Little
Ms Katrhrina Lo
Mr Peter Mathews
Dr Andrew McDonald
Sr Margaret McGovern
Dr Elisabeth Murphy
Mr Graham O'Rourke
Prof Kim Oates
Ms Carol Peltola
Ms Alice Silva
Ms Toni Single
Prof Graham Vimpani
Mr Stephen Wilson

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**The Hon. CARMEL TEBBUTT:** Under the existing legislation, the Act was to be reviewed within five years of its assent. Accordingly, the "Report of the Review of Legislation Governing the NSW Child Death Review Team" was tabled in Parliament on 4 June 2002. The report was widely distributed and was received by relevant interest groups without comment or criticism. In preparing the report, the co-chairs of the review, Dr John Yu, AC, and the Commissioner for Children and Young People, held targeted consultations with key individuals and organisations using a short discussion paper. The consultations demonstrated strong support for the work of the team. In particular, the continuance of the child death register and the team's research functions were endorsed during the consultation process.

There was a clear view that New South Wales was leading Australia in research into preventable child deaths and that the team, as the sole body able to access the full range of information about deaths, made a valuable contribution to public policy. The report identified, for example, the death of toddlers in driveways as an issue that had emerged in public debate because of the work of the Child Death Review Team. Initially the team was co-located with the Child Protection Council. With the establishment of the Commission for Children and Young People in June 1999 the commissioner became the team's convenor. The commission provides research, policy, secretariat, community education, and administrative support to the team. More recently, the Community Services Legislation Amendment Act 2002 gave the Ombudsman responsibility for a key function formerly held by the team: reviewing the deaths of children due to abuse, neglect or deaths that occurred in suspicious circumstances.

These review functions sit more appropriately in a watchdog body like the Ombudsman's office, with its monitoring and investigation powers and its existing function of oversighting the child protection system than in a research team that considers all children. The Government is now introducing legislation to implement the findings of the "Report of the Review of Legislation Governing the NSW Child Death Review Team" by Dr Yu and the Commission for Children and Young People. The main effect of the bill is to insert revised provisions into the Commission for Children and Young People Act 1998 and to remove provisions relating to the team that is currently constituted by the Children (Care and Protection) Act 1987 and the Children and Young Persons (Care and Protection) Act 1998. The bill also makes consequential amendments to the Community Services (Complaints, Reviews and Monitoring) Act 1993, with the Ombudsman's support.

The Commission for Children and Young People Act 1998 is a logical place for the provisions to sit because the commission provides support to the team and because of the compatibility between the functions of the commission and the team, particularly the commission's broad role of research into issues affecting children. With the transfer to the Ombudsman of the function of reviewing child abuse deaths there is no synergy between the team's remaining functions and its current location in the care and protection legislation.

The bill also sets out the objects, functions and procedures of the child death review team as recommended by the report of the review. The team's functions remain to maintain a register of all child deaths in New South Wales, to undertake research into child deaths and to make recommendations aimed at preventing or reducing child deaths. The consultations undertaken as part of the review supported the team's having a research focus encompassing all types of child deaths. This does not involve giving any new functions to the team or expanding its role as the team already has these functions. 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 and to exclude them would distort the analysis of motor vehicle accidents. In these circumstances the bill permits the team to include those reviewable deaths from motor vehicle accidents. Under subsections (2) (b) and (3) of new section 45N the team can also conduct research about reviewable deaths when the Minister has approved the research after seeking and considering the Ombudsman's advice.

The bill provides for the Minister to approve research projects undertaken by the team upon receipt of a research proposal from the team. In most research settings a higher authority generally approves research proposals, whether that is the funder, the chief executive officer of the agency or a university committee. The Minister fulfils that function in relation to the team and the provision is continued in the existing Act. The bill extends the team's access to records about child deaths to private health agencies and practitioners, to non-government schools and to people or agencies providing services such as family support, child care, education, residential out-of-home care, disability services or foster care. The professionals, practitioners and non-government representatives consulted during the review supported this. Their reasons for doing so include that there is a strong public interest in obtaining a more complete picture of why children die, the total number of requests would not be great so it is not an onerous provision, and the records are required for the purpose of promoting systemic change not investigating individual deaths or people's responsibility for them.

This proposal would not require non-government organisations to maintain any particular records. If they possessed any records and the team requested a copy, the organisation would be obliged to provide a copy. Since these requests will be limited to records about children who have died and who are the subject of a particular research project, this type of request would be made only rarely to any one organisation. While it will not be an offence to fail to comply with the duty, the convenor would have the capacity to draw to Parliament's attention failures by agencies to comply. The records are an important information source to help us understand the circumstances of children's deaths, and this preventative role justifies the team's gaining access to them. The information gathered by the team will be 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 convenor to take part in research projects and to members of joint research projects.

The bill also sets out the circumstances in which this confidentiality provision does not apply. These circumstances include research to be conducted to help prevent or reduce the deaths of children in New South Wales; reporting possible criminal matters to the police; reporting to the Department of Community Services that a child may be at risk of harm; and reporting information to the State Coroner and Ombudsman that supports his or her functions. This power is limited to the convenor and must be reported annually to Parliament. Privacy NSW raised no objection to these proposals. The bill also provides for an exemption to the Minister following receipt of the draft report so that I can seek the advice of other relevant Ministers and heads of government agencies about a draft team report. The report of the review argued that this would help test that the recommendations in a report are appropriate and likely to obtain the results they aim to achieve without jeopardising the much-valued independence of the team. While there is an obligation on the team to consider the Minister's comments, there is no requirement for it to accept or change anything in those reports.

The bill changes the team's composition in light of the team's broader research agenda and the transfer of reviews of child abuse deaths to the Ombudsman. Membership of the team requires expertise in health care, child development, research methodology and child protection. The Department of Ageing, Disability and Home Care is included on the team as a child with a disability can be more vulnerable to the risk of death. The bill also provides that two of the team's standing members must be Aboriginal, continuing the provision in the existing legislation. As the team will now be involved in conducting research into a broader range of child deaths, the bill provides for the team's convenor to appoint special advisors depending on the skills required for a particular project. These individuals will have their terms limited to the particular project and must comply with the confidentiality provisions.

The report of the review found that the current legislation sets unrealistic deadlines for the gathering of and reporting on annual data about child deaths. As a result the data may be incomplete, and the report of the review recommended that reporting times be made more realistic. The bill therefore allows for an extra six months between the reporting period and the tabling of an annual report. With the agreement of the Ombudsman, this bill also replicates these arrangements for his child and disability death review functions and makes consequential amendments to the Community Services (Complaints, Reviews and Monitoring) Act 1993. The bill provides for another review of the legislation after five years. It is important to assess whether the changes made because of the legislative review and the Community Services Legislation Amendment Act 2002 achieve their aims and to check that the legislation accommodates new developments that may occur. The bill also provides for this review to coincide with a review of the Commission for Children and Young People Act 1998.

Only one subclause of one recommendation in the report of the review is not implemented by this bill. That is the proposal that the team should, as an additional accountability measure, report to Parliament and give reasons if it has not undertaken a research project in any three-year period. Since the team is required to report annually on all its activities and the Minister is required to approve research projects, I believe the process is already accountable and transparent and that this additional reporting requirement is unnecessary. Finally, the bill deals with minor miscellaneous matters regarding the operational provisions. These were all recommended in the report of the review and were supported during the consultations. In summary, this bill implements the recommendations of the "Report of the Review of Legislation Governing the NSW Child Death Review Team". It continues the proud record of New South Wales of once again leading Australia in this area of research and will contribute to the valuable work many of us are undertaking to try to reduce the number of children and young people who die in this State. I commend the bill to the House.