

**CHILDREN LEGISLATION AMENDMENT (CHILD DEATH REVIEW TEAM)  
BILL 2011**

19 October 2011 Page: 21

**Bill introduced on motion by Ms Pru Goward.**

**Agreement in Principle**

**Ms PRU GOWARD** (Goulburn—Minister for Family and Community Services, and Minister for Women) [12.15 p.m.]: I move:

That this bill be now agreed to in principle.

The Government is pleased to introduce the Children Legislation Amendment (Child Death Review Team) Bill 2011. The bill delivers on the Government's election commitment to support the Ombudsman's role in independently reviewing child deaths in New South Wales. This Government is committed to real reform. I am working with my colleagues, including Andrew Constance, the Minister for Ageing and Minister for Disability Services, to improve services for vulnerable children, young people and families; improve accountability and transparency about what we do—what we do well, what we need to do better, and how we are working to improve; reduce the number of children in out-of-home care and increase restoration and permanency to their support and care; improve the performance of the Family and Community Services cluster and its divisions, including Community Services, to integrate services, including for regular clients of the cluster with complex and varied needs; and finally, of course, to keep our children safe.

This legislation is another example of this Government boosting accountability and transparency, and in so doing meeting an election commitment. The Child Death Review Team was established in 1996, with the primary objective of preventing or reducing the incidence of child deaths in New South Wales. It does this by identifying trends and patterns relating to the causes of child deaths, and then making recommendations on legislation, policies, practices and services to government and non-government agencies and the community for the prevention of further child deaths.

In 2008, the Hon James Wood, AO, QC, handed down the report of the Special Commission of Inquiry into Child Protection Services in New South Wales. The report recommended that the Ombudsman be appointed as the convenor of the team, and that the secretariat and research functions associated with the team be transferred from the Commission for Children and Young People to the Ombudsman. Clearly, Justice Wood recognised the importance of allocating this task to an independent body with forensic capacity and a depth of experience in investigating the deaths of those children living in parlous circumstances. It is also implicit that the commission recognised the strong culture of independence within the Ombudsman's office.

In April 2009 the New South Wales Parliament passed legislation that finally transferred responsibility for the New South Wales Child Death Review Team from the Commission for Children and Young People to the New South Wales Ombudsman. At the time the Coalition knew and observed that the Labor Government's bill went only part-way to transferring the team. We said at the time that the Labor Government was seeking to pervert the commissioner's recommendation. That is why we, in opposition, proposed amendments to strengthen Labor's bill. On 5 March in this place, speaking to the Children Legislation Amendment (Wood Inquiry Recommendations) Bill 2009, I said:

It [the Labor Government] cherry-picked and supported the recommendation that reduced the authority of the Ombudsman but did not support the recommendation that ensured adequate systemic review, despite the loss of authority by the Ombudsman.

Public accountability in New South Wales is again the loser. Once before the Government reduced the authority of the Ombudsman to review child deaths. In this [Labor's bill in 2009] it has done so again.

Not that Labor, bitter and twisted about external scrutiny, had any intention of doing the job properly. Labor's transfer was so problematic, so ineffective, that on 4 November 2010 the Ombudsman went to the lengths of releasing a report. The report, entitled "Unresolved Issues in the transfer of NSW Child Death Review team to the Office of the NSW Ombudsman", detailed the difficulties experienced by the Ombudsman due to the botched and twisted nature of the former Government's transfer. Transparency and accountability were clearly foreign notions to the previous Government.

The transfer came into effect on 11 February 2011. Since then the Ombudsman has been the convenor of the Child Death Review Team, and his office provides support and assistance to the team in the exercise of its functions. But the transfer remained incomplete, a bitter Labor piece of payback to an Ombudsman who had been too independent. Labor in government had to be dragged kicking and screaming to implement Justice Wood's recommendation in the first place. When it did make the transfer, which as I said came into effect in only February this year, it was, as Labor had always intended it to be—half-hearted. It did not fulfil Justice Wood's recommendation or indeed his vision.

With this bill the Liberal and Nationals Government will finish that job; it will complete that vision. Its measures will remove the administrative complexities brought about by Labor's half-hearted transfer and acknowledges the importance of the Ombudsman's independence. Let us hope now that Labor has the decency—even if belatedly—to do the right thing by children in New South Wales and support our efforts to do what it should have done. It is in everyone's interest that there be strongly independent oversight, and I would have thought that was especially attractive to oppositions.

This bill completes the transfer and boosts accountability and transparency by supporting the Ombudsman's independence and his office's work with child deaths. The team reports annually to Parliament on child deaths in New South Wales. To date it has published eight special research reports on issues including child deaths involving parental substance dependence, suicide and risk-taking deaths, and sudden unexpected deaths in infancy. The death of any child is a tragedy, and the work of the team is enormously important to the community. I would like to take this opportunity to thank the members of the Child Death Review Team for their dedication to this complex and difficult task. The bill will assist them in carrying out their work, by strengthening their autonomy and ensuring that the Ombudsman can carry out his team functions more efficiently and, crucially, more effectively.

Some of the changes in the bill were the focus of the special report to Parliament by the Ombudsman in November 2010. Other changes in the bill were subsequently requested by the Ombudsman during consultation on the bill. The first amendment I draw to the attention of the House concerns legislative provisions and parliamentary responsibility. The bill will transfer the legislative provisions regarding the Child Death Review Team out of the Commission for Children and Young People Act 1998 and into the Community Services (Complaints, Reviews and Monitoring) Act 1993. This will mean that the Ombudsman's functions in relation to the Child Death Review Team, and in relation to community services and reviewable deaths, will now all be contained in the same Act.

The bill will also ensure that the Ombudsman will not have to report to two different parliamentary joint committees in relation to his Child Death Review Team functions. Currently, the Ombudsman reports to the Parliamentary Committee on the Office of the Ombudsman and the Police Integrity Commission in relation to all his functions. This includes his functions with respect to the Child Death Review Team that he took on in February this year. The Parliamentary Committee on Children and Young People also currently has parliamentary responsibility for monitoring and reviewing the work of the Child Death Review Team, as well as the Commission for Children and Young People. To avoid this duplication of roles in relation to the Child Death Review Team, the bill will transfer parliamentary responsibility for the Child Death Review Team from the Committee on Children and Young People to the Committee on the Office of the Ombudsman and the Police Integrity Commission.

The Committee on Children and Young People will continue to apply its valuable experience and knowledge on issues affecting children and young people, and it will continue to be responsible for monitoring and reviewing the work of the Commission for Children and Young People. The Committee on Children and Young People will continue to be responsible in general for examining trends and changes in services and issues affecting children and young people, but the bill will ensure that only one parliamentary committee—the Committee on the Office of the Ombudsman and Police Integrity Commission—will have oversight of the Child Death Review Team.

The bill also makes a small number of changes of an administrative nature, relating to the appointment of members of the Child Death Review Team and the team's research and reporting functions. These changes were requested by the Ombudsman in order to enhance the efficiency of the Child Death Review Team. In relation to the members of the team, the bill will appoint the Deputy Ombudsman, in his capacity as Community and Disability Services Commissioner, to be a statutory member of the Child Death Review Team. The other statutory members of the team are the Ombudsman, as the convenor of the team, and the Commissioner of the Commission for Children and Young People.

The Deputy Ombudsman leads the Community Services Division within the Ombudsman's office, and I understand that staff supporting the work of the Child Death Review Team are

also within this division of the Ombudsman's office. Appointing the Deputy Ombudsman as a statutory member of the team will therefore ensure he is best placed to support the team in carrying out its functions. The non-statutory members of the team include experts in child health care, Indigenous health care, medical specialists and representatives from the New South Wales Police Force, the Coroner's office, the Department of Family and Community Services, the Department of Education and Communities, the Ministry of Health and the Department of Attorney General and Justice. The bill extends the maximum term of office of these members of the team from the current period of two years to three years. Team members are also eligible for reappointment.

With respect to the team's research functions, the bill will remove a requirement for the team to obtain ministerial approval before it can undertake research on preventing or reducing the likelihood of child deaths. The team will still require the approval of the Minister before conducting research in one specific area to do with "reviewable deaths", as those deaths are already looked at by the Ombudsman in another capacity, rather than by the team. This means the team's research cannot be constrained by the political agenda of the government of the day. For example, it cannot be sidetracked or sidelined from issues of public disquiet by the government of the day—perhaps a government obsessed by spin, say, keen to avoid scrutiny or any challenge to its authority.

With respect to the team's reporting functions, the bill removes the requirement to provide a copy of its draft reports to the Minister. Again, that removes that legislated final temptation for a government hiding from scrutiny and the responsibility to improve its service to the people of New South Wales. In addition, the bill makes it clear that a member of the team can disclose information, such as extracts from a draft report, to any person or organisation for the purpose of obtaining information or advice, or enabling comments to be made to the team, in connection with the draft report. This will ensure that the team will be able to consult more widely in the preparation of its reports and recommendations, should it wish to do so.

The Child Death Review Team has a task that is vital to the welfare and wellbeing of the children of New South Wales. The team's work has greatly added to our capacity to understand the causes of child deaths in New South Wales and how to reduce the numbers of preventable child deaths. The recommendations that have flowed from the team's reports have led to improvements in our policies and practices. As a result of its work, we now have better systems in place to prevent or reduce these deaths. The team's research is being translated into action to make our State a safer place for children. Its work has identified areas of concern for policymakers and the wider community, some of which would not have been recognised otherwise.

The team not only makes recommendations; it also monitors and follows up with agencies on the implementation of its recommendations. To take one example from its latest annual report, the team has been monitoring the implementation of its recommendation regarding the risk of drowning for children and young people with epilepsy. A fact sheet on epilepsy and seizures is now available from a number of New South Wales children's hospitals which

includes educational messages on the dangers of children and young people swimming alone, and the importance of supervising children at risk of a seizure when bathing or swimming. The bill will assist the Child Death Review Team in carrying out its valuable role of researching and advising the government and the community on ways to prevent or reduce child deaths.

We are serious about reform to improve services and boost accountability and transparency in the work we do for vulnerable children, young people and families. After 16 years of Labor the reform process undoubtedly will be long and challenging—there is so much to do. This bill not only is part of that reform challenge; it meets another election commitment and is part of the Government's elevation of accountability and transparency about how we work and improve. I commend the bill to the House.