PARLIAMENT OF NEW SOUTH WALES

Committee on Children and Young People

REVIEW OF THE CHILD DEATH REVIEW TEAM REPORT FATAL ASSAULT AND NEGLECT OF CHILDREN AND YOUNG PEOPLE

Transcript of Proceedings, Written Responses to Questions and Minutes

Report No.4/53 – March 2005

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Functions of the Committee

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 s.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

Reading the Child Death Review Team's report *Fatal Assault and Neglect of Children and Young People* (2003), which reviews the deaths of 75 children aged 0 to 17 years registered in the three year period between 1 July 1999 and 30 June 2002 in New South Wales, is a sobering experience, and brings us face to face with the tragic reality of some children's lives. The Committee would like to acknowledge the comprehensive and thorough research the Child Death Review Team has conducted into these deaths.

The *Fatal Assault and Neglect* Report makes two recommendations and suggests ways that further deaths from assault and neglect may be prevented. Poor interagency collaboration and coordination was one factor, and the Commissioner for Children and Young People advised the Committee that the report's findings have informed the Child Protection Senior Officers Group's 2004-05 work plan, including updating and promoting the Interagency Guidelines.

I would like to thank the Commissioner for appearing before the Committee to assist the Members to review the report.

Barbara Perry MP
Chair

Chapter One - Questions on Notice

REVIEW OF THE CHILD DEATH REVIEW TEAM REPORTS: FATAL ASSAULT AND NEGLECT OF CHILDREN AND YOUNG PEOPLE

1. The report makes the following two recommendations:

   (a) That the NSW Government consider undertaking a comparative research study to identify differences between reported children and young people who are injured, and reported children and young people who are fatally assaulted, to inform interagency practice and response; and

   (b) That the NSW Government consider undertaking a research study into the factors that promote and hinder adherence to interagency policy and practice.

   With regard to Recommendation 1, the Child Death Review Team (CDRT) 2003 Annual Report notes that DoCS was conducting a literature review and also redesigning its data capabilities in realtion to child deaths. Have both these projects been completed and will the CDRT encourage DoCS' Centre for Parenting and Research to undertake research along the lines of its recommendation (*CDRT Annual Report* p 97)?

   With regard to Recommendation 2, the CDRT 2003 Annual Report notes that the CDRT will continue to review the progress of research by the Child Protection Senior Officer Group into interagency policy and practice. Is the CDRT satisfied with the direction of the strategies the Group plans to implement in 2004-05 (*CDRT Annual Report* p 94)?

2. One of the report's findings is that child deaths arising from inadequate supervision were preventable. The report notes that not all families require statutory intervention. How could appropriate intervention with families with children at risk from inadequate supervision occur?

3. The report found that the three most common errors made by agencies and practitioners were:
   - not recognising and reporting serious and unstable situations;
   - inadequate risk assessment; and
   - poor interagency collaboration and coordination.

   Has this finding lead to any changes to agency practice?

4. Boys are at a much greater risk of fatal assault and neglect than girls in the 1 to 4 year age group, and again in the 13 to 17 year age group. What are the reasons for this and what prevention programs may be appropriate?

5. Does the Commission know if the Ombudsman intends to continue to conduct further reviews of fatal assaults and neglect of children and young people?

Chapter Two - Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

INQUIRY INTO REVIEW OF CHILD DEATH REVIEW TEAM REPORT "FATAL ASSAULT AND NEGLECT OF CHILDREN AND YOUNG PEOPLE"

———

At Sydney on 23 November 2004

———

The Committee met at 3.15 p.m.

———

PRESENT

Ms B. M. A. Perry (Chair)

Legislative Council	***Legislative Assembly***
The Hon. J. C. Burnswoods	Mr J. R. Bartlett
The Hon. A. Catanzariti	Ms S. R. Cansdell
The Hon. K. F. Griffin	Mr B. J. Collier
Ms S. P. Hale	Mrs J. Hopwood
The Hon. M. J. Pavey	Ms D. V. Judge

———

GILLIAN CALVERT, Commissioner for Children and Young People, Commission for Children and Young People, on former affirmation:

CHAIR: We will commence the second part of the proceedings, that is, our inquiry into the 2003 report of the Child Death Review Team entitled, "Fatal Assault and Neglect of Children and Young People." Before we start, Ms Calvert, I forgot to ask you earlier whether you wanted to table anything in relation to the annual report, including anything you prepared in relation to questions on notice that were sent to you.

Ms CALVERT: If the Committee would like it I would be happy to do so.

CHAIR: It would be good if you could table that later today. I refer to question No. 2 relating to the report of the Child Death Review Team [CDRT] entitled, "Fatal Assault and Neglect of Children and Young People." One of the findings in the report is that child deaths arising from inadequate supervision were preventable. The report notes that not all families require statutory intervention. How could appropriate intervention occur in relation to families with children at risk from inadequate supervision? Would you prefer us to refer to one report and then to the other?

Ms CALVERT: It would be easier. I am happy to answer that question, Madam Chair. Issues in these families arose as a result of parents not appreciating that their children were in a risky situation. So they did not deliberately harm or deliberately fail to protect their children and, therefore, a statutory child protection response was not needed. At a family level it might be helpful if parents knew more about their children's development and, in particular, how to judge the supervision needs of children at that developmental stage. It might also be beneficial for parents to be much more aware of what a hazardous environment is, for example, swimming pools, and hazardous environments outside their houses, such as the road, the street and so on.

At a planning level it may be helpful if the designers of homes and housing or community facilities paid attention to possible injury and risk and also to how they supervise children and design for supervising children in those risky situations. The CDRT 2003 annual report indicates that the Team wants to continue exploring the evidence base for successful interventions in improving the supervision of young children. From that the Team anticipates being able to make some recommendations for future action. We did not want to do it based on what information we just had in the room at the CDRT; we wanted to establish whether there was anything that had previously been shown to work in dealing with this problem of overestimating children's capacities and underestimating the risk that they were facing. That seems to be the sort of thing that can lead to fatal outcomes.

CHAIR: We saw as a much greater risk fatal assault and neglect. Statistically, boys in the one-year-old to four-year-old age group are at much greater risk of fatal assault and neglect than are girls and, again, in the 13-year-old to 17-year-old group. Are you able to say what are the reasons for that? The second part of that question would be: What preventive programs may be appropriate?

Ms CALVERT: There are probably biological reasons why boys die at a greater rate than girls, from almost all causes of death.

The Hon. MELINDA PAVEY: I have a son.

Ms CALVERT: It is distressing if you have boys.

The Hon. MELINDA PAVEY: It stands to reason; they are little boys and they are far more adventurous.

Mr BARRY COLLIER: I object to that.

Ms CALVERT: I will not get into that debate. I am saying that there are probably biological reasons for that difference, because it occurs from natural causes as well as from, say, external causes involving risk-taking. The thing is that we do not yet understand the potential for socially based interventions to redress that biological difference. Notwithstanding that fact, in terms of preventing deaths for kids from the age of, say, nought to four, there is increasing evidence that providing good quality support and particular types of support to families can reduce abuse and neglect in high-risk families and it can also possibly reduce child deaths.

For example, Professor Julie Quinlivan at the University of Melbourne conducted a randomised trial of nurse home visiting for families with significant problems. As a result of that study she found that those that received the sustained nurse home visiting had reduced abuse and neglect rates of up to 75 per cent. Although the numbers in her study were too small to be conclusive, they do suggest that death probably can also be reduced, through sustained nurse home visiting for families that are high risk. The CDRT has recommended that sustained home visiting be available to all high-risk families.

CHAIR: What age group did that study cover?

Ms CALVERT: I think the general home visiting was for children in the nought to four-year-old age group. So it is the early years. In relation to teenagers, the majority of fatalities in the 13-17-year-old group were in the context of fighting with groups or other young people, or with individual adult men. So it was in the context of fights, either individual or group type fights. I think these deaths reflect greater risk taking by adolescent males. As I said earlier, over the next two years we will be looking at the evidence base for successful interventions in improving the supervision rate of children in the nought to four-year-old age group, and also the serious risk taking. From that we would hope to make some recommendations.

Mr BARRY COLLIER: I have great difficulty with the concept that boys under the age of one die more than frequently than girls because of risk taking or biological issues.

Ms CALVERT: No, it is nought to four.

Mr BARRY COLLIER: I have nought to one.

Ms CALVERT: No, it is nought to four.

Mr BARRY COLLIER: I have a graph that shows statistics for boys under the age of one. So we are talking about boys aged nought to four. Is there something in the psychology or make-up of persons who fatally assault a young boy because they have an expectation of the way in which a boy should behave, or they believe that they need to be firmer with a boy, or something like that?

Ms CALVERT: The nought to fours were not dying because they were being assaulted by someone else, and the teenagers were dying as a result of fighting with each other. The nought to fours died because they were not adequately supervised. They were in very risky situations and they then did something that meant that they were killed.

Mr STEVE CANSDELL: Reflecting on the fact that they are male, do their parents or stepparents think that they can leave them in that situation without having to mollycoddle them?

Ms CALVERT: That may be one reason; we do not know. It may also be because they are more exploratory and more curious; we do not know. All we know is that they tend to die at a higher rate. That applies to natural causes as well as to external causes. So that is why we are saying it is biological.

Mr BARRY COLLIER: So is the rate of assault among boys aged nought to four greater than the rate of assault for girls aged nought to four?

Ms CALVERT: Slightly more boys are assaulted, die from fatal assaults, 0 to 4, than girls, but it is not as significant as the 13 to 17 year group.

Mr BARRY COLLIER: What about 0 to 1, boys versus girls?

Ms CALVERT: No. Under one, the rates of death at the same; one to four, males are higher than girls; five to nine, it is much the same; 10 to 12, it is much the same; and 13 to 17, boys die at a higher rate than girls.

CHAIR: You might want to show Gillian that table.

Ms CALVERT: I have it here.

CHAIR: I have a different table.

Mr BARRY COLLIER: Children and young people's age and gender.

Ms CALVERT: If you look at page 22 of the report under examination—

Mr BARRY COLLIER: I am looking at this document. It may be out of date.

Ms CALVERT: I understand the difference. What you are looking at is a Fact Sheet called *Fatal Assault of Children and Young People*, but the report under examination looks at fatal assault and neglect. So you are only looking at part of—

Mr BARRY COLLIER: I am looking at assaults.

Ms CALVERT: Yes, and I am looking at both fatal assault and fatal neglect.

Mr BARRY COLLIER: As combined.

Ms CALVERT: Yes, as a combined category.

Mr BARRY COLLIER: Do you think it is a bit misleading having both of those as a combined thing? Why do you not just separate them? It seems fairly broad. One is assault and the other is neglect. One is a deliberate act; the other one is not caring.

Ms CALVERT: Some people would argue that they are both deliberate acts. One is by commission and one is by omission—you are absolutely right about that. I am happy to see if we can divide those figures. The reason I have not is that the legislation at the time required me to review deaths from fatal assault and neglect. So we tended to do them together in response to the legislation. But you raise a very good point in that the deaths from assault are different to the deaths from neglect, and in the report under examination we talk about the differences in some detail.

Mr BARRY COLLIER: Are we harder on boys than girls, do you think?

Ms CALVERT: I think some people are and I think some people are not.

Mr BARRY COLLIER: I mean generally.

Ms CALVERT: No. I think both boys and girls have their challenges.

The Hon. MELINDA PAVEY: I refer to page 39 of the annual report of the New South Wales Child Death Review Team.

CHAIR: It is not a report that we are looking into. Unless you can make it relevant to the actual report that we are looking into—

The Hon. MELINDA PAVEY: You can move on to someone else while I get the detail.

Mrs JUDY HOPWOOD: The report found that the three most common errors made by agencies and practitioners were not recognising and reporting serious and unstable conditions, inadequate risk assessment and poor interagency collaboration and co-ordination. Has this finding led to any changes to agency practice?

Ms CALVERT: This finding has been made in a number of CDRT reports and I think it has led to changes in practice, although we have not had any formal evaluation of the improvement in agency practice. One of the impacts of the Child Death Review Team is that, because it comes out annually, it keeps the momentum going on continuous improvement in the area of child protection and in relation to agency practice and services. For example, as a result of the Child Death Review Team there has been a senior officers group set up, one of whose jobs it is to update and promote the interagency guidelines. That was as a result of the Child Death Review Team. So I think it is probably helpful to think about these things as continuous improvement. The CDRT no longer have carriage of that issue. It has been

transferred over to the Ombudsman, and I know that he will continue to monitor agency performance in that area and to report annually on the issues that he finds.

CHAIR: Melinda, there might be another way to deal with your issue. Although we are not doing the report, we will be doing the report in detail early next year as a review, as we have to. I am just wondering whether you would like to give Gillian a question on notice and deal with it that way.

The Hon. MELINDA PAVEY: Yes, but I can also relate it back to this report. My question relates to page 39. Of the 25 children who died last year through accidental suffocation, strangulation in bed, which includes suffocation or strangulation due to bed linen and mother's body and pillow, on notice can you tell us the locations where they occurred and break it up into whether it was bed linen or whether they were in bed with their mother and pillow? How many of the parents had evidence of some intoxication within them if that was the case?

CHAIR: I think that needs to be on notice, does it not?

Ms CALVERT: It does but perhaps for the information of the Committee—

CHAIR: But we are not strictly doing this report.

Ms CALVERT: Just to flag—

The Hon. MELINDA PAVEY: In relation to suffocation, strangulation at page 1 of the report that we are looking at today, there is evidence of it happening within this report.

Ms CALVERT: The CDRT is completing a special research report into sudden unexpected deaths of infants, and we anticipate that being tabled early next year. That certainly addresses some of the issues that I think you are implying with bed sharing, loose covering, overheating and things like that.

The Hon. MELINDA PAVEY: I think it is important for the community to understand that it is okay to have your child in bed with you but not if you are drunk or stoned. I think the community has a right to know as much evidence as is available, rather than saying you should not sleep with your child.

CHAIR: We will take that on notice. As I said, we will be looking into those reports in detail early next year.

The Hon. TONY CATANZARITI: What action is taken when neglect is identified? What actually happens? What is the next step to take?

Ms CALVERT: If a person believes that a child is at risk of harm from neglect, then the professionals are required to report it to the Department of Community Services. If you are a member of the general public or a family member and you have concerns you are also able to report it to the Department of Community Services but you are not required. The Department of Community Services will then respond to the matter in whatever way they see fit. But generally if they have concerns over neglect or you as a person has concern over

neglect there are a number of services available that can work with that family to try to improve the circumstances of the child. In those cases where they are unable to do that and it is unsuccessful, of course the department always has the option of taking the matter to the Children's Court and seek to have the child placed with someone who is able to care for it.

Mr STEVE CANSDELL: If a child dies through neglect and it is found it is through neglect, there are probably two solid questions here. First, if the authorities, for example DOCS, had been notified or warned of this neglect and taken no action and the child dies, what repercussions are there or what action does the department take? Secondly, is there any action against the parents if it is wilful neglect or just ignorance? Is there any action taken there?

Ms CALVERT: In relation to action against the department, is that what you are talking about?

CHAIR: I am not clear on the question.

Mr STEVE CANSDELL: If a child dies through neglect, first, the department may have been forewarned about this and taken no action. Secondly, what action is there against the department or is there action against the parent for being neglectful in the death of their child? It is one thing if it is manslaughter, but if it is just complete ignorance and neglect through ignorance is there some action that can be taken?

Ms CALVERT: In relation to neglect, the department knowing about a neglect case and not taking any action, the Ombudsman reviews all those deaths now and he will table his report in Parliament. So that is one thing that can be done. Someone can make a complaint to the Ombudsman. He can then investigate that complaint. Of course, there are always political processes which address issues of agency performance or failure to perform. In respect of parents, my understanding is that you can be charged with neglect and convicted. So there are, in a sense, criminal sanctions.

Mr STEVE CANSDELL: Neglect causing death or something like that.

Ms CALVERT: Yes.

Mr JOHN BARTLETT: Sitting where you were sitting yesterday was the Ombudsman, and we were discussing deaths in police pursuits. It came out that the only time he will investigate that situation is when there is officially a complaint that comes to him. I am getting around to question 5: If the Ombudsman intends to continue to conduct further reviews of fatal assaults and neglected children and young people, does he do that automatically in the case of young people and children or does it have to be triggered by a complaint. The answer we seemed to get yesterday was that he had to be driven by a complaint to act. Do you in fact act as a complaint person?

Ms CALVERT: In relation to children it is slightly different. Under part 6 of the Community Services (Complaints, Reviews and Monitoring) Act 1993 the Ombudsman is required to monitor, review and formulate recommendations in relation to deaths of a child in care; a child who died within three years of being the subject of a risk of harm report to

DOCS or was a sibling of such a child; a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances; a child who died while an inmate of a children's detention centre, a correctional centre or a lock-up; and a child or adult who died while living in a disability residential care service. He is required to investigate those deaths and to report on them annually.

Mr JOHN BARTLETT: And that will continue?

Ms CALVERT: That will continue.

Mr JOHN BARTLETT: Even without a complaint.

Ms CALVERT: Even without a complaint.

Mr BARRY COLLIER: Looking at page 39 of your report, fatal assault non-accidental injury, it states, "Twenty children, seven males, 13 females aged between seven week and six years died from non-accidental injury." The last sentence states, "All but two of the fatal non-accidental injuries occurred within the family. The suspects were the biological parents, 13, and mother's de facto, three."

Ms CALVERT: Yes.

Mr BARRY COLLIER: I find that extraordinary because the view out there tends to be that it is most likely to be mum's de facto who does the damage. That is wrong, is it?

Ms CALVERT: Yes. It is the parent.

Mr BARRY COLLIER: Is that a common misnomer out there that it is the de facto killing these children?

Ms CALVERT: You need to be careful about what ages you are talking about. Certainly, the younger the child is, the more likely it is to be a family member, that is a parent, who kills the child. Once the child is over 14 years then it is rarely a parent who kills the teenager and it tends to be a peer or someone older than them who kills them. But certainly for younger children, it is the parent who kills the child.

Mr BARRY COLLIER: There is a feeling in the community—maybe I have got it wrong—that it is the de facto who assaults and kills children, but it depends on the age group.

CHAIR: I think there have been some highly publicised cases as part of that perception.

Ms CALVERT: And I think that is the value of the Child Death Review Team because it looks at all of the cases and then is able to correct those perceptions by providing facts.

Mr BARRY COLLIER: Have they corrected that one?

Ms CALVERT: We try.

The Hon. MELINDA PAVEY: Thirty-nine children and young people who died had been the subject of 110 reports to the Department of Community Services prior to their death. Twenty-three died as a result of assault and 15 died as a result of neglect and one child died in suspicious circumstances. Are you satisfied with the level of interagency co-operation when you have 39 children dying that have been the subject of a DOCS investigation?

Ms CALVERT: The CDRT in fact recommended that the Government consider undertaking a research study into the factors that promote or hinder adherence to interagency policy and practice because those results do indicate that there are some difficulties and concerns. The Team was concerned about that and in fact made a recommendation relating to further work being done.

The Hon. MELINDA PAVEY: What was that recommendation?

Ms CALVERT: That is a recommendation of that report that you are looking at.

The Hon. MELINDA PAVEY: In relation to Aboriginal children—well overrepresented in the statistics, four times the rate of other children—what measures is the Government taking to help that issue?

Ms CALVERT: I suspect you would need to ask Government that.

The Hon. MELINDA PAVEY: Are you happy with the measures the Government is looking at?

CHAIR: I do not know that that is a matter for Ms Calvert to comment on, but rather for our processes to have a look at in the adversarial system that we have.

Ms CALVERT: I bow to your ruling, Madam Chair.

CHAIR: That is my ruling. We will go on to the next report.

(The Committee adjourned at 3.45 p.m.)

Chapter Three - Follow-up to Questions on Notice

The Report makes the following two recommendations:

(a) That the NSW Government consider undertaking a comparative research study to identify differences between reported children and young people who are injured, and reported children and young people who are fatally assaulted, to inform interagency practice and response; and
(b) That the NSW Government consider undertaking a research study into the factors that promote and hinder adherence to interagency policy and practice.

What has been the response to the recommendations contained in the report? In particular, has any agency conducted the proposed research and, if not, would it be appropriate for the Commission for Children and Young People to undertake such research?

Recommendation 1(a) has not yet been supported as a research priority by the Department of Community Services. The Department of Community Services' Research Advisory Council is currently undertaking a literature review on child deaths. In addition, the Department of Community Services' Child Deaths and Critical Reports Unit has commenced a project to redesign its data capabilities relating to child deaths.

The Child Death Review Team will review progress on these projects in its next Annual Report.

In relation to recommendation 1(b), the Child Protection Senior Officers Group has conducted a small scale review of agency practice in relation to the Interagency Guidelines for Child Protection Intervention. The project helped identify barriers to good interagency practice and to the use of the Guidelines.

The findings have informed the Child Protection Senior Officers Group's 2004-05 work plan, which includes updating the Interagency Guidelines to better reflect contemporary interagency and intra-agency structures and arrangements.

The Child Protection Senior Officers Group will also undertake a campaign to promote the Guidelines.

Regarding whether it would be appropriate for the Commission to undertake the proposed research, the Commission does not have ready access to the data, particularly data on children reported to the Department of Community Services who are injured. For this reason, the Child Death Review Team recommended that the Government undertake this project.

The Child Death Review Team Annual Report for 2001-2002 noted that children and young people from rural and regional NSW die at a greater rate than their urban counterparts, and are particularly at risk from transport incidents, drowning, abuse and neglect. Has there been any change in this trend found during the research for the *Fatal Assault and Neglect* report?

Fatal assault and neglect are rare events. Over the three year study period, there were 75 cases. The numbers become very small when we look at deaths year by year at geographic locations. For example, there were only three fatal assault and neglect deaths in remote areas over the three year study period.

Small variations in the number of deaths can double the observed rate. As a result any trend should be interpreted with caution. Deaths need to be monitored over at least 10 years before trends can be confidently looked at.

However, more generally, the trend for children and young people in remote areas to die at a greater rate for all causes of death was observed again in the 2003 Child Death Review Team's Annual Report.

Question taken on Notice during 23 November hearing

The Hon. MELINDA PAVEY:
I think it is important for the community to understand that it is okay to have your child in bed with you but not if you are drunk or stoned. I think the community has a right to know as much evidence as is available, rather than saying you should not sleep with your child.

Response:
I need to distinguish between bed sharing and co-sleeping.

Bed sharing means circumstances where a carer and a baby share a bed for the purpose of feeding and settling.

Co-sleeping means a carer and baby sharing the same sleeping location.

It is generally agreed that the potential for accidental death is increased by co-sleeping. If infants are sleeping with parents, safe sleeping conditions for the infant are needed. This includes the infant sleeping on their back on a firm surface without pillows and immobilised in some way to prevent them sliding down under the bedclothes or becoming wedged.

The American Academy of Pediatrics also suggest that parents who choose to co-sleep with their infants should not smoke or use other substances such as alcohol or drugs that may impair arousal. As an alternative to co-sleeping they suggest that parents place the infant's crib near their bed to allow for more convenient feeding and parent contact.

I anticipate that the Child Death Review Team's special report into sudden unexpected deaths of infants will be tabled early next year. This report addresses the issues associated with co-sleeping.

Appendix 1: Committee Minutes

PARLIAMENT OF NEW SOUTH WALES
COMMITTEE ON CHILDREN AND YOUNG PEOPLE

Minutes of Proceedings of the Committee on Children and Young People
Tuesday 23 November 2004 at 2.00pm
Room 814/815, Parliament House

Members Present
Ms Perry (Chair), Mr Bartlett, Ms Burnswoods (Vice-Chair), Mr Cansdell, Mr Catanzariti, Mr Collier, Ms Griffin, Ms Hale, Ms Hopwood, Ms Judge and Ms Pavey.

Also in Attendance
Helen Minnican, Hilary Parker, Pru Sheaves

PUBLIC HEARING

…

2. **REVIEW OF THE CHILD DEATH REVIEW TEAM REPORT *FATAL ASSAULT AND NEGLECT OF CHILDREN AND YOUNG PEOPLE***

The hearing resumed at 3.15pm.

Ms Gillian Elizabeth Calvert, Commissioner, NSW Commission for Children and Young People, on former affirmation.

The Chair questioned the Commissioner, followed by other Members of the Committee.

Questioning concluded on the *Fatal Assault Report*, the Committee adjourned at 3.45pm.

…

The Chair then thanked the witness and the witness withdrew. The Committee adjourned the hearing at 4.09pm.

Chair

Committee Manager