PARLIAMENT OF NEW SOUTH WALES

COMMITTEE ON THE OMBUDSMAN, THE POLICE INTEGRITY COMMISSION AND THE CRIME COMMISSION

REPORT ON THE FIRST GENERAL MEETING WITH THE CONVENOR OF THE CHILD DEATH REVIEW TEAM

REPORT 1/55 – DECEMBER 2012

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission

Report on the General Meeting with the NSW Ombudsman regarding the 2010 annual report of the Child Death Review Team / Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission . [Sydney, N.S.W.] : the Committee, 2012. – [v] p. 46; 30 cm. (Report ; no. 1/55).

Chair: The Hon. Catherine Cusack, MLC.

"December 2012".

ISBN 9781921686504

1. New South Wales Child Death Review Team. Annual report ; 2010.
2. Children—Mortality—New South Wales.
3. Sudden death in children—New South Wales.

I. Title
II. Cusack, Catherine.
III. NSW Ombudsman.
IV. Series: New South Wales. Parliament. Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission. Report ; no. 1/55

362.709944 (DDC22)

The motto of the coat of arms for the state of New South Wales is "Orta recens quam pura nites". It is written in Latin and means "newly risen, how brightly you shine".

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Terms of Reference

The Committee on the Ombudsman, the Police Integrity Commission and the Crime Commission is constituted under Part 4A of the *Ombudsman Act 1974*. The functions of the Committee under the Ombudsman Act are set out in section 31B(1) as follows:

- to monitor and to review the exercise by the Ombudsman of the Ombudsman's functions under this or any other Act;
- to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Ombudsman or connected with the exercise of the Ombudsman's functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed;
- to examine each annual and other report made by the Ombudsman, and presented to Parliament, under this or any other Act and to report to both Houses of Parliament on any matter appearing in, or arising out of, any such report;
- to report to both Houses of Parliament any change that the Joint Committee considers desirable to the functions, structures and procedures of the Office of the Ombudsman;
- to inquire into any question in connection with the Joint Committee's functions which is referred to it by both Houses of Parliament, and to report to both Houses on that question.

These functions may be exercised in respect of matters occurring before or after the commencement of this section of the Act.

Section 31B(2) of the Ombudsman Act specifies that the Committee is not authorised:

- to investigate a matter relating to particular conduct; or
- to reconsider a decision to investigate, not to investigate or to discontinue investigation of a particular complaint; or
- to exercise any function referred to in subsection (1) in relation to any report under section 27; or
- to reconsider the findings, recommendations, determinations or other decisions of the Ombudsman, or of any other person, in relation to a particular investigation or complaint or in relation to any particular conduct the subject of a report under section 27; or
- to exercise any function referred to in subsection (1) in relation to the Ombudsman's functions under the *Telecommunications (Interception) (New South Wales) Act 1987*.

The Committee's oversight of the NSW Ombudsman includes oversight of his role as Convener of the Child Death Review Team, which was transferred to his office in February 2011. Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*

governs the work of the Child Death Review Team, with sub-section 34C(2) outlining that the Ombudsman is to convene the Team.

Chair's Foreword

This was the first year in which the Committee on the Office of the Ombudsman and the Police Integrity Commission met with the Ombudsman in his capacity as the Convener of the Child Death Review Team.

Since the Ombudsman took responsibility for this Team in 2011 he has faced considerable challenges in ensuring that the team is properly resourced and able to fulfil its statutory functions. A major concern for the Ombudsman has related to technological platforms and data integrity issues. The Committee understands that the current data collection and analysis system does not allow detailed and accurate analysis to be undertaken, one of the prime responsibilities of the Team. The Ombudsman is in the process of addressing this through business and budget planning and the Committee supports him in these efforts.

The general meeting provided the Committee and the Ombudsman with an opportunity to discuss concerns about cross-jurisdictional reporting of child deaths. It is clear that there are discrepancies in the way the deaths of children who die in a different state to their home state are reported, and this affects the overall analysis that is underpinned by this data. This is a complicated issue of serious concern to the Committee, and the Committee is keen to see it resolved.

The Committee appreciates that the Ombudsman has worked with limited resources since taking on responsibility for the Child Death Review Team and has established a team and completed an annual report as well as making considerable progress toward resolving data collection and storage issues. The Ombudsman is in the process of conducting a project examining sudden unexpected death in infancy and this is expected to be finalised in 2013.

The Committee thanks the Ombudsman for his time during the general meeting and commends him for the achievements of his office in circumstances of limited resources.

The Hon. Catherine Cusack MLC
Chair

Chapter One – Commentary

1.1 On 18 June 2012, as part of its general meeting with the New South Wales Ombudsman, the Committee met with the Ombudsman, Mr Bruce Barbour, in his capacity as Convener of the Child Death Review Team. Ms Monica Wolf, Director Systemic Reviews, and Mr Jonathan Gillis, Deputy Convener also attended the general meeting.

1.2 As part of its preparation for the general meeting, the Committee sent to the Ombudsman a series of questions on notice arising from the matters canvassed in the Child Death Review Team Annual Report for 2010. The answers to these questions on notice can be found at Chapter Two of this report.

1.3 Responsibility for the Child Death Review Team transferred from the Commission for Children and Young People to the NSW Ombudsman in February 2011 but it was not until November 2011 that the team was fully operational. During this period of transition, the Ombudsman, as Convener of the Child Death Review Team, has faced significant challenges in ensuring that the team is properly established. Some of these issues are outlined below.

1.4 The general meeting heard evidence in relation to issues arising out of the Annual Report as well as current issues relevant to the Ombudsman's jurisdiction. The commentary that follows focuses on a number of these issues including funding, concerns with respect to data integrity, technical database issues and state based legislative constraints.

DATA ISSUES

1.5 During the general meeting, the Ombudsman noted that there are technical problems with methodology used by the Team in capturing and storing data, and that this limits the capacity of the team to provide accurate analyses:

> As I indicated in my response to questions on notice, we have found that the child death register has outgrown its original platform and has limited reporting and analytical capability. Because of its limited capacity, the database is now in two segments, linked by a separate program. One of the main functions of the team – to identify trends and patterns – has been, and remains, somewhat hampered by this unsophisticated technology.[1]

1.6 The Ombudsman informed the Committee that he had conducted a review of the way in which the Child Death Review Team reported on patterns and trends. A key element of this assessment involved the use of an external review to evaluate the Team's processes. This external review was undertaken by the National Centre for Health information Research and Training at the Queensland University of Technology and confirmed the view of the Ombudsman that:

[1] Mr Bruce Barbour, Ombudsman, NSW Ombudsman, *Transcript of evidence*, 18 June 2012, p. 21.

> In summary, the approach to reporting was largely descriptive and it provided little interpretation of patterns and trends and what these might mean in a preventative sense.[2]

1.7 The Ombudsman described the way in which the data was presented when he commenced his role as Convenor as only allowing for limited analysis to be performed. This meant that, for example, the reporting focus was on children who died *with* a certain condition, rather than *of* a certain (underlying) condition. While the data is not being stored and reported upon accurately, the reliability and integrity of its analysis is likely to be compromised.

1.8 Following the recognition of these issues, the Ombudsman made changes to the Team's reporting processes. He noted that there had been a limited response to these changes:

> Under significant time constraints, and in consultation with existing members of the team, we changed the reporting approach to address these issues. Given the changes we made and the concerns that had been expressed to me about how policy-makers would view this change, I included in the report a link to an electronic survey to find out whether these people were happy with the changes, or otherwise. Interestingly, since tabling the report last year, we have received only 15 responses; and the responses within that 15 were mainly positive.[3]

1.9 In addition to uncertainties with respect to the integrity of data that is captured and stored on the Child Death Register, there are technical problems relating to the management of that information. The Ombudsman described the technical problems with the database:

> It is breaking down. It is built on a very unsafe platform that is not designed to hold so much data.[4]

1.10 External consultants have reviewed the business and data needs of the Child Death Review Team and provided a cost estimate in the order of $250,000 to implement a system that would enable best practice reporting.[5] The Ombudsman told the Committee that the Team intends to make an enhancement bid from the Budget to cover this cost:

> But we are also going to need to look at if that is rejected whether or not we are going to need to try to find funds somehow from within the office.[6]

1.11 The Committee understands the importance of accurate data to the work of the team and will monitor progress that is made in this area.

CROSS JURISDICTIONAL ISSUES

1.12 During discussion between Committee and the Ombudsman it became apparent that there are serious and significant issues with respect to the way in which child

[2] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 21.

[3] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 21.

[4] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 26.

[5] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 25.

[6] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 26.

deaths are recorded and reported across different jurisdictions within Australia. Of particular concern is the fact that a child's death is included in the records of the state where the record is made, and not necessarily recorded in the state where the child died. The Chair of the Committee explained:

> With the data collection, the problem with the New South Wales' children's deaths where the death certificate is issued interstate – for example, at a hospital in Brisbane – is that for many years that data was not captured in the New South Wales Child Death Team Review Reports.[7]

1.13 The Chair outlined her concerns that vital information with respect to child deaths is missing from the Child Death Review Team analysis due to a lack of information that can be obtained across state borders:

> I live in Northern New South Wales and the second Child Death Review Team report listed no drowning of children in northern New South Wales and we all knew locally that that was untrue; there had been a number of child drownings. The police and the paramedics attend, people do not want to leave the body there and distress the family so they take the child to Brisbane Hospital – a helicopter takes that child to Brisbane Hospital where the death certificate is issued and that death is not being included in any of the statistics. I assume that this is also a problem around Canberra and it is also a problem potentially in places like Broken Hill where children who are seriously ill or seriously injured are being transferred to interstate hospitals. New South Wales has a lot of cross borders and I would put it to you that this is not a small matter and it affects the statistics of those communities and the direction of resources if that information is not being captured.[8]

1.14 The Ombudsman agreed that this is a matter of some concern, and while the Child Death Review Team endeavours to obtain relevant information, they are limited by the legislation:

> Unfortunately the way the legislation is drafted at the moment the register and what goes on the register and what we are supposed to technically report on each year is quite limited.
>
> You are quite right, there will be from time to time deaths that will fit within those circumstances and which create some problems in terms of them being regarded as a statistic for New South Wales. It is certainly something we are live to, but it would require legislative amendment and it would also require us to be able to get access to that information. One of the challenges is we can obviously get access to information that is created and arises in New South Wales but if there are doctors that treat and hospitals that deal with cases, we may not be able, with our legislation, to secure information from those places because we would not have a legal right to obtain it. That is why we seek the information from the other death review teams who would be looking at those deaths.[9]

[7] The Hon Catherine Cusack MLC, Chair, *Transcript of evidence*, 18 June 2012, p. 22.

[8] The Hon Catherine Cusack MLC, Chair, *Transcript of evidence*, 18 June 2012, p. 22.

[9] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p.23.

1.15 The Chair pointed out that not only does this problem affect the statistics of remote and rural areas through depressing their number of child deaths, but it is also likely to have a significant impact on organ retrieval.[10]

1.16 The Chair expressed the view that this is a serious issue that needs to be addressed:

> Can I ask that you inquire into that matter because it is not a few deaths here or there that are going missing, it is a very substantial number and it virtually renders the entire work of the committee useless for a very substantial part of the State? Also, that then impacts on information in terms of rural and remote deaths because, I would suggest to you, even though they stand out as having a higher morbidity rate that is probably an understatement due to these deaths not being captured.[11]

1.17 The Ombudsman agreed and noted that this would require a national approach:

> But certainly I agree with the concern, and it would require legislative amendment and I think it would require probably a universal position to be developed by all State agencies because it raises issues with every single State, obviously not just Queensland. Each State has got different teams, different registration systems and different processes. So I think to get to the bottom of the heart of the issues that you are talking about it would require a great deal of support that was across borders to have a uniform system in place.[12]

1.18 The Chair and the Ombudsman discussed how national unity on this issue may be achieved:

> CHAIR: But really all you need is the Premiers to sit down and say, "This is important, we'll do it", and it could be done, could it not?
>
> Mr BARBOUR: If you can get the Premiers to do that it could be done. I am not sure I would have much success in doing that.[13]

1.19 Although the discussion during the general meeting indicated that there is little the Ombudsman can do to rectify the situation whereby it is currently possible for child deaths not to be correctly attributed to their home state, in his answers to the Questions on Notice prior to the general meeting, the Ombudsman discussed the Australian and New Zealand Child Death Prevention Group:

> The aim of the group is to identify and share information about trends and issues in infant, child and youth mortality, and to work collaboratively towards national and international reporting. Although capacity to exchange information varies, the group is committed to working to achieve national consistency in reporting, particularly in relation to the risk factors associated with child deaths and injuries.
>
> ...In addition, most states now formally exchange information (generally on a de-identified basis) about the deaths of children who die in a different state to the child's home state.[14]

[10] The Hon Catherine Cusack MLC, *Transcript of evidence*, 18 June 2012, p. 23.

[11] The Hon Catherine Cusack MLC, *Transcript of evidence*, 18 June 2012, p. 23.

[12] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 24.

[13] The Hon Catherine Cusack MLC, and Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 24.

1.20 The Committee will follow the work of the Australian and New Zealand Child Death Prevention Group with interest to better ascertain whether the work of this Group is sufficient to address the concerns outlined by the Chair above.

BUDGET

1.21 In his answers to Questions on Notice the Ombudsman outlined the original budget estimates and the actual needs of the unit now that it is established.

> In September 2009, we provided an estimate of what we believed would be the minimum level of funding to perform the Child Death Review Team functions. We estimated this to be $539,000 per annum. As we have progressed the work however, it has become apparent that this level of funding is not sufficient to meet necessary staffing and infrastructure costs.[15]

1.22 Whilst the Ombudsman has reported that additional staff costs have been met to date, new positions and upgrades to current positions have been identified as necessary to properly undertake the work of the Team. Significant infrastructure needs have also been identified. Of critical importance is the need to review, and likely update, the Child Death Register. The Ombudsman expressed the view to the Committee that:

> the costs of building a new and effective technology solution are likely to be substantial.[16]

1.23 With respect to securing further funding, the Ombudsman told the Committee that:

> We have not sought the dollars yet. We have just finished doing the business case and the analysis. We have had an external team of consultants come in and review it for us. They have reviewed not only the system in place but what our needs are and what our reporting obligations are and they are looking at it in terms of best practice reporting across the board. We have only just received the estimate costing and it is in the order of a quarter of a million dollars.[17]

1.24 The amount of money has not yet been fully estimated but the Ombudsman expects to seek additional funding as part of the 2013-2014 budget cycle.[18]

CURRENT THEMES

1.25 The Child Death Review Team has reported that the two leading external causes of death for children and young people are transport incidents and drowning.[19]

1.26 In the past year the Child Death Review Team has provided a submission to the review of the Swimming Pools Act and released an issues paper on swimming pool drowning deaths. In addition to this, the Team has established connections

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[14] NSW Ombudsman, *Answers to Questions on Notice*, 7 May 2012, p. 38, question 9.

[15] NSW Ombudsman, *Answers to Questions on Notice,* p. 18, question 21.

[16] NSW Ombudsman, *Answers to Questions on Notice,* p. 19, question 21.

[17] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 25.

[18] NSW Ombudsman, *Answers to Questions on Notice* p. 19, question 21.

[19] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 20.

with related agencies such as the Australian Medical Association, Royal Life Saving and Kidsafe in order to promote safety around swimming pools.[20]

1.27 Sudden Unexplained Death in Infancy (SUDI) is an ongoing area of concern. The Chair noted that seventeen of the 50 infants who died of SUDI had previously been the subject of a report of a risk of harm, and a further six had siblings who had been reported as being at risk.

> I wonder if there is some means, given that so many of those sudden infant death syndrome deaths are of children known, or whose sibling is known, to the Department of Community Services (DOCS) – I think that would make it half of the sudden infant death syndrome deaths now – if there is a way that the Department of Health and the Department of Community Services should be focusing on this?[21]

1.28 The Ombudsman responded that this is an area of concern that the Child Death Review Team has investigated in the past and some of their recommendations have been incorporated into Department of Health protocols:

> Of course, our work in relation to reviewable child deaths and broader child protection is also focussed on this in other ways. We have certainly been monitoring that since we took over the team. We recently engaged in correspondence with the Department of Health to determine whether or not these new policies are working, what audit they have done in relation to them, and to see, in an evaluative sense if you like, how those processes are going. We are continuing in relation to that. Interestingly and on point, the team has agreed that the major project work that will do in 2013 is going to look at deaths of children who have also had a child protection history. That potentially will be one component of that work as well.[22]

1.29 Following further discussion with the Committee the Ombudsman undertook to provide the Committee with further information on what types of programs and services the Department of Community Services provides to at-risk children and families, both indigenous and non-indigenous. In his follow-up answers, the Ombudsman noted previous work which the Child Deaths and Critical Reports Unit has done on a co-sleeping project and likely future work reviewing those children who died of SUDI and had a child protection history. See Chapter 3 for his full response.

1.30 The Ombudsman explained that the Child Death Review Team has a role in reviewing the deaths of children who die in suspicious circumstances, of abuse or of neglect and that these children have often been the subject of a report to the Department of Community Services. He told the Committee that:

> …However, we are doing that project that I referred to earlier. It will be a significant project and it will be looking at the deaths of children over a 10-year period?...Over a 10-year period of our records that have had some sort of a child protection history and we will be looking at what those deaths were, how preventable they were, what the data provides us. We are doing it for the very same reasons of interest that you

[20] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 22.

[21] The Hon Catherine Cusack MLC, *Transcript of evidence*, 18 June 2012 p. 26.

[22] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 27.

> are referring to. That has been agreed to by the team and that will be reported in 2013.[23]

ACHIEVEMENTS

1.31 The Committee appreciates that the Ombudsman has established a unit and furnished an annual report with limited resources and while facing considerable data integrity issues. The Committee notes that the annual report has been successfully completed and the Child Death Review Team is currently working towards improving the way data is collected and analysed, which will have a positive impact on the work produced by the Team.

1.32 Discussion between the Chair and the Ombudsman focused on the nature of the work that the Child Death Review Team performs, including the review of individual cases and the identification of trends, with this information then being used to inform preventative policy. The Ombudsman acknowledged that it can be difficult to identify concrete outcomes from this work but:

> You can see significant reduction trends or significant trends which are reductions in some areas of deaths. I am sure that is due to improvements in prevention and the work that is being undertaken in those reviews.[24]

1.33 The Chair asked the Ombudsman his opinion of the effectiveness of the Team's work:

> CHAIR: I suppose from the public perspective, the question is: Are we getting better at preventing deaths of vulnerable children in care? Do we know the answer to that question?
>
> Mr BARBOUR: I wish I could say yes or no but it is a far more complicated question because apart from anything else the system in care has changed and continues to change. Overall, I think the statistics are not getting worse but what we are reviewing is whether or not they ought to be improving. That is what our reviewable death work largely goes to and focuses on, as well as the prevention focus from the Child Death Review Team.[25]

1.34 In noting the achievements of his office, the Ombudsman outlined some of the ongoing issues with which his office has made progress over the past year:

> We have progressed a number of issues of long-term interest to the team; these include actively pursuing monitoring of recommendations made by the team in relation to sudden unexpected death in infancy (SUDI) and representations to the Department of Forensic Medicine, the Office of the Coroner and the Minister for Health in relation to delays in forensic and coronial processes.[26]

CONCLUSION

1.35 The Committee appreciates that the Ombudsman has convened the Child Death Review Team in an effective manner since assuming responsibility for the team

[23] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 30.

[24] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 31.

[25] The Hon Catherine Cusack MLC, and Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 30.

[26] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 22.

and this has included the completion of important papers such as the submission for the review of the Swimming Pools Act, reports such as the 2010 Annual Report, and the review of internal work and procedures.[27]

1.36 The Committee also appreciates that one of the key benefits the Child Death Review Team provides is a comprehensive analysis which informs policy on matters relating to the deaths of children and young people.

1.37 Whilst the issues, administrative and budgetary matters facing the Team are significant, the Ombudsman told the Committee that:

> I believe the work we are doing is providing a significantly positive contribution.[28]

1.38 Based on the information available, the Committee is satisfied that the Child Death Review Team is operating in an effective manner and is keen to support the Team to achieve its objectives.

[27] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 22.

[28] Mr Bruce Barbour, *Transcript of evidence*, 18 June 2012, p. 31.

Chapter Two – Answers to Questions on Notice

NSW Child Death Review Team Annual Report 2010

QUESTION ONE:

At the time of writing the Annual Report you stated that there were outstanding issues around the legislative amendments necessary to transfer the function of the CDRT to the Ombudsman. Have these issues been satisfactorily resolved?

RESPONSE:

Almost all legislative issues have since been resolved.

The legislative provisions for the transfer generated a range of issues. Some administrative complexities were addressed in part through 'machinery' changes in November 2010. However, at the time of writing the CDRT Annual Report in mid to late 2011, significant problems with the legislation were still apparent.

Most problematic was that the legislation governing the Team had been retained in the *Commission for Children and Young People Act*. This effectively tied certain CDRT functions to Commission functions, and incorporated provisions relevant to the work of that agency that were unsuitable for the Office of the Ombudsman. For example, the Ombudsman, as Convenor of the CDRT, was required to provide a draft report to a Minister prior to tabling the report in Parliament. Retention of the legislation in that Act also required the Ombudsman to report to two different Joint Parliamentary Committees on overlapping work.

In April 2011, we wrote to the Premier seeking further legislative change, with a specific request for the legislation to be moved to the *Community Services (Complaints, Reviews and Monitoring) Act* (CS CRAMA).

In November 2011, Parliament passed the *Children Legislative Amendment (Child Death Review Team) Act 2011*, which provided for the majority of changes we sought.

In particular, the legislation governing the Team now sits as Part 5A within CS CRAMA; the Team is required to provide a *final* report to the Minister, with no requirement to provide a draft report. The oversighting parliamentary committee is the Joint Parliamentary Committee on the Police Integrity Commission and the Ombudsman.

There is only one provision that we sought that has not been implemented. Section 34P (1) provides that the Minister has responsibility for review of the validity of the policy objectives of Part 5A CS CRAMA. We had proposed that responsibility for such review would most appropriately sit with the Joint Parliamentary Committee.

QUESTION TWO:

You state that it is priority to determine a valid and reliable measure of socioeconomic status as the current instrument is not satisfactory. What is the progress on developing this?

RESPONSE:

We have engaged Professor Peter Saunders from the Social Policy Research Centre at the University of NSW to undertake a review of appropriate options for measuring and reporting socioeconomic status in relation to children who die. In addition and related to this, Professor Saunders will also advise on appropriate options for analysing and reporting child deaths in NSW on a geographic basis.

The advice will consist of a review and commentary about previous methods used by the Team; strengths and weaknesses of various methods used in social research; and in the context of the Team's purpose and access to data, methods the Team could adopt to effectively measure and report – including reporting on trends over time – socioeconomic status and child deaths by geographic location.

We anticipate the work will be completed by late June 2012.

QUESTION THREE:

You acknowledge the difficulties that may occur in making a correct determination of a person's indigenous status, particularly if one relies solely on birth and death records. Has the Team developed any internal policies or guidelines for staff in making such assessments, or is this still carried out in a relatively ad hoc manner?

RESPONSE:

We have developed internal policies and guidelines for staff in order to make assessments of Aboriginal or Torres Strait Islander status as accurately as possible.

Aboriginal or Torres Strait Islander status of children is determined following assessment of individual and family records accessed through:

- Registry of Births, Deaths and Marriages, related to the child's death
- Registry of Births, Deaths and Marriages, related to the child's birth
- NSW Perinatal Data Collection
- A range of government and non-government and private provider agencies, including police records, coronial records, health records, education records, community services records, non-government support service records, or private health provider records.

Staff record a child as Aboriginal or Torres Strait Islander if BDM data records a child as such, and/or where other information reviewed provides reasonable evidence that a child is of Aboriginal or Torres Strait Islander background. This process does require judgement on the part of a review officer, however where there is uncertainty, the decision is referred to senior and/or principal review staff.

In the 2010 report, the Team provided information about Aboriginal and Torres Strait islander status according to BDM data only, and in comparison, BDM and other sources. The comparative information will also be included in the report on deaths in 2011.

QUESTION FOUR

You note that Aboriginal children have a much higher rate of injury related death than non-Aboriginal children. Has the Team considered what type of response or research might be best in addressing this issue?

RESPONSE:

The Team has consistently identified an overall higher mortality rate for Aboriginal children, including among injury related deaths. To date, the Team has not identified any particular response that could address this issue, nor has the Team proposed specific research about injury related rates of death of Aboriginal children.

QUESTION FIVE

Seventeen of the fifty (34%) infants who died from Sudden Unexpected Death in infancy had previously been the subject of a report of risk of harm and a further six also had siblings who were reported as being at risk. Has the Team considered what type of response or research might best address this issue?

RESPONSE:

The Team has not considered any particular specific response to SUDI in the context of child protection history. SUDI is a complex area that continues to be a significant focus for the Team (refer question 8). We will continue to examine SUDI cases with a view to identifying any feasible preventive strategies, including specific child protection interventions.

This issue was however considered in some detail in the Ombudsman's *Report of reviewable deaths in 2008 – 2009* (August 2011). Of 90 SUDI in NSW in this period, 10 were reviewable. Eight of the ten families had a child protection history. The report notes some concerns identified about the response to child protection concerns by Community Services in five of these cases. These concerns mirror broader systemic issues about cases being closed while risks were still apparent, lack of timely and/or comprehensive risk assessment, and inadequate support to young parents. The five deaths were also subject to review by the Community Services Child Death and Critical Reports Unit, which identified similar concerns. The Unit's reviews resulted in practice and case reviews to incorporate lessons into current policy and practice.

The *Report of reviewable deaths* also describes relevant child protection initiatives, including:

- Community Services' *Safer Sleep* resource pack to assist caseworkers to highlight the risks of co-sleeping with parents and carers, and to promote safe sleeping options. The agency has also developed similar resources targeted specifically to Aboriginal families;

- Certain initiatives under Keep Them Safe, including the expansion of home health visiting services to work intensively with vulnerable families in pregnancy and in the first two years of life; and

- NSW Health drugs in pregnancy services, which have subject to review and development following a previous recommendation of the Ombudsman.

These issues, and the progress of various initiatives, will inform both the work of the Ombudsman and the CDRT in consideration of any recommended responses to prevent or minimise SUDI in families with a child protection history.

QUESTION SIX:

In June 2011 the Dept of Premier and Cabinet advised the Team that the Department was reviewing recommendations made around the inspection of swimming pools by local authorities. Are you aware of any updates of this review and if the recommendations have been accepted?

RESPONSE:

In January 2012, the Division of Local Government advised us that the Government was seeking views about proposed amendments to the *Swimming Pools Act 1992* to increase the safety of very young children. We were invited to make a submission to the Division on the review discussion paper.

The main amendments to the Act proposed in the discussion paper are new requirements for private swimming pool owners to register their pool with their local council and to self-certify the pool barrier's compliance with the *Swimming Pools Act*; and new requirements for councils to undertake private swimming pool inspections within their local government areas.

We provided a submission to the review in February 2012. The submission included an analysis of CDRT and reviewable death information relating to 40 children who drowned in private swimming pools over a five year period (2007 – 2011). The findings from this work provide support for the proposed changes to the Act.

The CDRT has prepared a public issues paper on the drowning deaths of children in swimming pools (see Attachment A).
Submissions are now closed and we are awaiting the outcomes of the review.

QUESTION SEVEN:

Can you provide an overview of how you are monitoring the implementation of the Keep Them Safe program?

RESPONSE:

Through our complaints, reviews, investigations and consultation work, we have been closely monitoring the implementation of Keep Them Safe since it commenced in January 2010. In the early phases of implementation, we consulted widely with key stakeholders including government agencies, non-government peak organisations, service providers and frontline human service, health and education staff to identify emerging issues relating to the capacity of the new system to meet the needs of vulnerable children and families.

After the new system had been operating for just over 12 months, we initiated an Inquiry in March 2011 to examine whether the post-reform capacity of the child protection system to respond to children at risk of significant harm had improved as a result of Keep Them Safe.

In August 2011, we tabled in Parliament our report, *Keep Them Safe?* which, amongst other things, found that despite a significant drop in demand as a result of changes to the threshold for making a child protection report to Community Services, fewer children were recorded as receiving a face-to-face- assessment under the new system.

Data we sought from Community Services showed that compared to the period before the Special Commission of Inquiry into Child Protection Services in NSW (Wood Inquiry), there was a 55% drop in the number of responses to reports recorded as resulting in a comprehensive face-to-face assessment – 19,826 compared to 46,757. In addition, during the first 12 months of Keep Them Safe, one quarter of reports assessed by Community Services as requiring some form of intervention received no response at all. Given that child protection reports to local Community Service Centres have reduced under the new system by over 100,000 – or more than 50% - we were concerned by the evidence which suggests there had been a substantial decrease in face-to-face work with families.

In responding to our draft report, Community Services acknowledged that the capacity of the statutory child protection system to respond to children at risk of significant harm is inadequate. Our report stressed that in order to address capacity shortcomings, there is a need for Community Services to enhance productivity and to more effectively target existing resources.

Our report also identified a range of major system challenges that need to be addressed before the Wood Inquiry's vision for an improved child protection system can be realised. We targeted recommendations to the Departments of Family and Community Services and Premier and Cabinet aimed at achieving this outcome.

Since we released our report, we have met with senior representatives from both agencies on several occasions to discuss the actions they are taking to address the issues identified in our report. Both agencies have committed to providing us with regular progress reports.

In February 2012, we received the Department of Premier and Cabinet's formal response to our recommendations. Noting that many of the initiatives referred to are in the early stages of development, we provided detailed feedback to the department indicating the areas in which we intend to seek further advice in due course. One of the key areas we will be monitoring closely is the Department of Premier and Cabinet's interim review of Keep Them Safe, which is due to be finalised in December 2012. We have had input into the department's plan for the interim review and the development of related performance indicators.

The Department of Family and Community Services is due to provide us with their response to our recommendations by the end of April 2012.

We will continue to actively monitor the action taken by relevant agencies to deliver on the Wood Inquiry's vision and to address the specific concerns we have raised in our *Keep Them Safe?* report. In particular, we will be keen to see progress in relation to:

- the development and implementation of an 'intelligence-driven' approach to child protection work that would, among other things, enable Community Services and partner agencies to systematically identify children at most risk of experiencing significant harm;

- the implementation by Community Services' of their *Action Plan to Improve Capacity in Child Protection* and related measures to improve productivity and substantially lift responses to risk of significant harm reports*;*

- filling staff vacancies - particularly in the chronically under-resourced Western region of NSW - and employing strategies to retain experienced staff;

- the upgrade of Community Services database to provide frontline staff with the necessary tools to quickly obtain comprehensive child protection history information; and

- the work of the newly formed Keep Them Safe Senior Officer's sub-groups to improve responses to older children and adolescents with complex needs (including those who are habitually absent from school) and to consider how various agencies could potentially play a greater role in providing practical support to families in circumstances where Community Services are unable to lead a child protection response.

QUESTION EIGHT

A Preliminary Investigation of Neonatal SUDI in NSW 1996-2008 made recommendations that were supported by NSW Health. NSW Health advised they would review the relevant policy and reissue it in late 2011 or early 2012. Are you able to provide a progress update on this?

RESPONSE:

The CDRT has actively pursued the progress of NSW Health in relation to reviews of two significant policy directives.

In December 2011, in response to our request, the Director General of the Ministry of Health provided copies of the audits of the policy directives *Death – Management of Sudden Unexpected Death in Infancy* and *Babies Safe Sleeping in NSW Maternity Facilities*.

The Director-General advised us that a full review of the *Babies Safe Sleeping in NSW Maternity Facilities* policy directive was underway, and that the '*having a baby book'*, which is distributed to all women birthing in NSW public health facilities, was also being revised in relation to the safe sleeping section. We were advised that the revised publication would be released in 2012.

In relation to the management of Sudden Unexpected Death in Infancy, an audit of compliance with the Forensic Protocol (which is an appendix to the *Death – management of Sudden Unexpected Death in Infancy*) has led to an early review of this policy directive. The Director-General advised that officers are auditing the compliance of Local Health Districts with the policy directive, with findings of this process expected to be available in mid 2012.

We have reviewed the compliance audit reports with CDRT experts in paediatrics and SUDI (Professor Les White, Professor Heather Jeffery and Dr Bronwyn Gould). In April 2012, we wrote again to the Director-General providing comments on some aspects of the audits. We also sought further advice on the outcome of audit recommendations, and about specific proposals to support the release of revised directives, such as educational resources.

We have requested a meeting with the Deputy Director-General to discuss the protocols in place and how these might be improved, staff education and training strategies, and the potential for a centralised approach to SUDI investigation.

QUESTION NINE

You mention that the formal exchange of information about child deaths between jurisdictions is currently an issue under discussion by the Australian and New Zealand Child Death Prevention Group. Are you able to elaborate on this process?

RESPONSE:

The Australian and New Zealand Child Death Review and Prevention Group brings together agencies that are responsible for review of child deaths in each state and territory, and New Zealand. The group is not a funded entity, and at present, is chaired by the Queensland Commission for Children and Young People.

At present, child death review functions across Australia and New Zealand are at varying stages of implementation and have individual legislative frameworks, jurisdiction, functions and reporting requirements.

The aim of the group is to identify and share information about trends and issues in infant, child and youth mortality, and to work collaboratively towards national and international reporting. Although capacity to exchange information varies, the group is committed to working to achieving national consistency in reporting, particularly in relation to the risk factors associated with child deaths and injuries. This commitment led to the inclusion of the work of the group in developing more consistent data as a strategy under the *National Framework for Protecting Australia's Children 2009–2020*.

Queensland, as the chair of the group, has published a basic national data set in its Child Deaths annual report, which includes data provided by NSW, Queensland, South Australia, Victoria and Tasmania. In addition, most states now formally exchange information (generally on a de-identified basis) about the deaths of children who die in a different state to the child's home state.

In June 2011, the group submitted a funding proposal to the Families, Housing, Community Services and Indigenous Affairs (FaCHSIA) for a project on preventable infant mortality utilising mortality data available from child death review mechanisms in each jurisdiction. The aim of this research was to assist the Commonwealth to establish an evidence-based national agenda for the further prevention of infant deaths by addressing modifiable risk factors. In addition, it was seen as a first major step to a national data collaboration by members.

In September 2011, the Group was advised by FaCHSIA that this proposal was not supported. The group has expressed concern about some assumptions underpinning this decision, including that the project would duplicate existing data collections in each state and territory, which is not the case.

The group has decided to continue to prioritise preventable infant mortality, and is considering how it can progress with a national data collection and analysis.

ATTACHMENT A

This is the attachment 'A' in response to question 6 in relation to the NSW Child Death Review Team 2010.

nsw cdrt child death review team

Child deaths: drowning deaths in private swimming pools in NSW

An occasional series to highlight issues and prevention strategies arising from reviews of the deaths of children in NSW

The NSW Child Death Review Team

The purpose of the NSW Child Death Review Team is to prevent and reduce the deaths of children in NSW. The work of the Team includes identifying trends and undertaking research in relation to child deaths, and making recommendations to prevent or reduce the likelihood of child deaths. The NSW Ombudsman is the Team's Convenor.

Drowning deaths of children in private swimming pools - NSW

On average, six children drown in private swimming pools in NSW each year. This figure has remained constant over the 15 years the Team has collected this information.

In 2012, the NSW government announced a review of the *Swimming Pools Act*. The Act, among other things, deals with requirements for child resistant safety barriers around private swimming pools.

This paper describes the findings of our review of the drowning deaths of children in private pools in NSW for the five years between 2007 and 2011. Over this five year period, the Team registered the deaths of 40 children.

The children

Most of the 40 children who drowned (24) were male; 16 were female.

The majority of the children (34 of 40) were under five years of age. Most of the under-fives (30) were aged three years or less, and more than half of the under-fives (18) were aged two years or less.

Six children were aged between five and nine years. Three of the six older children had a disability, injury or impediment that was a contributing factor in their drowning.

Where the children drowned

Most of the children (27) drowned in a swimming pool at their own home. At least four other children drowned in pools at properties where small children lived. In addition, a number of other children drowned at the homes of relatives, where they were regular visitors.

For the 38 pools where the information was known, most (28) were in-ground or semi-in-ground, and 11 were above ground portable or large inflatable pools.

In most cases, the properties were owned by the child's family. Six properties were rented; four from social housing providers and two from private rental agencies. The pools at four of the rented properties were above ground, portable pools.

The swimming pools: child safety barriers

Information about the standard of pool fences or safety barriers was available for 37 of the pools, and almost all of these (33) did not have a functioning safety barrier.

Unfenced pools

Nine pools were unfenced. Eight of these were above ground pools, all of which were required to have a barrier fence under the *Swimming Pools Act*. One in-ground pool met the criteria for exemption from fencing that the Act provides.

Seven of the nine children who drowned in unfenced pools accessed the pool from the house without the knowledge of supervising adults. Six of these children were under three years of age.

Defective child safety barriers

Twenty eight of the pools were fenced. The safety barriers for 24 of these pools had one or more defects that potentially enabled a child to gain access to the pool area:

- All 24 had reported issues with the gate or latch mechanism. In most cases, this meant that the pool gate did not self-close because it either had no latch mechanism, or the mechanism was damaged, or problems with the gate or fence resulted in the gate jamming open.
- In addition, 15 of the 24 barriers had additional defect(s), mostly related to the fencing. Fourteen fences were defective either due to broken palings or damage, or the fences did not meet the minimum height requirements under the Act. Another five had permanent structures built close to the pool that provided children with a potential climbing frame into the pool area.

For 20 of the children who drowned, investigations following the incident found that the defect was the most likely point at which the child entered the pool area.

Four pools had compliant child safety barriers. The children were either let into the pool area by an adult, or accessed the pool through gates that had been propped open.

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Issues Paper 01
April 2012

ISBN: 978-1-921884-65-8

Child deaths: drowning deaths in private swimming pools in NSW

Adult supervision

All children who drowned did so in the absence of adult supervision.

Royal Life Saving Australia promotes 'active supervision' of children around water. Active supervision means *'focusing all of your attention on your children all of the time, when they are in, on, or around the water. You must be within arms reach of your child and be ready to enter the water in case of emergency.'*[1]

While the level of supervision for some of the children who drowned was significantly inadequate, many of the children were unsupervised for relatively short periods of time, often as a result of a momentary lapse in direct supervision by parent(s) or carers.

For 26 children under five years of age who drowned, details were available about the length of time they were reportedly left unsupervised:

- The majority (15) were reportedly unsupervised for 10 minutes or less, with some children reportedly being out of sight for five minutes or less. Scenarios included parents changing another child's nappy, going to the toilet, cleaning or cooking. Where the child was in or around the pool area, the issue was lack of active arms-length supervision, with the child entering the water unseen.
- Seven children had been unsupervised for longer than 15 minutes. This included children who had been placed for sleep, but awoke earlier than expected and left the house unseen. Other circumstances including the responsible carer attending to other children, or the child leaving the house at a time when families were involved in a number of activities. Unclear responsibility for supervision was also an issue. This was particularly at gatherings of family or friends, and resulted in a situation where the child was assumed to be with another, but was in fact unsupervised.

Preventing drowning deaths in private swimming pools

For parents and carers

Our review of 40 drowning deaths of children in NSW confirms there are two critical factors to keeping children safe around swimming pools:

- Supervise: Adults must actively supervise young children in or around water, and
- Restrict Access: Pool fences must be regularly inspected and maintained to ensure they are - and remain - child resistant. Where a pool is not fenced, it is essential that doors and windows are secured and locks are child resistant.

Pool fences can never take the place of active supervision of children around pools, but where there is a lapse in supervision, a child resistant safety barrier will save lives.

Supervise and restrict access are major component of Royal Lifesaving Australia's Keep Watch program, which also promotes *water aware* and *resuscitate*.

See Royal Lifesaving http://www.royallifesaving.com.au/www/html/156-fact-sheets.asp

For government and policy makers

Relevant government and non-government agencies with a role in regulation of private swimming pools and drowning prevention initiatives should give careful consideration to the findings of our review. In particular:

- Most children drowned in pools at their own home, and in some other cases, in pools at homes where children resided.
- Almost a quarter of the pools in which children drowned were above ground portable pools.
- In all cases where the pool safety barrier was defective, the defects included issues with a gate and/or latch mechanism.
- In many cases, children were unsupervised for a relatively short period of time, during busy or distracting periods for parents or carers.

Six children, on average, die each year in NSW swimming pools. It is difficult to determine the number of near-drowning incidents as there is no centralised data collection that records this information in NSW. Such information is critical to understanding the impact of injury and death, and developing effective prevention strategies.

1 Royal Life Saving Fact Sheet 1 Supervise, accessed http://www.royallifesaving.com.au/resources/documents/Fact_Sheet_No_1_Supervise.pdf

For more detailed information, see the Ombudsman/Child Death Review Team submission to the Swimming Pools Act review, at http://www.ombo.nsw.gov.au/publication/PDF/other reports/Submission to the Swimming Pools Act Review 2012.pdf.

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Chapter Three – Answers to Further Questions on Notice

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The Hon Catherine Cusack, MP
Chair
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and the Police Integrity Commission
Parliament House
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SYDNEY NSW 2000

Dear Madam Chair

Additional question on notice

I refer to Ms Matthews' letter of 30 August requesting additional information as to the types of programs and services Community Services provides with respect to sudden unexpected death in infancy (SUDI) to both indigenous and non-indigenous communities. I am providing the following information as the convenor of the Child Death Review Team ('the Team'). If the Committee has a particular interest in this area, it may also choose to seek additional information from Community Services directly.

There are a number of modifiable risk factors for SUDI, including:

- exposure to tobacco smoke
- infants sharing a sleep surface (particularly when co-sleeping adults are affected by drugs or alcohol)
- not placing infants on their back to sleep
- loose bedding, and
- placing infants for sleep in bedding that is not infant-specific.

In this context, prevention strategies are best addressed across a number of relevant agencies, including NSW Health, Community Services, and non-government agencies such as SiDS and Kids.

In 2010 a significant number of SUDI were from families with a child protection history (23 of the 50 children). Work completed in relation to the Team's 2011 report indicates a similar proportion for this year. Deaths of children known to Community Services are reviewed internally by that agency's Child Deaths and Critical Reports Unit (CDCRU). The Team is likely to recommend this year that the CDRCU conduct a cohort review of SUDI where the children who died were living in a family with a child protection history.

In 2007/2008, the CDCRU conducted a co-sleeping project which focused on parental substance abuse and co-sleeping. The project was action based, with a focus on increasing awareness of staff about the dangers of parental substance abuse and co-sleeping, increasing the confidence and skills of workers to impact positively on the practice of co-sleeping, and the development of resources (posters, magnets etc) that could be used by caseworkers and community agencies to provide clear advice to parents about the risks of co-sleeping while substance affected. The CDCRU has also focused specific work around Aboriginal families and co-sleeping, including production of specific resources and guidance targeted to Aboriginal families.

These concerted efforts in modelling and promoting safe sleep practices and environments are very important, but the Team also believe there is a need to improve the multi-agency response to SUDI. This may include creating a specialist team to manage SUDI investigations.

This and other issues relating to child deaths in NSW will be discussed in the next annual report of the Team, which is scheduled to be tabled at the end of October this year.

Yours sincerely

B A Barbour

Bruce Barbour
Ombudsman 4/9/12

Chapter Four – Transcript of proceedings

NOTE: The general meeting with the Child Death Review Team was held at Parliament House, Macquarie Street, Sydney, on 18 June 2012.

CHAIR: Before the proceedings commence I remind everybody to switch off their mobile phones. If your phone is on silent please switch it off completely. I now declare open the hearing in relation to the review of the Child Death Review Team annual report 2010. It is a function of the Committee on the Office of the Ombudsman and the Police Integrity Commission to examine each annual report and other reports of the NSW Ombudsman and report to both Houses of Parliament in accordance with section 31B (1) (c) of the Ombudsman Act 1974.

BRUCE ALEXANDER BARBOUR, Ombudsman, NSW Ombudsman, and Convener of New South Wales Child Death Review Team, on former oath:

MONICA KATHLEEN WOLF, Director, Systemic Reviews, Child Death Review Team, affirmed and examined:

JONATHAN GILLIS, Deputy Convener, Child Death Review Team, sworn and examined:

CHAIR: The Committee has received detailed responses from you to its questions on notice relating to the Child Death Review Team annual report 2010. Do you wish these responses to form part of your evidence today and be made public?

Mr BARBOUR: Thank you, Madam Chair.

CHAIR: Would you like to make an opening statement before the commencement of questions?

Mr BARBOUR: Yes, I would. Can I forewarn that this is a little longer than my previous opening statement. It covers an enormous amount of information which I believe needs to go before the Committee for the purpose of this very important work. It is now 16 months since I became convener of the New South Wales Child Death Review Team. Since responsibility for support and assistance to the team was transferred to my office from the New South Wales Commission for Children and Young People I am very aware that the transfer has promoted a level of debate, with some people being concerned about the suitability of my office for the team's work. I have also been very open about problems I have encountered in taking on this new role, as indicated by my special report to Parliament 18 months ago where I described a range of unresolved issues in the transfer.

Given the background I believe it is important for the Committee to have a clear understanding of the rationale for the transfer, the challenges that we have dealt with in establishing the team within my office and the progress and achievements since the team came across to my office. At the outset I should state the comments I make about the issues I have encountered should not be seen in any way as finding fault with the team's previous work or the support provided to the team by the Commission for Children and Young People. The commission worked within very limited resources and assisted the team to achieve some

very positive outcomes. I also want to assure the Committee that the Child Death Review Team has added a valuable and valued dimension to the work of my office. Team members have been clear to me that the move has been beneficial and they are fully supportive of the new initiatives and approaches that have been introduced.

I did not seek the transfer of the Child Death Review Team to my office. The move came about as a result of the 2008 Special Commission of Inquiry into Child Protection Services in New South Wales headed by Justice James Wood. The inquiry itself was commissioned largely in response to the deaths of two children, both of which were the subject of review and investigation by my office at the time. In his final report Justice Wood recommended a number of changes to the system of child death review. He proposed that the role of reviewing the deaths of children or siblings of children who had previously been the subject of a report to community services should be removed from the definition of a reviewable death and therefore from my jurisdiction.

The reviews of these deaths should be undertaken by a community services agency and the Child Death Review Team [CDRT] should be convened and chaired by the Ombudsman and supported by the Ombudsman's office. Justice Wood went on to provide a rationale to support that view. The then Government accepted the recommendations related to reviewable deaths but opposed the recommended transfer of the Child Death Review Team. Clearly the recommendations were complementary and they were not severable.

In April 2009, however, the New South Wales Parliament did assent to legislative changes that would bring all three of Justice Wood's recommendations into effect. The transfer of the team took almost two years from the time of that assent. Negotiations to transfer the Child Death Review Team were difficult. Firstly, the funding initially offered to perform the work was inadequate. Negotiations around the cost impacts of the work were protected and a reasonable budget was not settled until August 2010, some 16 months following Parliament's assent.

Secondly, the legislative provisions for the transfer presented a range of anomalies, administrative complexity and requirements that compromised the independence of my office. Again there were long and difficult negotiations to achieve amendments that were simply about ensuring the team could effectively do its work whilst protecting the integrity of the Office of the Ombudsman. In November 2010 I advised Parliament through my special report of those issues and the overall lack of progress made in giving effect to Parliament's decision to transfer the team. Machinery changes to amend provisions that directly affected the capacity of the team to do its work were also made in that month—nineteen months after Parliament's assent to the change.

However, my main proposal, that the team's legislation be transferred to the Community Services Complaints Reviews and Monitoring Act, was not endorsed. Nor were other proposals that I put forward to ensure the independence of my office should the legislation remain within the Commission for Children and Young People Act. Negotiations continued for a lengthy period of time and in December 2010 the then Government sought my acceptance of the legislative framework in order for the legislation to be proclaimed. While I advised the Government that I was not in a position to endorse the arrangements as they stood, I noted that it was in the best interests of the team and also the public for the legislation to be proclaimed at the earliest opportunity.

I also advised that I was very willing to take on the role of the Convenor, and my office was ready and well equipped to provide the necessary support to the team. The legislation was ultimately proclaimed on 11 February 2011; and the physical transfer of the team's register, hardcopy files and one administrative staff member were transferred to my office shortly thereafter. The transfer itself introduced new issues. As part of the transition process, my office undertook a review of the protocols and processes developed by the commission to manage the team's work. The work identified that the team was not properly legally constituted. The terms of the majority of independent members and agency representatives had lapsed, either months or years previously, effectively rendering those positions vacant under the Act. Even disregarding this technical breach of the legislation, the number of members in any event had fallen below the minimum required by the statute for the team to be constituted.

Resolving this issue was significantly hampered by an election cycle, a change of government and the need for involvement of a considerable number of Ministers. My concerns were such that I sought advice from the Solicitor General about my legal basis for performing the functions of the team and reporting to Parliament. Whilst noting the imperative to properly establish the team, the Solicitor General advised that the work of the team could be undertaken in consultation with existing members; and consistent with the advice of the Solicitor General, that was how we ultimately progressed the work. New South Wales Cabinet approved independent and agency nominations for team membership in September 2011, shortly prior to our required obligation to table the team's annual report for that year.

Throughout this time I continued to raise my concerns about the significant legislative issues, and in November 2011—2½ years after Parliament agreed to transfer the functions—the Children Legislation Amendment (Child Death Review Team) Act was assented to. The legislation now sits appropriately within the Community Services (Complaints, Reviews and Monitoring) Act, and sufficient provision has been made to protect the independence of the Office of the Ombudsman. Transfer of the legislation has also meant that oversight of the team is now the responsibility of one parliamentary committee, and not two—as would have been the case. Now, I am aware that there has been some concern expressed about the team's work no longer being within the mandate of the Committee on Children and Young People, and I will briefly speak to those concerns, which I believe are not warranted.

Firstly, it would make little sense for the Child Death Review Team part of my work to be reported separately to the reviewable death part of my work. A significant reason for combining the functions was to integrate them for the purpose of providing context to child death reviews. Reporting to different committees on different aspects of my work in this important area would not have served any useful purpose. The work of the team is distinct from my core oversight functions, but this does not mean that it will not be done well; or that this committee will not provide effective oversight of the work. My office has a broad range of functions and areas of focus that directly link to issues for children and young people, including Aboriginal disadvantaged, child protection and disability. I have jurisdiction over agencies with responsibilities in many areas of significance for child deaths—for example, transport agencies and local government. Critical areas for the two leading external causes of death for children and young people are transport incidents and drowning.

Concerns that information arising from child deaths will not be used practically, or to its full capacity, are also not founded. The team has made a conscious decision to actively

pursue the potential within the Act to share data for prevention purposes. The legislation provides for me to release information in connection with research that is undertaken for the purpose of helping to prevent or reduce the likelihood of the deaths of children in New South Wales. We also intend to make full use of the data collected and analysed by the team; and the recent release of the team's first issues paper—one on swimming pool drowning—and public release of our analysis of the drowning deaths of 40 children is an example of this.

Beyond technical and administrative problems, performing the functions of the team was not straightforward. As I indicated in my response to questions on notice, we have found that the child death register has outgrown its original platform and has limited reporting and analytical capability. Because of its limited capacity, the database is now in two segments, linked by a separate program. One of the main functions of the team—to identify trends and patterns—has been, and remains, somewhat hampered by this unsophisticated technology. There were no transitional provisions in the legislation, so we knew when we took over the work that preparation of the 2010 annual report would be a priority. Our initial position was to replicate the team's previous framework for, and approach to, reporting. Notably, the team reporting had changed in 2006, from an analytical report to a new format that consisted largely of tabulations and descriptive statements. We identified very early a range of issues in preparing for this work, and came to the conclusion that the reporting needed to change.

To assist us, I commissioned an external review of the previous team's approach to reporting. The review was undertaken by the National Centre for Health Information Research and Training at the Queensland University of Technology. I asked the centre to base this work on national and international standards and best practice in reporting on mortality data and child deaths, and to provide advice about the best way forward for the team. The centre confirmed that our concerns were valid. In summary, the approach to reporting was largely descriptive and it provided little interpretation of patterns and trends and what these might mean in a preventative sense.

Much of the data presented in the report was essentially raw data; the report did not provide clear information about underlying cause of death, and multiple-cause reporting was disaggregated. This means that the very long tables in the reports were simply merged listings of any mention of a cause on a death certificate, whether it be underlying, contributory or direct—and that was for all deaths. That meant the reporting focus was on children who died with certain conditions, rather than of certain conditions. This clearly is not the most useful way in which to consider prevention issues.

Under significant time constraints, and in consultation with existing members of the team, we changed the reporting approach to address these issues. Given the changes we made and the concerns that had been expressed to me about how policy-makers would view this change, I included in the report a link to an electronic survey to find out whether these people were happy with the changes, or otherwise. Interestingly, since tabling the report last year, we have received only15 responses; and the responses within that 15 were mainly positive.

It has not been an easy road for my office or the team over the past three years. However, I am very pleased to say that we have made considerable progress and achieved significant outcomes already. We have achieved a legislative framework that is consistent across all reviewable and all child deaths, and comfortably accommodates the uniqueness of the Child Death Review Team function and the independence of the Office of the Ombudsman. The team is now fully and properly constituted. We have new members that complement the

expertise that existed on the team, including for example the Chief Paediatrician for New South Wales, the head of the Social Policy Research Centre at the University of New South Wales, and expert medical specialists in childhood injury and cancer.

The team is united and cohesive; and both new and previous members have been very supportive of the changes and initiatives made since the transfer. The team is welcoming of positive change and keen to build on its work in promoting prevention strategies. We have developed orientation materials that clarify the role and responsibilities of members, and we have worked to involve members in key activities. Our Deputy Convenor attends the office to work with staff on a weekly basis, and Dr Gillis is also planning to undertake a secondary project with our expert coder on the accuracy of death certificates. An expert member has been assisting staff with reviews of deaths classified as a serious injury or death incident. Other members have formed a subcommittee to develop the Child Death Review Team research project for 2013.

My office has achieved a lot of ground in moving towards one child death register and the integrated function that was envisaged originally by Justice Wood that provides for contextual review of child deaths. We have now streamlined the team and reviewable child death work, which has addressed previous duplication and confusion and minimised the burden on external agencies for the provision of information. We have completed the first stage of a major review of the register with completion of the business analysis and data needs specification for an integrated death register. The intended longer term outcome, pending resources, is a consistent, reliable and sustainable register that provides for the efficient extraction of meaningful data for prevention purposes. The team is also keen to share this valuable resource of information with genuine researchers focusing on injury prevention and improving health outcomes for children.

We have initiated work to improve the team's capacity to deliver on its functions. Professor Peter Saunders will advise us on the best way forward to measuring socio-economic status and geographic reporting of child deaths, and the National Centre for Health Information, Research and Training is working with us to develop an effective framework for reporting on multiple causes of death so the team can look effectively at risks associated with combinations of underlying contributory and direct causes of death.

We have produced and tabled an annual report, provided a comprehensive submission to the review of the Swimming Pools Act and released an issues paper on swimming pool drowning deaths. We are now working on the 2011 annual report and have developed a plan for a major project for the team in 2013. We have progressed a number of issues of long-term interest to the team; these include actively pursuing monitoring of recommendations made by the team in relation to sudden unexpected death in infancy [SUDI] and representations to the Department of Forensic Medicine, the Office of the Coroner and the Minister for Health in relation to delays in forensic and coronial processes.

We have also worked externally to establish connections with agencies that have complementary aims to the team; for example, we have participated in a joint promotional event with the Australian Medical Association, Royal Life Saving and Kidsafe to promote safety around swimming pools, and we have actively participated in the Australian and New Zealand Child Death Review and Prevention Group. The Child Death Review Team, along with reviewable child deaths, is co-organising a national conference on child death reviews with Community Services for later this year.

I trust that that substantial groundwork and the output of the team over the past 16 months have put to rest any remaining concerns that anyone might have about the capacity of my office to support the Child Death Review Team. The team is now well integrated into the work of the office, its independence is now stronger than it ever was and it has retained its unique focus while gaining a greater capacity to meet its full potential. There is still considerable work to do and it will be done collaboratively and with a clear focus on the team's primary purpose of preventing child deaths. I thank you for allowing me to make such a long opening statement, but given the history of this matter and given the very significant issues we have travelled through, I thought it essential for it not only to be on the record but for it to be uppermost in the minds of the committee members as they start with this very important function.

CHAIR: I thank you for the statement. There are members of the committee who were not in Parliament when the saga began and I am sure that they particularly appreciate that statement. With the data collection, the problem with New South Wales' children's deaths where the death certificate is issued interstate—for example, at a hospital in Brisbane—is that for many years that data was not captured in the New South Wales Child Death Review Team reports. Has that problem been addressed?

Mr BARBOUR: It has not been resolved completely, no. The practice has been to seek from other child death review teams information about any child that dies within their jurisdiction that would normally have been resident in New South Wales. We provided some information about those deaths in our last annual report and that is the only way that we can really deal with those issues at this time.

CHAIR: I live in northern New South Wales and the second Child Death Review Team report listed no drownings of children in northern New South Wales and we all knew locally that that was untrue; there had been a number of child drownings. The police and the paramedics attend, people do not want to leave the body there and distress the family so they take the child to Brisbane Hospital—a helicopter takes the child to Brisbane Hospital where the death certificate is issued and that death is not being included in any of the statistics. I assume that this is also a problem around Canberra and it is also a problem potentially in places like Broken Hill where children who are seriously ill or seriously injured are being transferred to interstate hospitals. New South Wales has a lot of cross borders and I would put it to you that this is not a small matter and it affects the statistics of those communities and the direction of resources if that information is not being captured.

Mr BARBOUR: Certainly the information is captured, just not by this team when the death is registered interstate. We certainly do get information from the other teams about those deaths and if we were to do, for example, particular strategic work in relation to our activities we could certainly contemplate those as well as part of what it is that we are looking at. Unfortunately, the way the legislation is drafted at the moment the register and what goes on the register and what we are supposed to technically report on each year is quite limited.

You are quite right, there will be from time to time deaths that will fit within those circumstances and which create some problems in terms of them being regarded as a statistic for New South Wales. It is certainly something we are live to, but it would require legislative amendment and it would also require us to be able to get access to that information. One of the challenges is we can obviously get access to information that is created and arises in New South Wales but if there are doctors that treat and hospitals that deal with cases, we may not

be able, with our legislation, to secure information from those places because we would not have a legal right to obtain it. That is why we seek the information from the other death review teams who would be looking at those deaths.

CHAIR: Most deaths in our region, which has a quarter of a million people, and possibly further south—our nearest most southerly teaching hospital is John Hunter, so north of that they are going into Brisbane and it impacts on organ donations because these children's organs are being retrieved in Queensland and those organs are not available for New South Wales; it impacts everything. Can I ask that you inquire into that matter because it is not a few deaths here or there that are going missing, it is a very substantial number and it virtually renders the entire work of the committee useless for a very substantial part of the State? Also, that then impacts on information in terms of rural and remote deaths because, I would suggest to you, even though they stand out as having a higher morbidity rate that is probably an understatement due to these deaths not being captured.

Mr BARBOUR: Certainly I do not disagree with the Chair's comments, and I think it is a bit of a lacuna in terms of the legislation. Actually working a way through it to ensure that you could utilise the information and be productive with it will present a few challenges given the border issues. In the annual report you will see on page 33 that chapter 5 deals with deaths of children outside of New South Wales and there is a table there. That table lists the number of children that we have been able to get information from that have been the subject of registration in other States, but beyond that we are not in a position to do much because we do not actually have access to the information that is held within the other State jurisdictions. But I certainly do not disagree with the point that you are making about the fact that it would be preferable for us to be able to deal with that information in some way.

Mr RYAN PARK: Madam Chair, if there is a legislative amendment needed should we ask the Ombudsman to maybe bring back something?

Mr PAUL LYNCH: Although the problem is not so much our law, it is the law in other States.

Mr BARBOUR: It is, but it is also the circumstances as well. The example that was provided by the Chair is a very clear case where just for the purpose of dealing with a medical emergency and the registration of the death someone has gone interstate. But there are obviously other cases where it would not be such a temporary connection where people would be temporarily resident in other States or would be travelling on vacation and might drown in a swimming pool that is at a hotel resort, for example.

CHAIR: In Queensland.

Mr BARBOUR: In Queensland. So trying to come up with some legislation that is going to be able to delineate through those issues is a little bit challenging because it will not be quite as clear-cut. In other words, the risk may not have arisen in the State; it may have arisen in the other State.

Mr RYAN PARK: Even though the person is from interstate.

Mr BARBOUR: Even though the person is originally from New South Wales. So there would need to be a way of being able to drill down through that so that we could make the most use of that information.

CHAIR: I am just suggesting to you that it is a worthy thing to try to solve. Almost all the road trauma involving children, their deaths are being registered interstate. We have higher road trauma in our area, and drownings. Can I say to you again that the issue of organ retrieval is very much impacted by this. A major factor, in my view, as to why there are fewer organs available to sick children and, for that matter, sick adults is because of the system of teaching hospitals being in Brisbane and everything north of Coffs Harbour going up to Brisbane and none of those coming back. It is a life and death matter for some people.

Mr BARBOUR: Can I say by way of some comfort that because the focus of our work is on prevention, the issues that are likely to arise, whether they be motor vehicle accidents, transport accidents, swimming pool drownings, or drownings, irrespective of the actual number that you record the risk factors are likely to be the same and our focus on prevention is going to pick those up. So the good thing I think that we are able to do notwithstanding that dilemma that you have identified is that at least in terms of prevention, strategic work, working with agencies, that will not be limited by those deaths not actually specifically being counted in our statistics because the same issues will arise from the broader information that we have got from the other deaths.

CHAIR: Respectfully, I disagree with you. Our drownings are in unfenced ponds in parks, they are at public beaches and they are not occurring in swimming pools. You do not know how many we have had and I do not know how many we have had because nobody has captured that data. But I can tell you anecdotally, from knowing what goes on in my area, that it is a different issue. It is a particular issue for our region and it is not going to come up on your data unless the issue of data collection is addressed. It also means that Department of Community Services supervised kids who die are not being captured in your reporting system.

Mr BARBOUR: They would be, depending on the circumstances, because they would probably come to attention through our other activities. But certainly I agree with the concern, and it would require legislative amendment and I think it would require probably a universal position to be developed by all State agencies because it raises issues with every single State, obviously not just Queensland. Each State has got different teams, different registration systems and different processes. So I think to get to the bottom of the heart of the issue that you are talking about it would require a great deal of support that was across borders to have a uniform system in place.

CHAIR: But really all you need is the Premiers to sit down and say, "This is important, we'll do it", and it could be done, could not it?

Mr BARBOUR: If you can get the Premiers to do that it could be done. I am not sure I would have much success in doing that.

Mr LEE EVANS: Can I just clarify a child is from the age of?

Mr BARBOUR: We look at the perinatal period, so we are looking at the period right through the birth process, pregnancy, to 28 days and then beyond and up to the age of 18.

Mr LEE EVANS: So of the 15 children who died as a result of unintentional injuries, what impact do you think some of the videos and alcohol and risk activities have had in that?

Mr BARBOUR: Certainly with young people if we look at the age of maybe 14 and above you see a spike in relation to issues associated with the sorts of things that you are talking about. Motor vehicle accidents are generally as a result of speeding, drugs, alcohol, or substance abuse. There appear to be all of those indicators as well in relation to suicides and other sorts of injuries. So I think they are all factors that need to be taken into account in terms of any assessment about those deaths.

CHAIR: How many of the children, though, are passengers?

Mr BARBOUR: The majority of children or young teenagers that die in motor vehicle accidents are in fact passengers.

CHAIR: Yes, so the main factor is not really dependent on what was affecting the driver.

Mr BARBOUR: There are also drivers that die and often the boundaries between behaviour and risk taking are not clear.

CHAIR: But my point is that those risk factors you have just given do not actually relate to the children; they relate to the drivers who are often adults.

Mr BARBOUR: If we are looking at just passengers then they will often be adults driving. But if we are looking at broader transport issues, there are issues with pedestrians, there are issues with kids engaged in risk-taking behaviour on roads. They are often linked into those issues as well.

CHAIR: I accept that but the majority of the deaths are passengers in vehicles, are they not?

Mr BARBOUR: On the last report, yes.

Mr LEE EVANS: So 35 children died as a result of transport incidents. What I am trying to drill down to are the 15 children who died as a result of unintentional injuries. Was that due to their behaviour or was it accidents at baseball or something like that?

Mr BARBOUR: Have you got a page reference? The unintentional related deaths tend to be house fires, poisoning and also during sporting activities. They are not the motor vehicle accidents; they are accounted for separately.

Mr LEE EVANS: That is what I am trying to get to. I am just trying to figure it out because I have got an 18-year-old and I see there are definite behavioural factors with violent videos and all of the rest of the stuff we see. I am just seeing if there is any relationship.

Mr BARBOUR: I think that would probably be more closely linked to the fatal assault deaths category that we have also got in here. There were 13 children and young people who died as a result of fatal assaults last year. Interestingly, for the first year in our reporting there was a majority of cases that were peer-related activity. So fights are between people of similar

ages, so that may well link into your question, as well as suicide of course which is also reported separately. Fourteen young people died in relation to suicide and in many of those cases we see issues around substance abuse and peer pressure and so forth.

CHAIR: That number increased last year?

Mr BARBOUR: Which number?

CHAIR: Fatal assaults.

Mr BARBOUR: Yes, it did. It did increase last year, but predominantly for peers. That was where the spike came. That was most unusual. One of the things we try not to do from year to year is focus too much on small spikes because the numbers are relatively small. It is very important to look at them contextually over a longer period of time. So with fatal assaults which are largely familial—they will normally happen in family circumstances—you will see when you look at the tables that although that number was a spike over the previous years it is not completely inconsistent with some earlier years as well.

Mr RYAN PARK: I think you mentioned in your opening about the software and the challenges around the child death register and things not marrying up. I am assuming that is a fixable problem with dollars and resources. It just concerns me that that is not fixed. It goes to the Chair's observation that the data therefore is not as rich or accurate as it could be. Does your agency know how much in terms of dollars is needed to fix that? It just seems ridiculous that we have got this register—this is not a political comment at all, I assume it has been going on forever and a day. We have got this register but it is not really as accurate as or as fulsome as it should be in a very important area and you have not been able to get dollars for it. That concerns me, to be honest.

Mr BARBOUR: We have not sought the dollars yet. We have just finished doing the business case and the analysis. We have had an external team of consultants come in and review it for us. They have reviewed not only the system in place but what our needs are and what our reporting obligations are and they are looking at it in terms of best practice reporting across the board. We have only just received the estimate costing and it is in the order of a quarter of a million dollars.

CHAIR: Does that include capturing interstate deaths?

Mr BARBOUR: No, that would not because at the moment that is not one of our obligations and there is no physical way we can do it legally and so we have not actually built that into the business case.

Mr RYAN PARK: That is sort of where I was going. I am assuming that you will make a budget bid for this in the next six to 12 months, or are you going to have an enhancement bid?

Mr BARBOUR: We are going to put in an enhancement bid. But we are also going to need to look at if that is rejected whether or not we are going to need to try to find funds somehow from within the office, which I think is going to be very problematic. There are two problems with the register. One is technical. It is breaking down. It is built on a very unsafe platform that is not designed to hold so much data.

Mr RYAN PARK: Yes, I understand.

Mr BARBOUR: We have had to split it up and there are problems with that and its functionality is problematic. The second problem is the data capture. There is a lot of information, but it is unreliable in the way it is tabulated and it does not work in a logical order. As a result, you get a lot of very, very strange issues that it directs you off to. Literally, if we run a report at the moment, we have to always check it manually because every time you write a report electronically, we get different results.

The Hon. SARAH MITCHELL: In the report last year, you referred to the decrease in the suicide rate for young people over the last 15 years. Is there any particular reason for that? Do you think that it is just better education, or is it something that is spoken about more often in society?

Mr BARBOUR: I think both. There has been an enormous amount of work done in relation to suicide prevention over the past decade in particular, but I think also it is an issue that receives a great deal more attention now and considerably more public debate, which is a very healthy thing. I think also a range of issues which might prompt young people to think and question their worth and their self-value are also being, in a community sense, addressed in a much more positive way now. Of course, that is tied in to a whole range of other activities that lead into that in terms of improvements in education and changes in child protection, welfare systems and so forth.

The Hon. SARAH MITCHELL: In relation to Aboriginal and Torres Strait Islander children, obviously that it is something that has been noted before as having a higher mortality rate both for injury-related death and others. In response to the questions on notice you state that your team has not identified any particular response or proposed any specific research. You think that is an area that should be covered by your organisation, or are there other agencies that could also carry out that sort of research? Would you recommend something in that area is sooner rather than later?

Mr BARBOUR: We will certainly be keeping a watching brief on that. Although the Committee has not decided to actually make that a project at this stage, it is obviously something that we could do in the future. One of the benefits of having the team with my office now is that we do work that is complementary. Because as Ombudsman we have spent such a great degree of time and effort and focus on Indigenous issues, many of the very issues that relate to potential higher mortality rates for Aboriginal kids are already being caught up in the work and recommendations that we are doing. Improvements in terms of child protection, better service delivery, better health care, better education, more appropriate law and order responses to issues are all things that at every age level Indigenous communities are actually going to have some traction on. If we were minded to do a review down the track, all of that work would be extremely useful and would provide a very, very good base for anything that we might want to do.

CHAIR: I would like to ask about sudden infant death syndrome [SIDS]. I think there are 552 child deaths in total for the year.

Mr BARBOUR: It is 589. I think we had the records for about 542.

Ms WOLF: Yes, 542.

CHAIR: Thank you. Seventeen of the 50 infants who died of a fancy had previously been the subject of a report at risk of harm, and a further six also had siblings who were reported as being at risk. We put this question to you on notice and you have indicated that you have not actually specifically considered that as an issue for government. I wonder if there is some means, given that so many of those sudden infant death syndrome deaths are of children known, or whose sibling is known, to the Department of Community Services [DOCS]—I think that would make it half of the sudden infant death syndrome deaths now—if there is some way that the Department of Health and the Department of Community Services should be focusing on this?

Mr BARBOUR: The team has, over the years, done a significant amount of work in relation to sudden unexpected death in infancy [SUDI] deaths and made a number of recommendations which have formed the basis of two major protocols within the Department of Health. Of course, our work in relation to reviewable child deaths and broader child protection is also focused on this in other ways. We have certainly been monitoring that since we took over the team. We recently engaged in correspondence with the Department of Health to determine whether or not these new policies are working, what audit they have done in relation to them, and to see, in an evaluative sense if you like, how those processes are going. We are continuing in relation to that. Interestingly and on point, the team has agreed that the major project work that will do in 2013 is going to look at deaths of children who have also had a child protection history. That potentially will be one component of that work as well.

CHAIR: The campaign for ensuring your children sleep safely is a marvellous campaign targeting the entire population, but when we learnt from your report that half the deaths are occurring in a particular discernible group of the population, which thankfully is a minority of the population, why are we not doing more to put more resources into that target group?

Mr BARBOUR: It is a great challenge. One of the things that we have reported on previously in our work as Ombudsman is about what the department does when it receives child protection notifications of unborn children in circumstances where their parents are drug or alcohol abusers or there is significant violence in the home. It creates significant challenges for them about how they deal with that. Certainly the risk factors in relation to sudden unexpected death in infancy, and as a subset of sudden unexpected death in infancy sudden infant death syndrome, are well known, but trying to enforce them in a home environment is particularly challenging. One of the risk factors is exposure to tobacco smoke and another is about co-sleeping and sleeping inappropriately, bedding and various other things. Trying to get that information across often to vulnerable families and families that are in direct contact with Community Services and actually getting them to adhere to it is a particularly challenging task.

CHAIR: I am just interested to know if the Government is trying.

Mr BARBOUR: There are certainly major programs in place. Community Services has major programs. Health has major programs.

CHAIR: The Health ones are population-wide. I am just talking about this specific group.

Mr BARBOUR: Community Services has programs that would be targeting its client base in relation to these issues.

Mr RYAN PARK: I understand that the team applied for funding for Health through the sudden infant death syndrome [SIDS] program and got it knocked back. Is that right—or SIDS and Kids?

Ms WOLF: SIDS and Kids applied for a certain amount of funding, as I understand it.

Mr BARBOUR: Through the Department of Health?

Ms WOLF: It was not supported.

Mr BARBOUR: It is a separate group.

Mr RYAN PARK: Yes, it is a separate group. Again, this is not a political point. It was in our time, 2010. It concerns me that SIDS and Kids raised money, what I would have thought would be a small amount of money, to try to spread this message more broadly, and it was knocked back by the Department of Health. I just wonder whether they have gone back a second time with that?

Mr BARBOUR: Chair, I am happy to provide, if you would like, some further details about what Community Services actually provides around sudden unexpected death in infancy [SUDI], both to Aboriginal communities and also to non-Aboriginal communities around identifying some of these risk factors and how to deal with them.

CHAIR: Thank you.

The Hon. SARAH MITCHELL: In terms of the leading causes of death, you talk about the conditions originating during the pregnancy period and during the first 28 days and then congenital and chromosomal abnormalities. In the conditions during pregnancy, does that cover miscarried and stillborn babies? What classifies as the conditions that arise during pregnancy in terms of that being the leading cause?

Mr BARBOUR: There can be a whole range of issues. They can relate to all sorts of different health-related issues—deformities of the children and a whole range of different things.

The Hon. SARAH MITCHELL: Do deformities come in under the 22 per cent that is congenital and chromosomal?

Mr BARBOUR: It can, yes.

The Hon. SARAH MITCHELL: What is in the 34 per cent that is just conditions originating?

Ms WOLF: It is actually literally that. Jonathon might be able to elucidate.

The Hon. SARAH MITCHELL: I am just seeking some clarification.

Ms WOLF: These conditions actually start there.

Mr BARBOUR: They are not identified.

The Hon. SARAH MITCHELL: Okay.

Dr GILLIS: This illustrates why the database needs refining. You have honed in on one of the issues there. I am a paediatrician, and it is a bit confusing. Theoretically it is something that only arises in pregnancy versus something beyond that. You are right, some congenital defects come under that. If I can make the point about the database, a perfect example of what is wrong with how the database reports now is I might tell you that many children died of pneumonia and you would all say this is terrible. Then I might find that most of those had cancer and that was the terminal event of their cancer. That gives you a very nice example of what is wrong with the database. If there really was an outbreak of pneumonia you would want to know. But if it is secondary to cancer, that is a different issue, that is about the treatment of cancer. That is one of the problems of how the database relates to this. That is why it has to be cleaned up. Parliament and the public need to know.

Mr RYAN PARK: That is what I was saying before. We need to be using the database to drive preventative campaigns or, as the chair said, resource allocation perhaps. It is skewed.

The Hon. SARAH MITCHELL: I guess I would take from that that this is over 50 per cent but this is not from any issues in pre-natal care, it is just the luck of the draw.

Dr GILLIS: We have one of the lowest perinatal and mortality rates in the world in this country but it is very hard to get below a certain level—I think it is nine or something. There will be children who die of abnormalities and most of those happen within the first 28 days of life. There is another issue that comes up with a database and that is that modern medicine is such that sometimes you might die at the age of 10 of a congenital defect that you were born with but because of the care of a disability and improved care—that is why, as you point out, you need a much more sophisticated database that can tell you that.

Mr BARBOUR: I just identified—I did not have this in my head—some detail that we go into. If you want to reference page 36 of our report, that goes into some more detail about what is covered in that perinatal period. It includes prematurity, complications of labour, including hypertension, maternal haemorrhage disorders associated with foetal growth and so forth, and there is a descriptor there of what comes through.

CHAIR: I am sure it is in your report already, but the headline figures, did you say there were 542 child deaths?

Mr BARBOUR: No, 589 child deaths, and for 542 of those we had full and detailed information.

CHAIR: That was in the calendar year 2010, or the financial year?

Ms WOLF: Deaths registered in 2010.

Mr BARBOUR: It was the calendar year, which is reported at the end of the financial year period.

CHAIR: How many of those children were known to the Department of Community Services directly or via a sibling being notified?

Ms WOLF: I will find that number for you.

CHAIR: I am also interested to know how many of those notifications were perinatal and how many were made afterwards? Are these statistics able to be reported in that way?

Ms WOLF: It is 105 of the 589 children.

CHAIR: How many of those were the children themselves as opposed to a sibling?

Ms WOLF: I think they were the children themselves. Sorry, 101 children themselves were known to Community Services and four children were known to child wellbeing units. So, the system changed recently, it is a little different.

CHAIR: So which is the figure we should work on?

Ms WOLF: One hundred and five who had a child protection history, if you like, plus an additional 38 children on top of that who did not have their own child protection history but had a sibling history.

CHAIR: That is a total of 143 out of 589?

Ms WOLF: That is right.

CHAIR: Is that a consistent trend? Do you monitor that trend?

Ms WOLF: We used to. When we looked at all children with a child protection history it was generally between 20 per cent and 25 per cent of the child deaths population.

CHAIR: Of those 143, are you able to assess how many of those were preventable?

Ms WOLF: A lot of children with a child protection history die of natural causes, some with external causes. So, it is a bit mixed. We do look at that.

CHAIR: Do you do a separate analysis for children with a child protection history?

Ms WOLF: No, we haven't.

Mr BARBOUR: Not for this report, no.

CHAIR: That really is how the whole child death review process came about in the first place, to try to focus on those children.

Mr BARBOUR: As a result of the changes we have a reviewable death role in relation to children who die of suspicious circumstances, abuse or neglect, which are normally but not always the children who have been subject to notification to Community Services. The previous system had us reviewing all deaths where there has been a notification either of the child or the sibling for the three previous years before the death. That was changed, and now if it does not fit under the reviewable death category that is now monitored and reported on by Community Services, and it released its first report in relation to those reviewed deaths not

that long ago. However, we are doing that project that I referred to earlier. It will be a significant project and it will be looking at the deaths of children over a 10-year period?

Ms WOLF: Yes.

Mr BARBOUR: Over a 10-year period of our records that have had some sort of a child protection history and we will be looking at what those deaths were, how preventable they were, what the data provides us. We are doing it for the very same reasons of interest that you are referring to. That has been agreed to by the team and that will be reported in 2013.

CHAIR: How many reviewable deaths were there in 2010?

Mr BARBOUR: For our Ombudsman reviewable work?

CHAIR: Yes.

Mr BARBOUR: I think about 40-odd, but I do not have the figure in front of me.

Ms WOLF: It is now biannual.

Mr BARBOUR: It will be in my annual report but I do not think I have a copy, I am sorry.

The Hon. SARAH MITCHELL: But maybe not the calendar year?

Mr BARBOUR: Sorry?

CHAIR: The calendar year? The annual reports and financial year.

Mr BARBOUR: No, but it does report the calendar year now. We had for years made up as part of the changes in the legislation. But with our reviewable death work we only report biannually now rather than annually.

Ms WOLF: It is around 40 per year now.

Mr BARBOUR: We can provide those details or you can just have a look at our annual report.

CHAIR: Does that give a breakdown of causes of death?

Mr BARBOUR: Yes. And also our separate reviewable death report which we tabled at the end of 2010 would have had the data previous to that listed, and we are due to table another one at the end of this year.

CHAIR: I suppose from the public perspective, the question is: Are we getting better at preventing deaths of vulnerable children in care? Do we know the answer to that question?

Mr BARBOUR: I wish I could say yes or no but it is a far more complicated question because apart from anything else the system in care has changed and continues to change. Overall, I think the statistics are not getting worse but what we are reviewing is whether or not

they ought to be improving. That is what our reviewable death work largely goes to and focuses on, as well as the prevention focus from the Child Death Review Team.

CHAIR: Your reviewable death work focuses case-by-case and the bigger project you are doing for 2014 will be looking at trends. I suppose both perspectives are needed to inform public policy?

Mr BARBOUR: Yes. If we are preventing deaths, it's certainly focusing on case by case as one of the best ways of doing that because it is that data and that information in detail which often provide you with the impetus to be able to identify what the problems are.

CHAIR: How do we know if it is working though?

Mr BARBOUR: I am not sure that the entire child protection system is working particularly well. This Committee well knows I am on record as having said that many times. My report around the Keep Them Safe initiatives that was tabled last year in Parliament had Keep Them Safe with a question mark at the end of it quite intentionally, because despite well over 12 months of the reforms being in place, one of the major child protection initiatives which is a face-to-face evaluation of children who are at significant risk of harm had reduced by a significant percentage rather than increased. As a result of recent decisions to take out of home care responsibilities into the non-government sector what we will need to be looking at is now how that sector deals with those children as well as government.

CHAIR: Are they accountable to you in the same way?

Mr BARBOUR: They are for the provision of those services, yes. So, we can still review them but that system change we need to look at. In terms of the Keep Them Safe changes the introduction of the higher threshold for reporting and notifications has meant that with the use of wellbeing units the system has changed. Sometimes it is quite difficult. At the end of the day you have children who are being abused physically or sexually that we need to review the cases of and you also have deaths that we need to look at. The end result is something that you can be firm on, but trying to work through at what time they came to the attention of the system and which part of the system was working or not working presents some of the challenges.

CHAIR: I appreciate the complexity, but the intention of the public and the Government, all governments, of having this process is to get better outcomes for our children. I guess my question is: Is the process accountable for delivering that result?

Mr BARBOUR: I believe—

CHAIR: Is there a vision for knowing at what point this process has worked and the outcomes are better as a result?

Mr BARBOUR: That is one of the very reasons this team exists and why we report on this data. You can see significant reduction trends or significant trends which are reductions in some areas of deaths. I am sure that is due to improvements in prevention and the work that is being undertaken in those reviews.

CHAIR: But not in the case of DOCS?

Mr BARBOUR: That is not necessarily the case. What I am trying to say is that you cannot just say yes or no as to whether deaths are being reduced. Have systems been put in place to try to minimise deaths? Absolutely. Are agencies focussing on those to try to learn from those to ensure that that does not happen again? Absolutely. But with significant changes in the system and also to areas of responsibility, it is just very difficult to say at any one point, is this or is this not improving? The data would seem to suggest that we are not getting any worse in terms of death numbers, which, I suspect, given the increasing population of children being notified to Community Services, is probably a positive sign.

CHAIR: I hear what you are saying, but your job now is to manage the system. After a tortuous process you are convening the child death review process. I guess as a Committee member oversighting your work, what indicators we can be looking for that show the process is informing public policy and that deaths are reducing both in relation to the cases where there is a child protection background and the other cases?

Mr BARBOUR: That is exactly what the annual report provides. It provides a systematic review of particular types of death. It reports on the nature of those deaths in that year and it also looks statistically at how those deaths measure up against previous years to see whether there are any trends. Then we need to identify particular project work that we can do more in-depth analysis in, and that is why we have targeted deaths where there is a child protection history as our first big project of 2013. That is already underway. We are already in the process of doing that and that will be something we will report on publicly.

CHAIR: Basically, you are saying that we are doing a better job now? That is what I am trying to find out. I know that you see that as a simple question, but we are looking for the simple outcome.

Mr BARBOUR: I believe that the work we are doing is providing a significantly positive contribution.

CHAIR: I am sure that it is.

Mr BARBOUR: And I think in some areas you can actually document reductions in death, but in a conversation around whether or not Community Services-related matters are leading to more or less deaths, I am not in a position to say yes or no. But if you are talking about child deaths generally, then absolutely. I think we have come a long way and the work we are doing has significantly reduced mortality rates across a number of different areas. One of the things I want to do is actually bring into the team's work more robust analysis. For example, with drownings, although the number of drownings in swimming pools seems to have been basically staying the same for a period of time that analysis has not contemplated how many more pools there are in the State. So it is a figure that probably is not representative of a lot of the very positive outcomes that have come from surf life saving programs, from Kid Safe swimming pool programs and from the work of the team.

CHAIR: You upset me every time you refer to drownings because an enormous number of drownings in public places are not being recorded and, therefore, are not getting any priority in government policy because your database will not capture them and you are not seeking to capture them. In my opinion, the work you are doing is misconceived.

Mr BARBOUR: I was talking then only about drownings in swimming pools. Clearly the report reflects other drownings that have registered during the year—in open bodies of water, in bath tubs and in other activities. We talk about that as well.

CHAIR: But they are very significantly underreported.

Mr BARBOUR: I cannot, and it would be grossly inappropriate for me as Ombudsman or the convenor of the Child Death Review Team, try to secure information I am not lawfully entitled to have. Until such time as there is a legislative mandate to allow me to gather information about the deaths you have mentioned quite rightly concern you, I have my hands tied.

CHAIR: I guess I am asking for your assistance. Obviously, this Committee would be prepared to assist, but we need the assistance of the person responsible, which is you, to know what to do to try to get this data captured because every child's death is an issue.

Mr BARBOUR: Yes.

CHAIR: Every preventable death is an issue?

Mr BARBOUR: Yes, I absolutely appreciate that.

CHAIR: And they are not being captured.

Mr BARBOUR: I absolutely appreciate that but, as I said, even the ones we do review provide very good insight into risk factors and preventative mechanisms. Although we have not got every single one, I think last year there were five deaths in open bodies of water, there was one in a dam and two in a bath. The sorts of risk factors and prevention issues that apply to those are applicable even to those areas where we do not necessarily have the registered death. With open bodies of water it is particularly difficult because in so many of these cases it really revolves around appropriate level of supervision by adults at the time children are near any open bodies of water. That is the same, of course, for all drownings, but it is particularly the case where you have bodies of water that cannot logistically be fenced or so forth.

CHAIR: Just to clarify: is that a no, you are not going to help us to know what to do to capture the data?

Mr BARBOUR: No, not at all. This is the first time we have had a meeting and I am certainly hearing your interest in this and it is an area in which we have interest. As I said though, it is going to require all States to get involved because it is not a simple issue of us just doing something here.

CHAIR: Would a national system be a better approach than a State-based system? If a State-based system cannot be made to work, the only alternative is to look at a national system of data collection?

Mr BARBOUR: I do not think it is black or white like that at all and I do not think that is the case. The State systems work very well. It is just that a lot of authorities have limitations on who they can share information with. If there was agreement across borders that information in relation to child deaths of the kind you are talking about was able to be exchanged, that

would be very valuable, but that would need to incorporate access to medical records from GPs, from hospitals and from a raft of different agencies. It is a very complex issue and one that would require in each State very high level and very significant negotiations before we could even come to the table about a shared responsibility.

CHAIR: My understanding is that it would require access to the death certificate in the other States, and we are not talking about thousands of deaths—we are talking about dozens.

Mr BARBOUR: But it would be more than just the death certificate, depending on the circumstances. As I said before—

CHAIR: But you could quickly identify those cases, could you not?

Mr BARBOUR: Only for the purpose of recording them statistically but not the circumstances of the death. The review of child deaths requires much more than a death certificate. Indeed, the death certificate often is the most useless information we get.

CHAIR: But it is helpful in identifying the case?

Mr BARBOUR: We need to gather data from the people who have seen the child medically, from Community Service records, from police records, who attended from hospitals. It is only by going through all of that information that you can develop a clear picture about what were the issues and the circumstances.

CHAIR: I am talking about New South Wales deaths that are recorded in Queensland. The death certificate in Queensland alerts you to the death and all that documentation you are referring to will be in New South Wales.

Mr BARBOUR: Not necessarily.

CHAIR: Only the death certificate will—

Mr BARBOUR: Not necessarily. If the child does not die straight away, if the child is unconscious and receives treatment for several months, there will be a multitude of doctors and also hospital records that will relate to that. You are focussing only, with respect, on drownings that happen across a border in circumstances where the drowning actually took place but not the death in the State. We are talking about a much broader issue. There are multiple deaths across borders that are not going to fit quite as neatly into that sort of category. You cannot automatically assume that that will be easy to follow up. Drowning deaths in particular do not happen immediately. If a child becomes unconscious, is unable to be revived and does not receive treatment it may be some time before they die. Those pieces of information are essential if we are effectively to report on the child's death and contemplate what we need to do in terms of prevention.

CHAIR: Thank you for appearing before the Committee today. Should we have any further questions can I ask we put these questions to you on notice and you respond to us in written form?

Mr BARBOUR: Yes, that would be fine.

CHAIR: Before the hearing concludes may I ask members for a resolution to publish the transcript of the witnesses' evidence on the Committee's web site, after making corrections for recording inaccuracy and the answers to any questions on notice? Ombudsman, the statement that you made earlier, could I ask that you table a copy of that statement and would you be willing for the Committee to publish that on the website?

Mr BARBOUR: Absolutely. I provided a copy of the statement from the Ombudsman hearing and I have a copy of this statement for transcription and for publication.

CHAIR: It was a succinct statement of the history of the matter and would be beneficial.

Mr BARBOUR: Pleasure, thank you.

(The witnesses withdrew)

(The Committee adjourned at 12.32 p.m.)

Appendix One – List of Witnesses

18 June 2012, Waratah room, Parliament House

Witness	Organisation
Mr Bruce Barbour Ombudsman	NSW Ombudsman
Ms Monica Wolf Director, Systemic Reviews	Child Death Review Team
Dr Jonathan Gillis Deputy Convenor	Child Death Review Team

Appendix Two – Extracts from Minutes

MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION (NO. 4)

10:00am, Wednesday, 7 September 2011
Room 1254, Parliament House

Members Present

Mr Anderson, Ms Cusack, Mr Evans, Mr Lynch, Mrs Mitchell and Mr Searle.

Apologies

An apology was received from Mr Park.

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4. Transfer of duties for Child Death Review Team to NSW Ombudsman

Resolved on the motion of Mr Lynch, seconded by Mrs Mitchell, that the Committee note the briefing note on the transfer of duties for the Child Death Review Team to the NSW Ombudsman. Also resolved on the motion of Mr Lynch, seconded by Mrs Mitchell, that the Committee will hold a separate meeting with the NSW Ombudsman to discuss the work of the Child Death Review Team.

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MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION (NO. 9)

10:03AM, Wednesday, 22 February 2012
Room 1136, Parliament House

Members Present

Ms Cusack (Chair), Mr Anderson , Ms Mitchell, Mr Park and Mr Searle

Apologies

Apologies were received from Mr Lynch and Mr Evans

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3. Public Hearings

Resolved on the motion of Ms Mitchell:

'That the Committee hold public hearings on the 21 May 2012 with the following

- Commissioner of the Police Integrity Commission

- The Inspector of the Police Integrity Commission
- The NSW Ombudsman, in his capacity as Ombudsman
- The NSW Ombudsman in his capacity as Convenor of the Child Death Review Team
- The Information Commissioner
- The Privacy Commissioner;
  And inform the above mentioned of the proposed 21 May public hearing date'.

Resolved on the motion of Ms Mitchell:

'That the Committee staff members prepare an explanation of the remit of this Committee'.

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MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION (NO. 10)

10:00AM, Wednesday, 28 March 2012
Room 1254, Parliament House

Members Present

Ms Cusack (Chair), Mr Anderson , Mr Evans, Mr Lynch and Mrs Mitchell

Apologies

Apologies were received from Mr Park and Mr Searle

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4. General Meeting – 18 June 2012

The Chair noted the upcoming meeting with the NSW Ombudsman on 18 June 2012.

Resolved, on the motion of Mrs Mitchell:

'That the Committee meet with the Ombudsman in both his capacity as NSW Ombudsman and as Convenor of the Child Death Review Team on 18 June 2012.'

Resolved, on the motion of Mr Lynch:

'That the Committee endorse the draft questions on notice to be sent to the NSW Ombudsman.'

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MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION (NO. 13)

09:30am, Monday, 18 June 2012
Waratah Room, Parliament House

Members Present

Ms Cusack (Chair), Mr Evans (Deputy Chair), Mr Lynch, Mrs Mitchell, Mr Park and Mr Searle

Apologies

An apology was received from Mr Anderson

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4. General Meetings – 18 June 2012

Members noted the briefing packs that related to the General Meeting with the Ombudsman in his capacity as Ombudsman and the General Meeting with the Convenor of the Child Death Review Team.

Members noted the draft questions without notice, as circulated.

Members noted the answers to questions on notice received from the Ombudsman in his capacity as NSW Ombudsman and convenor of the Child Death Review Team.

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The Committee convened a General Meeting with the Ombudsman in his capacity as Convenor of the Child Death Review Team at 11:20am. The public and media were admitted.

Mr Bruce Barbour, NSW Ombudsman and Convenor of the Child Death Review Team, was affirmed and examined.

Ms Monica Wolf, Director – Systemic Reviews, Child Death Review Team, was affirmed and examined.

Dr Jonathan Gillis – Deputy Convenor, Child Death Review Team, was sworn and examined.

The witnesses agreed to take further questions from the committee on notice.

Evidence completed, the witnesses withdrew.

Resolution –

On the motion of Mrs Mitchell,

> 'That the corrected transcript of the witnesses' evidence be published on the Committee's website, including the answers to questions on notice.'

As the Hearing was concluded, the public and media withdrew.

5. General Business

Members noted the following:

- That the transcript would be circulated to Members for correction;
- That questions taken by witnesses on notice would be sent to those witnesses, along with any outstanding questions on notice that the Members wish to ask of the witnesses. Questions to be finalised via e-mail by Friday 22 June at 12pm.

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Resolution –

On the motion of Mr Park,

'That the opening statement provided by the Convenor of the Child Death Review Team be made available as a separate document on the Committee's website.'

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MINUTES OF PROCEEDINGS OF THE COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION (NO. 21)

3:30 PM, Monday, 10 December 2012
Room 1153, Parliament House

Members Present

Ms Cusack (Chair) and Mr Searle
Via teleconference: Mr Anderson, Mr Evans, Mr Lynch, Mrs Mitchell and Mr Park

Staff in attendance: Rachel Simpson, Emma Matthews, Hilary Parker, Todd Buttsworth and Rohan Tyler

The meeting commenced at 3:33 PM.

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2. Consideration of the Chair's draft reports – Review of Annual Reports following General Meetings on 21 May 2012 and 18 June 2012

Members noted Standing Order 301(3) in relation to report consideration, and resolved on the motion of Mrs Mitchell:
'That the Committee consider each of the Annual Report Reviews in globo.'

In relation to Report 1/55: *First General Meeting with the Convenor of the Child Death Review Team*, resolved on the motion of Mr Evans:

- that the draft Report be the Report of the Committee and that it be signed by the Chair and presented to the House;
- that the Chair and the Secretariat be permitted to correct stylistic, typographical and grammatical errors; and
- that, once tabled, the Report be placed on the Committee's website.

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The Committee thanked the secretariat for its assistance in the preparation of the reports.
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