Committee in the Ombudsman, Police Integrity Commission and the Crime Commission
Second general meeting with the Convenor of the Child Death Review Team

Questions taken on notice

1. **Please provide the Committee with an update on the progress of the Ombudsman's bid for funding for a new database for the Child Death Review Team (p. 5)**

The Ombudsman met with Treasury officials on 1 March to discuss the bid. We are yet to receive further advice.

2. **Can you provide the Committee with an update on the response to your recommendations to the review of the swimming pool legislation in relation to the registration of private swimming pools and prioritisation of homes where small children reside (pp. 9 – 10)**

The Swimming Pools (Amendment) Act 2012 commenced on 29 October 2012. The Act provides for:

- A NSW Swimming Pools Register available for use by 29 April 2013.
- NSW Swimming pools to be registered by owners by 29 October 2013.
- A requirement that pool owners have a compliance certificate before sale or lease of their property from 29 April 2014.

The Team has supported these amendments. The Team's recommendations propose a number of administrative and policy initiatives that would enhance the effectiveness of the changes.

In March, we wrote to Mr Ross Woodward, Chief Executive of the Division of Local Government, Department of Premier and Cabinet seeking a formal response to the seven recommendations. We have asked for advice regarding:

- the extent to which the Division accepts the recommendations;
- for those recommendations accepted, details of progress toward their implementation; and
- for those recommendations not accepted either in part or entirely, the reasons for this.

Further questions on notice

1. **What efficiencies do you think have been achieved through changing the Convenor of the Child Death Review Team from the Commission for Children and Young People to the Ombudsman's Office?**

In commenting on efficiencies, it should be noted that the Team's review, reporting and prevention work since transfer to this Office is markedly different to the Team's approach while situated within the CCYP. As the Committee is aware, major changes have been made to the Team's mode of operating and overall approach to its role in preventing child deaths.

Noting this, the efficiencies that have been achieved since the transfer include:

- The establishment of a single child death register for NSW, which has reduced duplication and the need to 'match' two separate registers. It has also significantly alleviated the burden on agencies in providing records required for review; previously records were provided separately to the CCYP and to this office.
- Reduced administrative costs through elimination of duplication. A child's death is now reviewed only once and more holistically. Previously, if a child's death was 'reviewable' under the

Community Services (Complaints, Reviews and Monitoring) Act 1993, it would be reviewed twice; once by the Ombudsman's office and separately, by the CDRT / CCYP.
- Reduced burden and cost associated with records management. This office has direct access to the NSW Police Force Computer Operated Policing System (COPS) and Community Services' Key Information Directory System (KiDS). This alleviates the need for retrieval of records by those agencies, and for records management by this office.

It is anticipated that efficiencies will continue to improve with the implementation of a new data system.

2. **Thank you for the data you provided in response to the Committee's questions about the Australia and New Zealand Child Death Review Team. In your view, what factors account for the variations in the rate of child deaths between the different jurisdictions that provided data? In light of this data, how well do you think NSW performs in preventing child deaths?**

It is difficult to comment on the variation in overall rates of death across the states and New Zealand, and consequently, whether NSW is performing well in preventing deaths. At face value, the NSW rate of 36.4 deaths per 100,000 children and young people is the second lowest of the jurisdictions reported, with South Australia having the lowest mortality rate.

However, the Australia and New Zealand Child Death Review and Prevention Group is not a funded entity, and at present has little capacity to analyse why there are differences, and what might underpin those differences. The cautions expressed in the data indicate the difficulties in comparing rates. It is possible that differences may be influenced by a range of factors, such as:

- fluctuations in small numbers;
- counting issues (eg deaths registered or occurring in a particular year; inclusion of otherwise of deaths of residents interstate); and
- the provisional nature of data for some states.

In relation to particular death types, there are likely to be a number of reasons for differences in rates. This may include different definitions across jurisdictions. For example:

- some states include probable or likely cases in suicide data, while others use Coronial determinations;
- 'SIDS or undetermined' classifications are not uniformly defined and may also be influenced by different approaches by Coroners across the states.
- States do not uniformly use the International Classification of Diseases (ICD) to code deaths, which can result in differences in how deaths are classified and subsequently, rates in particular death types.

At its annual meeting in February, the Group agreed to work on how each state includes the deaths of resident children who die outside of the state in data and reporting. The second agreed area of focus will be comparing definitions of Sudden Unexpected Death in Infancy, and considering ways to achieve a common definition. This work would be a step toward understanding differences in reported mortality rates.

3. **The report from the interjurisdiction comparison of child death statistics for 2010 says that 'more meaningful conclusions and specific targeting of prevention initiatives will become more apparent through future analysis of data over multiple years' What data do you think is most important to enable effective targeting of prevention initiatives.**

Data at a range of levels is necessary for understanding why children die and what can be done to prevent this. This includes for example, classifications of underlying causes of death and multiple causes of death, demographic information, and detailed data relating to the circumstances of a child's death.

In a prevention context, different data is required for different death types. For natural cause deaths, relevant medical history provides key data, while for unintentional injury cause deaths, environmental, technical and behavioural information is particularly relevant.

4. What is the Team's key focus for the coming year?

The Team will present two reports to Parliament in the coming year, with both to be tabled by the end of October. Reports, including the case reviews that support them, are resource intensive and the preparation of these reports will be the key focus for the Team in 2013.

The first report is the Team's *Annual Report 2012*. The Team intends to include in this report some specific focus on off-road motor vehicle fatalities over a ten year period to 2012.

The second report is the Team's triennial report under s 34H and 34F (2) (d) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*. This report will examine the causes of death for children with a child protection history. The report will include analysis of any differences in causes of death for this group and for children with no child protection history.

The Team will also focus on improving the identification and reporting of Aboriginal and Torres Strait Islander status, and will engage expert assistance in undertaking this work. The Team's views about the need for improved accuracy in reporting on the deaths of children from Aboriginal and Torres Strait Islander backgrounds, including the reporting of trends, is well documented in the *Annual Reports* 2010 and 2011.

5. Does the Team set itself goals? If so, what are they?

The Team as presently constituted and convened by the Ombudsman held its first formal meeting in May 2011. Since that time, its goals have been pragmatic and focused on reviewing and improving core business. These goals have included implementing best practice in mortality reporting, identifying suitable methods for reporting socio-economic status and geographic reporting in the context of child deaths; and improving the structure and approach to the Team's annual reporting.

The Team is now at a point where it is looking to the future and how the key goal of the Team - to prevent child deaths – can be most effectively progressed.

On March 25, the Team has scheduled a planning / strategic directions day. The agenda will focus on three key areas:

- Processes (what needs to be in place for the Team to meet its responsibilities?);
- Outcomes (What does the Team want to achieve in the context of its legislated responsibilities?) and
- Engagement (How should the Team engage with, and inform, other relevant stakeholders?)

The meeting will consider current priorities and future plans in this context.