Opening statement by the NSW Ombudsman

Joint Parliamentary Committee hearing – Child Death Review Team

June 2012

It is now 16 months since I became Convenor of the NSW Child Death Review Team, and since responsibility for support and assistance to the Team was transferred to my office from the NSW Commission for Children and Young People.

Being the first General Meeting with the Committee since this change, my opening statement is more detailed and longer than would normally be the case. I seek the Committee's indulgence. It describes a somewhat long and difficult journey to get to where we are today, but one I think should be set out to enable a proper foundation for the Committee's important work.

I am very aware that the transfer has promoted a level of debate, with some 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, indicated by my special report to Parliament 18 months ago where I described a range of unresolved issues in the transfer. Given this background, I believe it is important for the Committee to have a clear understanding of the rationale for the transfer; the challenges we have dealt with in establishing the Team within my office; and the progress and achievements of the Team since that time.

At the outset, I should state that 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 CDRT has added a valuable, and valued, dimension to the work of my office. Team members have also been very clear to me that the move has been beneficial, and that they are fully supportive of the new initiatives and approaches I have introduced.

Rationale for the transfer

I did not seek the transfer of the CDRT to my office.

The move came about as a result of the 2008 Special Commission of Inquiry into Child Protection Services in NSW, 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.

In his final report, Justice Wood recommended a number of changes to the system of child death review. He proposed that – in tandem:

- 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.
- that reviews of these deaths be undertaken by Community Services; and
- that the CDRT should be convened and chaired by the Ombudsman, and supported by the Ombudsman's office. Justice Wood noted:

It is evident to the Inquiry that in considering reviewable deaths it is critical to examine and compare the contexts in which the deaths occur. This can be enhanced through an integrated function that examines all child deaths in NSW to enable the making of more systemic recommendations to prevent child deaths.[1]

The (then) government accepted the recommendations related to reviewable deaths, but opposed the recommended transfer of the CDRT.

In April 2009, however, the NSW Parliament assented 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.

[1] Hon James Wood AO QC 2008, Special Commission of Inquiry into Child Protection Services in NSW, State of NSW, Sydney

The process of change – challenges

Negotiations to transfer the CDRT were difficult.

Firstly, the funding initially offered to perform the work was inadequate. Negotiations around the cost impacts of the work were protracted, 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 complexities 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 Ombudsman.

In November 2010, I advised Parliament of these issues, and the overall lack of progress that had been made in giving effect to Parliament's decision to transfer the Team, through my Special Report.

Machinery changes to amend provisions that directly affected the capacity of the Team to do its work were also made in that month - 19 months following Parliament's assent to the change.

However, my main proposal that the CDRT legislation be transferred to the *Community Services (Complaints, Reviews and Monitoring) Act 1993* 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's 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 the public of NSW for the legislation to be proclaimed at the earliest opportunity. I also advised that I

was very willing to take on the role of Convenor, and my office was ready and well-equipped to provide the necessary support to the Team.

The legislation was proclaimed on 11 February 2011, and the physical transfer of the CDRT register, hard copy files and one administrative staff member were transferred shortly thereafter.

Team membership

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.

This 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 these 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 statutory requirement to form a Team.

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. While noting the imperative to properly establish the team, the Solicitor general advised that the work of the Team could be undertaken by my office. In consultation with existing members, and consistent with the advice of the Solicitor General, this was how we progressed the work.

NSW Cabinet approved independent and agency nominations for Team membership in September 2011, shortly prior to the tabling of the CDRT *Annual Report 2010*.

Throughout this time, I continued to raise my concerns about the significant legislative issues, and in November 2011 - two and a half years after Parliament agreed to transfer the function -

the *Children Legislation Amendment (Child Death Review Team) Act 2011* 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.

I am aware that there has been concern expressed about the Team's work no longer being within the mandate of the Committee on Children and Young People. I will briefly speak to these concerns, which I do not believe are warranted.

Firstly, it would make little sense for the CDRT 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 serve a useful purpose.

The work of the Team is distinct from my core oversight functions, but this does not mean it will not be done well, nor that this Committee will not provide effective oversight of this 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 disadvantage, 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: 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 NSW.

We also intend to make full use of the data collected and analysed by the Team. The recent release of the Team's first issues paper - which is on swimming pool drowning – and public release of our analysis of the drowning deaths of 40 children is an example of this.

The work of the Team - reporting and related issues

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 Register has outgrown its original platform and has limited reporting and analytic 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 unsophisticated technology.

There were no transitional provisions in the legislation, so we knew that when we took over the work, 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 CDRT reporting had changed in 2006 from an analytical report, to a new format that consisted largely of tabulations and descriptive statements. We identified 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 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 provided little interpretation of patterns and trends and what these might mean in a preventive context. 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. What this means is 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 - for all deaths. That meant the reporting focus was on children who died with certain conditions rather than of certain conditions. This is not the most useful way in which to consider prevention.

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 concerns that had been expressed to me about how policy makers would view the 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.

Since tabling the report last year, I have received only 15 responses. Responses were in the main very positive.

Resolution of issues and achievements since the transfer

It has not been an easy road for my office or the Team over the past three years. However, we have made considerable progress and achieved significant outcomes.

We have achieved a legislative framework that is consistent across reviewable and all child deaths, and comfortably accommodates the uniqueness of the CDRT 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 NSW, the head of the Social Policy Research Centre at the University of NSW, and expert medical specialists in childhood injury and cancer.

Team

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 material that clarifies the role and responsibilities of members, and have worked to involve members in key activities. Our Deputy Convenor attends the office to work with staff on a weekly basis. Dr Gillis is also planning to undertake a secondary project with our expert coder on accuracy of death certificates. An expert member has been assisting staff with reviews of deaths classified as SUDI. Other members have formed a sub-committee to develop the CDRT research project for 2013.

Integrated function

My office has achieved a lot of ground in moving towards one child death register, and the integrated function envisaged by Justice Wood, that provides for contextual reviews of child deaths. We now have streamlined CDRT and reviewable child death work, which has addressed previous duplication and confusion and minimised burden on external agencies.

We have completed the first stage of a major review of the CDRT register, with completion of a business analysis and data needs specifications for an integrated death register. The intended longer-term outcome – pending resources – is a consistent, reliable and sustainable register that provides for 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.

Output / the work

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 socioeconomic status and geographic reporting of child deaths. 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 working on the 2011 annual report and have developed a plan for the Team's 2013 research project.

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 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.

Collaboration

We have worked to establish connections with agencies that have complementary aims to the Team. For example, we participated in a joint promotional event with the Australian Medical Association, Royal Lifesaving and Kidsafe to promote safety around swimming pools. We have actively participated in the Australian and New Zealand Child Death Review and Prevention Group.

The CDRT – along with reviewable child deaths – is co-organising a national conference on child death reviews with Community Services. The conference will be the first of its kind, providing professional development opportunities for review staff and Team members relevant to both child protection and all-cause perspectives.

Conclusion

I trust that the substantial groundwork and the output of the Team over the last 16 months have put to rest any remaining concerns about the capacity of my office to support the CDRT.

The Team is now well integrated into the work of my office. Its independence is stronger, and it has retained its unique focus, while gaining a greater capacity to meet its full potential. There is still work to do, and it will be done collaboratively and with a clear focus on the team's primary purpose of preventing child deaths.