REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION

GENERAL MEETING WITH THE NSW OMBUDSMAN IN RELATION TO THE 2009-10 AND 2010-11 ANNUAL REPORTS

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At Sydney on Monday 18 June 2012

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The Committee met at 10.00 a.m.

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PRESENT

The Hon. C. Cusack (Chair)

Legislative Council	**Legislative Assembly**
The Hon. S. Mitchell	Mr L. J. Evans (Deputy Chair)
The Hon. A. Searle	Mr P. G. Lynch
	Mr. R. J. Park

CHAIR: Before the proceedings commence may I remind everybody to switch off their mobile phones as they can interfere with Hansard recording equipment. If your phone is on silent please switch it off completely. I now declare open the hearing in relation to the review of the NSW Ombudsman's annual report 2009-10 and the NSW Ombudsman's annual report 2010-11. 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 report 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

LINDA MICHELLE WAUGH, Deputy Ombudsman, Police and Compliance, NSW Ombudsman, affirmed and examined:

CHRISTOPHER CHARLES WHEELER, Deputy Ombudsman, Public Administration, NSW Ombudsman, sworn and examined:

CHAIR: The Committee has received detailed responses from you to its answers to questions on notice relating to the Ombudsman's annual report 2009-10 and the annual report 2010-11. I thank you for those answers. Do you wish those responses to form part of your evidence today and to be made public?

Mr BARBOUR: Yes. First, can I apologise? It was our intention to have Mr Steve Kinmond, Deputy Ombudsman, and Community and Disability Services Commissioner represent the office today. Unfortunately he has taken ill and was not able to attend. He and I both extend our apologies to the Committee for that. As this is the first formal meeting of the parliamentary committee since November 2009 my opening statement is a little longer than normal. I hope the Committee will indulge me. It is important for me to brief the Committee on major developments and some key activities undertaken by my office since the last meeting. Can I state at the outset how important the constructive and positive relationship we have with the Committee is to my office. I welcome the opportunity to provide information to the Committee about the work we do and our overall approach to that work. Many of the questions on notice were directed to our previous annual reports so I thought it would be useful to focus my opening statement on work currently being undertaken as well as some of the current challenges faced by my office.

As you well know, our work now encompasses a broad range of areas and significant issues. Perhaps this is best demonstrated by looking at some specific current examples of our work. We are involved in a number of matters that have attracted significant public interest including oversight in the investigation of a number of policing incidents: the NSW Police Force investigation into the death of Roberto Laudisio Curti, a young Brazilian man, in the Sydney central business district; as well as the shooting and surrounding events involving several young aboriginal men in Kings Cross. This involves senior investigation officers from my office monitoring in real time the conduct of these extensive police investigations. We are also in the final stages of completing a large systemic review of the use by the NSW Police Force of tasers.

You will recall that in November 2010 I tabled a report in Parliament called "Responding to the asbestos problem: the need for significant reform in New South Wales." The issues of asbestos management in New South Wales continue to be of significant concern to me and my office. My office is currently completing two further large investigations; one into how asbestos identification in public schools has been managed and the other into how the NSW Police Force manages asbestos in police operational premises and also residents. Our recommendations are likely to include that a plan is developed to properly identify all asbestos containing materials in schools, that a new model is developed to manage police properties and that a review be conducted of New South Wales Government properties to ensure hazardous building materials are being properly managed.

We are also conducting a number of investigations into how well, or otherwise, the State is protecting and managing environmental issues, including water. We are particularly concerned about allegations appropriate enforcement action has not been taken in relation to pollution incidents and the unauthorised extraction of water. In October last year my office tabled a report in Parliament titled "Addressing Aboriginal disadvantage: the need to do things differently". The report was one of the most comprehensive from my office in recent years and it put forward a number of significant proposals as a blueprint or road map for consideration by the new Ministerial task force. It focused on many important issues, including improving education outcomes for Aboriginal children and building economic capacity. Unfortunately, it also highlighted major inadequacies in service delivery to Aboriginal families in crisis, particularly those in high need communities. We continue to do significant work in the area of Aboriginal disadvantage, including auditing the implementation of the New South Wales interagency plan to tackle child sexual assault in Aboriginal communities. We are due to report on the completion of that work at the end of this calendar year.

We are in the process of finalising an inquiry into the access of people in mental health facilities to accommodation and support services under the Disability Services Act. The key part of our inquiry consists of the review of the files of 95 mental health inpatients from 11 mental health facilities across New South Wales.

Each of the individuals has been identified by the public guardian, the official visitors and/or the Mental Health Review Tribunal as someone who is continuing to live in hospital due to a lack of available community based accommodation and support options. This is only a very brief snapshot but it does demonstrate how our work has changed since the Ombudsman was established in the 1970s. Our core work has always been and will continue to be dealing with complaints from members of the public. As at the end of last month we have received 8,700 complaints which is an increase of 6 per cent over the same period last year. And, we have dealt with over 22,000 inquiries.

In addition to that we have an increased focus on conducting audits and large systemic investigations and projects. It is, however, in the nature of those that they are complex and resource intensive which brings me to the resources we have to do the work that we are charged to do. I recognise that all Government agencies are currently under considerable financial strain. The expectation on all public sector agencies is to do more with less. We are all subject to significant budget cuts. However, for my office decisions about funding are not just about work challenges; they are also tied to questions of independence.

When the previous government restructured the public sector into super agencies we were assured that we would continue to be treated independently. However, this has not consistently proved to be the case. For many issues, including some budgetary matters, we continue to be regarded as part of the Department of Premier and Cabinet cluster. I bring this situation to the Committee's attention due to my concerns about the potential impact on my office and its reputation. It is essential that integrity agencies are both independent of Government and are seen to be so. Inappropriate inclusion of my office in the super agency structure for budgetary, financial or indeed any other purpose poses a significant risk to this fundamental principle and will cause us to be viewed as part and not separate of the broader public sector.

More generally, what I find concerning is something that I have raised previously with the Committee and that is the continued blanket application and approach to budget reductions. I believe this approach is arbitrary, it is unsophisticated and an inappropriate method of finding savings. This is particularly true for smaller agencies such as mine where most of our budget is dedicated to staff related expenses and we have already done the hard yards of becoming effective, efficient and lean. In my view, consideration prior to making budget cuts should always be given to the size, the efficiency and the nature of work of each agency before decisions are made to cut; and application should not be made across all agencies of the same level of cut. These financial pressures make it more important than ever that we continue where possible to identify ways in which to improve how we do our business. We have already undertaken a number of initiatives in this regard.

The restructure in 2009-10 led to the deletion of two statutory officer positions. The increased workload that has resulted from this change for the remaining statutory officers and senior managers we have had to manage in a number of ways, including improving our work practices to ensure that we have a more coordinated approach to dealing with agencies and issues, particularly in our human services area. We now have a greater focus on internal consistency of work process and benchmarks. Stage one of the key performance indicator project has been included—in which we examined how we collect, record and report complaint information. We have aligned, where possible, like work processes across our division, so that we can compare performance statistics across common internal benchmarks. Scoping for stage two of the project is about to begin, and that deals with our non complaint handling work.

We have also carried an extensive review of our website. The new website will be launched soon. It will be more functional, and it will include a more user-friendly process to lodge a complaint online, and more easily accessible information, including links to our reports and publications. As well as extensive information about what we do and how we can help people, it will have tailored pages for some of the vulnerable residents of New South Wales, including separate areas for young people, people with disabilities and Aboriginal communities. Staff from my office have also been involved in developing an innovate review process with other Australian and New Zealand parliamentary ombudsman officers, recognising the value of sharing work in our various practices. I provided one of my officers to conduct a review of complaint handling practices in the Victorian Ombudsman's office. The Victorian Ombudsman then did the same, sending one of its officers to review the Public Administration Division in my office.

We found the benefits of participating to be two-fold: having an experienced independent colleague bringing a critical eye to how we do business, as well as the benefits of having one of our officers immersed for a number of days in the work practices of a nature similar to but different from our own. The process is efficient, as the degree of similarity between our work is sufficient for the reviewers to hit the ground running, as it were; but the differences in the detail of how we do our business is where a real opportunity arises for us to learn. The

reviewing officers have now developed a methodology which has been shared with all ombudsmen offices, and they have recently assisted the Commonwealth's Ombudsman's office in a significant review of its work practices.

Since the last meeting, we have also gained a number of new functions and responsibilities. A little over a year ago we were given additional responsibilities for public interest disclosures. Our newly-established Public Interest Disclosures Unit is responsible for promoting public awareness and understanding of that legislation, providing advice and training to agencies, developing publications and guidelines, and monitoring and auditing agencies' handling of public interest disclosures. In its first year of operation, the unit has prepared model internal reporting policies for public authorities and councils, plus detailed fact sheets, checklists and guidelines to assist agencies and also public officials. To date, we have provided training to approximately 5,000 staff across New South Wales. The interest in training has been very encouraging, with a mix of regional and metropolitan councils as well as small agencies and principal departments taking it up.

We have also been given responsibility for conducting a number of new legislative reviews, to scrutinise a range of additional powers that have been provided to NSW Police. We are currently reviewing the operation of the Crimes Amendment (Consorting and Organised Crime) Act, removal of face covers for identification purposes under the Law Enforcement (Powers and Responsibilities) Act, the Summary Offences Amendment (Intoxicated and Disorderly Conduct) Act, and the Crimes (Criminal Organisations Control) Act. We use, as the Committee knows, a variety of techniques to analyse the exercise of such new powers, including literature reviews, developing issues papers, data collection and analysis of focus groups. Finally, as the Committee is aware, I am now also the Convenor of the NSW Child Death Review Team; and responsibility for providing support and assistance to the team has been transferred to my office from the NSW Commission for Children and Young People. No doubt I will have an opportunity at our next hearing to talk about issues relating to that role. I thank the Committee very much for allowing me to make this opening. My staff and I are very happy to answer any questions that you have.

Mr PAUL LYNCH: You mentioned in your opening statement the role of the Ombudsman's Office in investigations into the death of Roberto Curti and the incident at Kings Cross with some Aboriginal teenagers. I think what you said was that the role of your office is to monitor in real time what the police are doing. What does that actually mean?

Mr BARBOUR: Can I perhaps start by saying there has been some tension around our role in relation to critical incident matters. As it stands at the moment, when a complaint is made about police conduct it must be notified to us, provided it meets the threshold set by the particular agreement in place with the Police Integrity Commission. Secondly, there is another avenue for complaint to be made, and that is under regulation 49, when police officers form a view that there has been misconduct. In the past critical incidents were often not referred to my office because there was, firstly, no complaint in existence and, secondly, because a police officer had not formed the necessary view to reach the threshold of it then being reported, as they are obliged to do under the legislation. So, as a result, many critical incidents do not actually receive any independent oversight or scrutiny by my office in terms of the management of the investigation process. But, when there is a death, the cause of death obviously will be reviewed by the coronial process and an inquest.

In relation to these two particular matters, we are oversighting those because there was a view formed fairly early on that there was the possibility of police misconduct involved. In relation to the matter involving Mr Curti, we have been involved from the outset. By real-time monitoring we mean we have been provided with access to eagle.i, which is the primary computer system used by police for the purposes of high-level and significant investigations. We do not normally have access to that directly; it is normally only the Police Integrity Commission that has access to that. As information is put on that system—in other words, the moment it is complete and it goes on that system—that has allowed us access to that information. That has meant that our oversight and monitoring has been real-time, rather than towards the end of the process, when a report is completed and Police provide us with a 150 report under the legislation. So it has been a far more effective way of monitoring and oversight, and it is something that I have already had discussion with the commissioner about in terms of potentially extending our access to use of eagle.i for other matters.

Importantly, I have also proposed to the Commissioner of Police and the Minister for Police a new model, which would see my office having an automatic role in relation to all critical incidents that relate to or cause serious injury or a death, so that there is no longer a need for there to be a complaint in place, or for Police to reach a threshold and form an opinion that there is police misconduct present. As you can imagine, their focus is not usually on that in the first instance.

Mr PAUL LYNCH: I take it from that that, in the vast majority of investigations over which you have a review or oversight role, you normally do not have the capacity for real-time monitoring.

Mr BARBOUR: We can do real-time monitoring in different ways, but we do not have access to eagle.i. We have a breadth of powers and capacities provided to us under legislation, so we can initiate from the first time that we receive information about a complaint a process whereby we monitor more closely the investigation. That can include our staff being in attendance when witnesses are interviewed during the course of the investigation. We can get updated reports. But that is not normally the case. So it would generally be where we consider the matter to be one of a significant public interest or, alternatively, one of a significant potential abuse of power, or where the people involved are particularly vulnerable. Those are the sorts of criteria that we would look to to actually involve ourselves on a more close-monitoring basis.

Mr PAUL LYNCH: Am I correct in assuming from what you have said that the vast majority of critical incidents do not have an oversight or a review role for the Ombudsman?

Mr BARBOUR: That is correct. Indeed, some matters that we believe ought to have been notified to us have not been notified to us. One particular notable matter we only became aware of once the Coroner made adverse comment about the police investigation of the matter.

CHAIR: Your annual report refers to 100 complaints that you believe should have been referred to you but were not referred to you by the police.

Mr BARBOUR: That would not include a figure for critical incidents. That would cover only those matters which are required to be notified to us under our class or kind agreement and/or as a result of Regulation 49 that have been identified during our audit processes. The dilemma around critical incidents is that arguably they do not have to be notified to us because unless there is a complaint in place or unless a police officer reviewing the circumstances of the matter concludes that there is misconduct then they do not have to be notified to us, and that is the problem with the current system.

CHAIR: How many complaints are you talking about? How many critical incidents?

Mr BARBOUR: At the moment we have seen a particular spike in critical incidents, particularly ones that have become very much the subject of public interest. Generally I would not think the number would be particularly high. I do not have a figure in front of me because we are not actually involved directly in that, but I would think serious injury and also death you would probably be looking at maybe somewhere in the order of 30 to 50 a year.

Ms WAUGH: Possibly higher.

CHAIR: If the police were to automatically refer to you it would be additional 30 or 40 cases a year?

Mr BARBOUR: It would, but, importantly, we would be able to identify fairly quickly with some of those matters whether there was any real likelihood or assumption of police misconduct, and in those cases we would be able to very quickly say to police we do not need to oversight this.

CHAIR: You want to do the assessment at the ombudsman's level rather than have the police do the assessment?

Mr BARBOUR: The police will still have to do the assessment but what we are recommending is that there is an automatic notification to the Ombudsman so that the Ombudsman can determine whether or not to formally oversight the matter, and that would require an amendment to the legislation so that it was not left up to police to decide whether they should notify us, it was automatic. We would be able to then do an assessment and if we could decide early on we could do so; if we need to wait and see what further information came out of the investigation process we could then follow and monitor the investigation.

CHAIR: Could I ask you to on notice give the committee details of what amendment would be required?

Mr BARBOUR: Certainly.

Mr PAUL LYNCH: I think you also indicated that you had had discussions with the Minister for Police or had made suggestions to the Minister for Police and the commissioner about this issue. Have you had any response or any preliminary indication of where it is likely to go?

Mr BARBOUR: The informal discussions I have had to date have been largely positive. Unfortunately, the Coroner was provided with some incomplete information about the process and raised some concerns about whether or not this would mean an inappropriate intrusion on the independence of the coronial process. I have subsequently written to the Coroner to assure her that that is not the case and that we see this being entirely independent of and running separately to the coronial process. But certainly that would be something that we would need to be conscious of.

In much of our work at the moment—child review deaths, for example, and also these critical incident matters—inevitably we are doing work oversighting police investigations that will ultimately also go before the Coroner and we have managed very successfully to ensure that there is no duplication, wherever possible, and also no interference in that process. So we have gained a lot of experience in relation to dealing effectively with the coronial process. I anticipate and I have asked the police commissioner to call a meeting with the Coroner and myself and himself so that we can further progress discussion about these issues.

Mr PAUL LYNCH: On the broader point there is some criticism that the police should not be investigating the police certainly in relation to critical incidents. Do you have a view about that? Is there a better way of doing this than currently exists?

Mr BARBOUR: There have been calls for there to be some additional powers provided to independent agencies to investigate critical incidents. I do not support that. What I do support is stronger and more effective independent oversight, and that is what the proposal I have put forward would achieve. The type of investigation that has to be undertaken, the extent of it and the experience and technical ability of those involved in the investigation do not reside in external agencies other than the police. Clearly, the police are the most appropriate agency to investigate those matters.

What I want to be concerned about and what I want to be able to deal to some extent with the public concern about is to be able to say in all of these matters there is some independent scrutiny over the investigation to make sure that the investigation is being conducted appropriately. Part of the problem with the existing process is if there is no death then it will not go to the Coroner and so often there will not be an independent scrutiny process and, secondly, even in matters that do go to the Coroner often the inquest is not held sometimes until one year or two years after the events in question. If there is police misconduct evident, that needs to be addressed much more quickly than two years down the track and that is, of course, only if the Coroner who is hearing the matter determines to actually look at police misconduct; it may not be necessarily relevant to the cause of death and so they may not necessarily look at it.

CHAIR: So unless the police are notifying you, you are basically finding out about these cases in the paper?

Mr BARBOUR: Sometimes, yes.

Mr PAUL LYNCH: As you have correctly noted, there has been an apparent spike in critical incidents. I wonder whether you think there is a role for you in a broader review, a broader oversight or a broader inquiry as to systemic issues that might have led to that spike in critical incidents?

Mr BARBOUR: I would welcome the resources to be able to do something like that. There are a number of very difficult issues because critical incidents arise in all sorts of different ways. They could arise as a result of a vehicle pursuit and an accident and injury or death as a result of a police chase. We have obviously already looked at those issues and we have reported on some of those issues in the past. The firing of weapons, the firing of some tasers, can lead to particular injuries. The Curti matter is an example where that has become a critical incident investigation.

So there are a wide range of reasons why a matter might constitute a critical incident. To look at them all in a way which would be able to address systemically issues that come up would be very challenging, but what one might be able to do is hive off particular areas and look at those much more closely, because I think

many of the issues that are likely to lead to a critical incident are going to be quite discrete in terms of operational procedures of police.

Mr PAUL LYNCH: Have you given any thought as to doing that or as to how it might be done?

Mr BARBOUR: We have not. What I would like to do first is get the opportunity to oversight critical incidents; otherwise it is going to be rather challenging to be able to look at them in more detail.

Mr PAUL LYNCH: Just flowing from one of the comments you made, how is your work going with the review of the use of tasers?

Mr BARBOUR: It is going well but, unfortunately, it—like a number of our other big projects—has been somewhat a victim of our resourcing situation. Big projects require a considerable amount of resources and when you do need to make decisions about how you are going to get your work done sometimes those projects, unfortunately, need to suffer. In relation to this project, I see it as being a very significant one and so I have not pulled away resources from this, and the time that this is taking is more as a result of the breadth of the work and pulling all of the information together and making sure that the information is accurate. I think in one of the questions on notice we provided some of the details, but the period that we are looking at involves analysing over, I think, 1,600 taser incidents and we have viewed the footage of over 600 TaserCam videos of specific uses. So it will be, when we table it, probably the most comprehensive review of taser use in Australasia. At this stage I am hoping that it will be tabled in Parliament within the next few months.

Mr RYAN PARK: Will you be making recommendations as a result of that?

Mr BARBOUR: Absolutely, and what is interesting about that review is that we have been putting forward information as we identify particular issues to police for them to comment on so that we can include that in any final report that we do, and a number of the issues that we have raised with police have already led to police accepting changes to operating procedures and protocols. I am very pleased that the response of police to date has been quite positive in terms of many of those. Not all, but many.

Mr PAUL LYNCH: If it is such a large piece of work and taking up so many resources and you have elected to continue with it, what other sorts of things have you not been able to do as a result of the resources going into that bit of work?

Mr BARBOUR: Mainly some of the less important project work we have allowed to drift a little bit in terms of time. We have not actually made a decision to suspend anything completely or to cancel it, but what we have done is reprioritised things in terms of the order of work. There are a number of areas about which we provided answers to questions on notice which deal with some of the project work. The Committee quite rightly noted that in our previous reports we had said that we had planned on having those completed by a certain date. Some of those things have unfortunately drifted because of that.

Mr RYAN PARK: In terms of budgetary purposes you mentioned the problems of being a part of a super cluster or a large cluster, whatever bureaucratic term is floating around in this current Government. Why is that a problem? I accept the independent component of it, but can you give me a breakdown as to why you being a part of the DPC cluster, or whatever it is, is a particular problem? Is it because you are fighting for resources, or what is problematic about it?

Mr BARBOUR: Part of the problem is that we are then seen by the head of that agency as being just one of a number of agencies within a broader grouping. Secondly, many of the issues that need to be determined are determined on a discretionary basis by that individual rather than by me for my office, which I quite frankly believe is inappropriate. I think any decisions that are made on where cuts ought to rest and what work ought to be affected should rest with me.

What also happens is, because we are in some correspondence and in some materials linked in as part of a cluster, other central agencies when they deal with us propose to deal with us through that cluster. So sometimes we have had in the past Treasury correspondence coming via the Director General of Premier and Cabinet asking us for information and we are then to provide it back to the Director General so that the Director General can communicate it. I think that is problematic. In correspondence that we have received we have been advised that the Director General would resolve all budget issues relating to the cluster and that included the distribution of budget saving initiatives across the cluster, the approval of new capital works and any

reprioritisation of existing programs, and prioritising requests for increased recurrent funding for existing programs.

The Department of Premier and Cabinet is within my jurisdiction. Apart from the fact that I think it is inappropriate, given the nature of what my organisation does and where it sits in terms of the integrity landscape within the State it is just inappropriate for an agency that is technically within my jurisdiction to potentially be making decisions about my budget and other matters and then for that to be compounded and be taken up by other central agencies who then want to treat us as part of the cluster.

Mr RYAN PARK: So what is it overall headline figure dollar cut that you have had to the budget?

Mr BARBOUR: The dollar cut is problematic because on the one hand we have received increases which are sometimes one-off increases over a period of time for new temporary functions or for new permanent functions that are built into our underlying budget. It is the core budget which is the one that is affected most. Then with the new programs it comes off the bottom of those. If I can give you an indication, the efficiency dividend which is being applied to us for this financial year is $316,000. That will increase another $210,000 in the following year.

Our program savings, which have been determined for this year, are $123,000 and that will increase in future years. They all have nice titles. Our procurement savings for 2012-13 is $112,000. Also we now have recently a labour cost adjustment which has been applied to all agencies and that is $314,000 for this year, going up in 2015-16 to $957,000. So the total for 2013 is $865,000 and we estimate that at the moment it will go up in 2015-16 to a total of $1.78 million.

Mr RYAN PARK: Out of what percentage of a total global budget that you have?

Mr BARBOUR: My budget at the moment is approximately $24 million, which is an increased budget over the past few years but that is because of increased funding associated with new functions and temporary roles, so it is quite deceptive.

Mr RYAN PARK: Because you have increased workload but not exponentially in the same way you have increased funding. Okay.

Mr BARBOUR: There was a parliamentary Committee review undertaken in the Commonwealth sector about the impact of efficiency dividends and budget cuts across the public sector. What they determined was that for small agencies who have very little discretion about how they actually spend their money, the budget cut in an arbitrary way was a very blunt instrument and the impact on small agencies that were very efficient and very effective was a very, very onerous impact. That is the situation that we are in.

Essentially budget cuts to me mean I have to get rid of staff. If I have to get rid of staff I cannot do as much work. The challenge of course is that much of my work now is statutory based, so I must do it, which means what I have got to do is I have got to look at what is discretionary. So important project work or our general complaint handling work where we have got discretion about what we take up, they are the things that we need to cut yet they are the things that the people of New South Wales really expect the Ombudsman to be dealing with.

Mr RYAN PARK: In terms of total staff cuts, how many staff do you have and how many have you had to let go? You mentioned two senior people in your report that you had to let go. Is that going to continue? Given that you are facing significant pressures, where is that cut going to go to next?

Mr BARBOUR: We have a strategy at the moment of basically not filling positions as they become available. Any positions that we have got on temporary contract we need to review depending on where they are actually working in the office. If they are working on a project that has been specifically funded, like a legislative review, we are able to keep them on for the duration of the project because we have got funding. But if they are working in other areas of the office we need to get rid of them. The actual staffing levels do not disclose very easily the impact it has had on the office because with the introduction of the public interest disclosures responsibility, the moving over of the child death review team and the legislative reviews and other things staffing numbers have actually gone up a bit rather than down.

CHAIR: Perhaps if you could just give us a figure based on the core budget you referred to earlier.

Mr BARBOUR: I am happy to take that on notice and we can give you an indication of exactly what that means.

CHAIR: Is it fair to say that you are a demand driven agency, unlike some other government departments which are supply driven?

Mr BARBOUR: We are. We do have some inbuilt discretion in terms of what we do, and certainly how we do our business is very much up to us. But we are absolutely. I think what is potentially most disappointing for me is that we have established over the last decade the very real value that the Ombudsman can bring as a result of large projects, systemic work. What we are able to do, unlike many other oversight bodies, is look across the entire way in which government delivers services, for example to Aboriginal communities, and do very detailed work which has to be of significant benefit not only to the community but also to government. Those very issues are the ones that probably in future if we do not have the resources to do will be the ones that we are going to need to cut back on.

CHAIR: I just want to ask a few questions about that because it seems to me the Ombudsman, particularly with this training work and the systems reviews that you are doing, contributes to the efficiency of government overall and better value for dollar in the services if the services are functioning ethically and achieving outcomes, which is what you are reviewing. The work that you have done with other Ombudsmen around Australia, I understand that there is common computer software now for complaints management that all of the Ombudsmen around Australia are using. Is that correct?

Mr BARBOUR: I am not sure all of them but I think most of them are using Resolve, yes.

CHAIR: Is it possible to get some assessment of complaints management or the type of complaints that you are getting in New South Wales and their outcomes comparing that with other States?

Mr BARBOUR: That is partly what the review process was looking at. It was looking at the systems that were in place to deal with it and how we were actually identifying what was a success and what was not and what the systems were in place. That was why we were doing that. That is also partly why we have developed those new key performance indicators within the office so that we can get a better handle on that. There is still a challenge though from State to State because the only area of our work which is common is just the cross-government and local government area.

Other offices do not deal with police. Some deal with Community Services, some do not. Some have child death review functions, some do not. Some have functions over corrections, others do not. So although we can potentially do that for a small area of our work, the public administration area of our work, that probably would be the only area where we would be able to get those sorts of synergies. It is something we are working on. We now have regular meetings with deputy ombudsmen from across the country and also ombudsmen. We are looking at ways that we can assist each other to better improve and better perform.

CHAIR: It would assist the management of the State, I would have thought, to know.

Mr BARBOUR: Yes.

CHAIR: On the issue of asbestos, are you going to do a follow-up report on the actual recommendations you made in the initial review that you undertook of asbestos? I am particularly thinking of Woodsreef. I have actually been to see Woodsreef. Nothing is happening out there. I am just curious to know if you are going to take an ongoing interest in those outcomes?

Mr BARBOUR: We certainly will be taking an ongoing interest in those outcomes. The Government prepared a very detailed response as a result of the recommendations that we made. They tabled that publicly and they created a new entity that is called HACA, which stands for Heads of Asbestos Coordination Authorities. It chose to do that rather than set up a statutory body, as we recommended, to have oversight of asbestos issues and control of asbestos issues. We go along as an observer to those meetings and we are monitoring what is happening with those meetings. There was money provided for an initial remediation project for Woodsreef, consistent with the money that we had said should be provided. We have been monitoring that, but not as actively, but certainly we will be monitoring that.

CHAIR: What is your impression of how the money is being spent? When I looked at it, nothing had happened on the ground.

Mr WHEELER: As we understand it, the money was primarily to be spent on improving the security around the mine area. To actually remediate the whole site would be enormously expensive, but just to keep people out of it we had to do some initial remediation of the premises. Apparently, the premises, as I understood it, were to be removed—the large building that is there. There is also the issue of the road, the public road, that goes—

Mr BARBOUR: Through the middle of the mine.

Mr WHEELER: That was to be closed. Now there is a dispute. I think there are certain parties who are arguing that it should not be closed. We have seen correspondence between Ministers trying to get movement on the closure of the road. We have not been out to have a look at what has been done on the site as yet, but it is something that we do have in mind to do before we have finished our work in this area.

CHAIR: Sure. The funding that you recommended included the demolition of the major buildings. They have not been demolished.

Mr WHEELER: No.

CHAIR: I am just curious to know how it has been spent.

Mr BARBOUR: I think there is also—and Chris might be aware of this more fully than I—some tension with the local council around some of these issues. I gather that representatives on the council have mixed views about what ought to be happening and what should not be happening, and that is largely being driven by different views within the community about how to deal with those issues. That may have impacted on some of those aspects.

CHAIR: In relation to your office, our Committee received correspondence about a disgruntled complainant who came into your office at one stage and claimed that he happened to have a phial of acid in his pocket, which then developed into an incident in your office.

Mr BARBOUR: Yes.

CHAIR: The reason I raise it is that for our Committee it just highlighted the nature of some of the complainants that you deal with and also how effectively that matter was handled.

Mr BARBOUR: Yes.

CHAIR: Nobody was killed and nobody was injured in the incident.

Mr BARBOUR: Yes.

CHAIR: I wonder if you could talk us through about your management of those situations.

Mr BARBOUR: We have a very detailed risk and security policy, which is in place for all of our staff, and we have introduced particular measures in our entry portal for the office. I think most of you have visited the office and you would be aware that we do have limited access now to the reception area. We have redesigned the counter, but we have not put in, like some ombudsman's offices have done, security glass that somebody speaks from behind because we think that is inappropriate. We have also put a closed-circuit television [CCTV] camera into the reception area as well so that we can get footage, and we have a call button. So the moment anybody feels in danger they are able to alert the office. That sounds throughout the office and we have a response team that goes in response to it. Any incident which involves a threat or a safety issue to my staff, we always involve the police, and we have the police attend if somebody does not leave the premises.

CHAIR: How many of those sorts of incidents occur?

Mr WHEELER: If I could just add something to that: In the incident that you are referring to, the gentleman arrived with a bottle. It was an acid bottle. Whether it had acid inside it is open to question. He was

not threatening our staff. He was threatening to drink it. He went into an interview room and he locked the door. We had a police response very quickly and they negotiated with him until he decided to give himself over to them. I also saw in his bag he had other things in there that were quite worrying.

CHAIR: What sorts of things?

Mr WHEELER: Generally speaking, the people who come to our office, if there is an incident, it is because of a lot of anger—yelling abuse, this sort of thing. We have very few occasions when people actually assault, very few. One occurred recently, but it was outside of our office. But on very few occasions do they actually attack. It is more expressions of extreme emotion.

Ms WAUGH: The other category is where they tell us on the phone that they are going to harm another person.

Mr BARBOUR: Or themselves.

Mr WHEELER: We always respond. We inform them that we are going to notify the police or the nearest mental health response team, whichever is relevant. We then do notify and we follow up to find if they have responded. In nearly every case they do respond very quickly and in most cases they know the person.

CHAIR: How many incidents would you have a year of that nature?

Mr BARBOUR: Not that many. I would think it would be less than five incidents in reception a year. We have other incidents where we become aware through a telephone contact or a letter. That is probably the more common occurrence. Interestingly, of course, this very much fits into the work that we have done on dealing with unreasonable complainant conduct, which we have to say has now internationally been recognised as being very, very significant work, and work that we are not only promoting through publications but also directly through training around the world. This particular issue is one that is increasingly common, not just for ombudsman's offices but really for any agencies that are dealing with people who are particularly difficult.

CHAIR: And that is part of your training rollout, is it?

Mr BARBOUR: Absolutely, yes.

The Hon. SARAH MITCHELL: I want to ask a question in relation to the Grafton Correctional Centre. You gave some information about that is in answer to one of the questions on notice and said that you were heading up there, or were planning to head up there, in May to have another look.

Mr BARBOUR: Yes.

The Hon. SARAH MITCHELL: Did that visit eventuate? Is there any update in terms of your concerns?

Mr BARBOUR: We did do the visit. There is nothing particularly to update the Committee on. In terms of that information, however, we still have the same concerns that we had before. Grafton, because it is such an old centre, has a range of problems which relate to health and amenity for the inmates. They are issues that we constantly raise. I think, really, in many respects they are only going to be resolved effectively if Grafton no longer is utilised. There was some decision to retire it some time ago, but I am not sure whether that is still an active matter under consideration. But certainly that, and many of the other prisons which are quite old, present problems.

The Hon. SARAH MITCHELL: In your opening statement you spoke about an inquiry or some work you are doing in relation to Aboriginal disadvantage and educational outcomes and economic limitations.

Mr BARBOUR: Yes.

The Hon. SARAH MITCHELL: Can you provide a bit more information about what you are undertaking in that area?

Mr BARBOUR: That report was tabled in Parliament last year. It came about as a result of very detailed work on a number of fronts: firstly, our Aboriginal unit and its relationship with Indigenous communities around a whole raft of complaints and work that came out of our police oversight functions, our child protection functions and the child death review functions and also broader reviews that are being undertaken as part of our ACSA review, the Aboriginal child sexual assault strategy that we are reporting on at the end of the year. It was a very detailed report and it tried to demonstrate that we believe failure to effectively address Aboriginal disadvantage in western New South Wales and vulnerable communities has largely been because government has failed to work as productively and collectively across agencies as it could. Different agencies trying to provide different models in those settings was not necessarily working in the best way. There was a lot of wasted money and duplication.

Educational neglect became a very critical issue because so many young Aboriginal children were not attending school. The systems in place for ensuring they attended were woefully inadequate. So, one of the areas we focused on was in relation to educational issues and strategies that could be adopted to improve that. I must say in a positive way the Department of Education and Communities has recently announced the new initiatives which relate to communities that we are speaking about in western New South Wales and changes to the way in which education will be delivered and strategies that will be in place to improve some of the problems that we identified. That is a positive step. The ministerial task force that is reviewing Aboriginal issues generally has also taken on board the issues we raised in that report. I believe a copy would have been sent to all Committee members but, please, if you have not received a copy let me know. I am more than happy to forward a copy to you.

Mr PAUL LYNCH: Have you had any meetings with the ministerial task force?

Mr BARBOUR: Yes. I was invited, along with the Auditor-General to address the very first meeting of the ministerial task force. Part of the recommendations we made in that report was for the task force to update us regularly on progress. Minister Dominello, who is the lead Minister, has kept up contact and provides information about that. My understanding is that work is progressing well in relation to that but this is an area where we have seen a lot of activity in the past so we will be looking very closely at what is proposed. One of the key differences of that task force, though, is that there are a number of very senior indigenous members on the committee, and I think it is probably the first time that has happened at a ministerial task force level. I think that is a very positive sign.

Mr PAUL LYNCH: Your focus on those issues seems to be very much on western New South Wales. Granted that the largest conglomeration of Aboriginal people in the country is in western Sydney, is there any focus on those issues in the urban areas and not just in remote areas?

Mr BARBOUR: Absolutely there is. We focus on indigenous issues wherever they arise. However, in our experience the quality and level of service provision in metropolitan areas that have fairly high Aboriginal populations are usually of a higher standard and tend to be working better in those locations. What we see there is not so much a direct link to those issues but more a failure across child protection issues generally to be dealt with effectively rather than more specifically in indigenous communities.

Mr PAUL LYNCH: But all those indicators from the Centre for Aboriginal Economic Policy Research suggest that the level of disadvantage is as huge in the city as it is in the country so it is not just about those sorts of issues.

CHAIR: We also have an unfortunate situation in the country where we seem to have the Aboriginal school and the white school in a town, which is not something I have picked up in Sydney but the Catholic or the government school in each town will be one or the other.

Mr BARBOUR: That very much is the case in western New South Wales. I also think a problem in western New South Wales is that it has been extremely difficult to attract staff. There is generally no difficulty in getting staff to meet particular positions across the human service providers, whether they are government or non-government agencies, in metropolitan regions. But in western New South Wales it is particularly difficult. One of the real challenges is not just the quality of programs but it is also whether there are people on the ground to make them work.

Mr LEE EVANS: In your preamble you were discussing the independence of the Ombudsman's office because it is within the Premier and Cabinet's stable, if you like. Where do you see the Ombudsman's office sitting if it was not going to be in the Premier's office to gain that independence?

Mr BARBOUR: Let me say firstly, we are seeing some progress. I received a letter from the head of Treasury recently indicating that he and the director general of Premier and Cabinet were meeting to discuss our role and budgetary issues. I am hopeful that my protestations are starting to pay some dividends. However, I would like to see there being a recognition of the integrity arm of government. It is not just my agency, it is also the Independent Commission Against Corruption, the Police Integrity Commission, the Auditor-General's office and the Independent Pricing and Regulatory Tribunal. I see no reason why those agencies cannot be seen as the integrity arm of government and that they be treated appropriately as such quite independently and that negotiations in relation to them be conducted directly by Treasury, by Parliament or by the responsible Minister. I have absolutely no problem at all being in the Premier's portfolio. It is clear that my organisation must sit, for the purpose of the way we do government and business, within a particular portfolio.

What has changed is as a result of the super agency creation, the creation of these clusters, and what is assumed is that the agencies that sit within a particular portfolio become part of that cluster. Despite assurances, as I said in my opening, that that would not happen with my office, that is happening. Not all the time, but it is happening and I continue to chip away at trying to fix that. I would like to see all of the independent integrity agencies joined together and be treated in the same way and independently. There is an enormous challenge for us, though, and that is we do not have champions around the Cabinet table or in financial committee discussions. Because of the nature of our work, despite the fact that I sit in the Premier's portfolio my day-to-day relationship with the Premier is a limited one. It is not like his agency head. So, I do not have a Minister who is able around the Cabinet table to argue for me as often agencies will have their Ministers argue. It is one of the disadvantages. It is a necessary disadvantage to maintain independence but it is one that causes some problems. That is why direct negotiations around things like budget cuts or budget enhancements or program delivery would be much better done directly.

CHAIR: I wonder whether our Committee should seek to meet with the Treasurer to discuss these issues particularly the reporting of the of the integrity agencies.

Mr RYAN PARK: I think it is valid. I think you raise the point, is not just for the Ombudsman. This is a problematic situation because a lot of the other oversight committees have the same issues. If you make an ambit cut to your budget, it is staff that go. I assume you do not have huge procurement issues, you do not have huge infrastructure or a lot of IT issues. There is only so much you can cut, so the only place generally in oversight agencies is staffing. The staffing means that projects go which means the whole fundamental tenure of your basis for being, which is the oversight of government projects.

CHAIR: We might at the conclusion of this meeting discuss that.

Mr BARBOUR: In the most recent budget papers that were released, Treasury did identify as independent agencies certain agencies. To our view, that was a positive step. The agencies that were listed were the Independent Commission Against Corruption, the Independent Pricing and Regulatory Tribunal, the Electoral Commission, the Ombudsman's Office, the Police Integrity Commission and the Public Service Commission. I think that is an excellent grouping and one I would certainly endorse. The only one that might also go in is the Auditor-General but it has a different budgetary framework because it is largely self-funding.

CHAIR: In the event that we resolve to meet with the Treasurer, we will certainly be in touch with you for assistance to prepare for that meeting. Has the office of the Ombudsman been provided with pirated software by the police?

Mr BARBOUR: That is not a question I would like to answer yes or no. I think you are referring to the Micro Focus issue?

CHAIR: Yes, but if there is any other pirated software we would be interested in that too.

Mr BARBOUR: No, I do not believe there is. Micro Focus owns the ViewNow software. The ViewNow software was provided to our office by police sometime ago under the clear agreement that police would be paying for the 25 licences. As a result of contact from legal representatives operating for Micro Focus we became aware that there was a dispute about whether or not those licence fees had been appropriately paid.

On the basis of that information we internally took a position to immediately minimise and mitigate our use. As you can imagine, direct access to COPS is essential for our work and that was the very reason we were provided with the software in the first place. Without it we cannot do our work effectively. As a result of information from that, we secured complete funding and support from the Treasury Management Fund, which provides to the State insurance in relation to legal issues and we retained independent legal counsel. As a result of various negotiations and discussions, we entered into a confidential settlement in relation to the matter. My primary concern was that my organisation is an organisation that must at all times represent integrity and ethical behaviour. I did not want anybody to be in a position to suggest otherwise. Secondly, from a practical perspective, we wanted to be able to use all of our licences and, thirdly, the legal cost associated with continuing to be involved would have been far and away greater than the cost of settling the matter.

CHAIR: Why is the settlement confidential?

Mr BARBOUR: That was what was agreed to between the parties.

CHAIR: I cannot imagine why it would be confidential.

Mr BARBOUR: That was what was agreed to between the parties because there is ongoing litigation involving New South Wales police.

CHAIR: Who would oversight allegations that software is being pirated in the public service?

Mr BARBOUR: Can I just say that police clearly deny that they have been pirating software. Their most recent public statement, which was provided to a journalist and ended up being referred to in this morning's *Sydney Morning Herald*, clearly sets out that they take a different view. So I am not in a position to confirm whether or not there is substance to the case that is being put forward by Micro Focus. That will be determined by the court. If that is substantiated and those allegations prove to have been the case by the court, then the obvious place that might review that would be the ICAC or, alternatively, the Auditor-General for any contractual arrangements that have been breached.

CHAIR: The police are supposed to investigate piracy allegations. Obviously, their understanding of piracy is pretty critical to the enforcement of anti-piracy laws around the State.

Mr BARBOUR: As I said, they are clearly taking an alternate view. They do not accept that they have actually done anything unlawful. I am not sure whether there is a problem of the kind you are alluding to. However, if it is determined that there has been inappropriate conduct and the court case determines that, then that may well be an issue that will need to be reviewed.

CHAIR: This has ended up in court because there was no mechanism in the New South Wales Government, it would appear, to resolve this matter as a complaint against the police?

Mr BARBOUR: I am not sure that that would be appropriate. As I understand it, essentially this is a contractual dispute. Both parties argue about the capacity for each under the terms of the contract. So the appropriate place for it to be determined is in litigation if it cannot be the subject of mediation beforehand.

CHAIR: I would agree with that except that your office has settled, as has the Police Integrity Commission—

Mr BARBOUR: The Police Integrity Commission and also the Department of Attorney General and Justice.

CHAIR: Given that the cases are being settled creates a perception that there is validity to the claim.

Mr PAUL LYNCH: You cannot say that unless you know the basis of the settlement.

CHAIR: Which is confidential. Basically, this company has no option other than legal action. What happens if the police settlement of this case is confidential as well?

Mr BARBOUR: I will not speculate on that because I do not know whether that will or will not happen. My understanding is that there have been efforts to settle the matter out of court. My understanding also is that there have been offers to mediate the matter. As far as I am aware, as at today's date the litigation is proceeding. I think there may well be some additional issues that will be the subject of further litigation and both parties seem to be digging trenches in relation to the matter.

CHAIR: How can the public be confident that the police have a correct understanding of anti-piracy laws and are applying and investigating those laws correctly?

Mr BARBOUR: That will be something that will need to be addressed once the litigation is complete and once there is actually a determination of whether the police have conducted themselves unlawfully.

CHAIR: But my point is that if the police make a confidential settlement, how are we going to know the answers to those questions in the way that the Ombudsman's office has made a confidential settlement?

Mr BARBOUR: I cannot answer that because I do not know whether there will or will not be. I do not know what the terms of the settlement will be. Part of the problem is that there appear as well to be multiple other agencies potentially involved in this particular matter. It would just be quite wrong of me to speculate on those types of concerns. Clearly, if there is any suggestion that a government agency is acting inappropriately in relation to software that they are acting unlawfully in relation to contractual obligations, then the place that those matters should be referred to is the ICAC. Similarly, the Auditor-General in reviewing the agency's performance in a financial sense under its contractual obligations has the capacity to look at those issues as well. There is a system in place to review those matters. Whether in this case the company involved ever sought to raise those issues with either of those agencies, I do not know.

CHAIR: Did you?

Mr BARBOUR: Did I?

CHAIR: Did the Ombudsman refer the matter to ICAC?

Mr BARBOUR: No. Why would I?

CHAIR: Because you have just described to me that that is the correct procedure to investigate allegations of this nature?

Mr BARBOUR: Only if you wish to put before them that there is some unlawful conduct and, as I have said, I am not aware at this point of there being unlawful conduct. However, if the court case determines that there was, then that may well be a matter that I would need to decide as to whether or not there should be a reference to the ICAC.

CHAIR: Are you confident that the police are handling this appropriately?

Mr BARBOUR: I cannot really answer that question. It is not within my purview.

CHAIR: Whose purview would it be?

Mr BARBOUR: The police commissioner's.

CHAIR: Who is going to oversight the police commissioner on this particular issue?

Mr BARBOUR: I imagine the police commissioner reports to the police Minister about these sorts of issues and, therefore, to government and I imagine they are also acting on the basis of legal advice. But once again, I am just speculating. My role is not to provide a view about how police are handling their litigation. I do not think that would be appropriate, particularly in public session. There is ongoing litigation. I do not think that would be appropriate.

CHAIR: It has reached the point of ongoing litigation; I am just interested in how they reviewed the investigation of whether the software was pirated. It now has developed into litigation, but the initial complaint

prior to it going to litigation appears not to have been investigated, which is how we have now reached this point where everyone is in court. As you have indicated, it would have been far cheaper to settle this.

Mr BARBOUR: You may have information that I do not have available to me. I am unaware of a complaint being made to anybody about this.

CHAIR: Surely they complained to you when it was pointed out that you were, in their view, using pirate software?

Mr BARBOUR: Sorry, who is "they"? Micro Focus?

CHAIR: Micro Focus, yes?

Mr BARBOUR: No. Micro Focus raised concerns with the police provision of that material and then we found ourselves listed as a respondent in court proceedings.

Mr PAUL LYNCH: It might be commercial dispute rather than anything else.

Mr BARBOUR: I think it is clearly a commercial dispute. It involves a substantial sum of money and it needs to be resolved.

CHAIR: Are there any further questions?

Mr PAUL LYNCH: I have some, but I am happy for them to be supplementary questions.

CHAIR: Yes, we have gone over time.

Mr BARBOUR: That is fine. I am in the next hearing anyway so if you want to go a little over time, that is fine with me. It is not a problem. I am very happy to assist the Committee.

Mr PAUL LYNCH: I will proceed with my questions as supplementary questions.

Mr RYAN PARK: I am happy also to do that.

CHAIR: Are you happy to take questions on notice?

Mr BARBOUR: Sure, absolutely no problems at all.

CHAIR: Is there anything further you wish to add to this part of the hearing?

Mr BARBOUR: No, not at all. I am not sure whether the Committee has the latest printed version. This is volume 2, the second edition. I will leave this with the Committee. If people are interested in having their own copies, please let me know and I will make additional copies available.

CHAIR: Thank you for appearing before the Committee and thank you for agreeing to take further questions on notice.

(The witnesses withdrew)

(Short adjournment)

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON THE OFFICE OF THE OMBUDSMAN AND POLICE INTEGRITY COMMISSION

GENERAL MEETING WITH THE NSW OMBUDSMAN IN RELATION TO THE CHILD DEATH REVIEW TEAM REPORT 2010

———

At Sydney on Monday 18 June 2012

———

The Committee met at 10.00 a.m.

———

PRESENT

The Hon. C. Cusack (Chair)

Legislative Council	**Legislative Assembly**
The Hon. S. Mitchell	Mr L. J. Evans (Deputy Chair)
The Hon. A. Searle	Mr P. G. Lynch
	Mr. R. J. Park

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, its 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.)