REPORT OF PROCEEDINGS BEFORE

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

SECOND GENERAL MEETING WITH THE CONVENOR OF THE CHILD DEATH REVIEW TEAM

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At Sydney on Friday 22 February 2013

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The Committee met at 2.55 p.m.

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PRESENT

The Hon. C. Cusack (Chair)

Legislative Council	**Legislative Assembly**
The Hon. S. Mitchell	Mr L. J. Evans
The Hon. A. Searle	

CHAIR: I now declare open the Committee's general meeting with the Child Death Review Team. In accordance with section 34J (1) of the Community Services (Complaints, Reviews and Monitoring) Act 1993 the Committee monitors and reviews the Child Death Review Team's exercise of its functions, examines the reports made by the Child Death Review Team and reports to both Houses of Parliament. On behalf of the Committee I thank you for appearing today.

BRUCE BARBOUR, Ombudsman and Convenor of the Child Death Review Team,

MONICA WOLF, Director Systemic Reviews, and

JONATHAN GILLIS, Deputy Convenor/Independent Member, affirmed and examined:

CHAIR: You have returned answers to questions on notice to the Committee. Are you happy for those answers to be published?

Mr BARBOUR: Yes, I am.

CHAIR: Can you please confirm that you have each received a copy of the Legislative Assembly standing orders that relate to the examination of witnesses?

Ms WOLF: Yes.

Dr GILLIS: Yes.

CHAIR: Does anyone wish to make an opening statement?

Mr BARBOUR: Yes, a very brief one if I may. It is now two years since the Child Death Review Team [CDRT] was transferred to my office. At our first general meeting in June last year I described the challenges that were presented to the team and to my office in the process of and subsequent to that change. I also noted the significant achievements of the team given those challenges. I am pleased to inform the Committee that the team has continued to progress its work and build on those achievements. I will very briefly outline the team's main area of focus since our general meeting in June.

The team has met on three occasions since then; July, September and December. In October I tabled the team's annual report for 2011. The report made 17 recommendations. I note the Committee has asked a number of questions on notice about this report and I have provided answers to those. In August and in the context of my role as convener of the CDRT and my role in reviewing reviewable child deaths my office co-hosted with Community Services the third Australasian Conference on Child Death Inquiries and Reviews. The conference brought together about 130 people from across Australia and New Zealand, with a focus on strengthening and developing practice in child death review. Four Child Death Review Team members conducted workshops at the conference.

We have also consolidated a number of areas of focus previously discussed with the Committee. We have produced an issues paper for public distribution on low-speed vehicle run overs. As you know, this was an area of special focus in the annual report. In the context of this work the team was also invited to participate in the Federal Government's National Road Safety Forum held in Canberra last August. The team was represented at the forum by Dr Susan Adams.

As I have outlined in my answer to your questions on notice, we have progressed our research project on causes of death for children with a child protection history. The project will analyse data over a 10-year period and will identify any differences in causes of death for the particular group of children compared with children who had no child protection history. The outcomes of the project will be tabled in Parliament in October. We have consolidated our work reviewing the team's data systems. Further to my response to the Committee's questions on notice about progress with this project, I have now provided Treasury with a more detailed cost-benefit assessment of options to replace the outdated system. I am very happy to go into that in some more detail in due course as I know the Committee is interested in it.

The team is very much looking forward to the future and new opportunities. In March we have set aside time for a planning day and a strategic review to consider how we can continue to work on and improve our capacity to meet our prevention mandate. We have already introduced a number of new ways of working. For example, we have established expert subcommittees on sudden unexpected death in infancy [SUDI] and on injury prevention to progress work in these specific areas. We are exploring also how we can draw in specific expertise to assist with certain reviews. For instance, we have appointed Dr Julie Brown, a research fellow from Neuroscience Australia, to work with the team on road crash fatality reviews. Dr Brown has particular expertise in this area. We are also looking at engaging more closely with genuine researchers to share important

information and promote effective research that may help to prevent childhood injury and death. Dr Gillis, Ms Wolf and I are very happy to answer any questions you have.

CHAIR: We will start with the IT issue and the database funding request that you have made to Treasury. As I understand it, it has been budgeted at about $250,000 and that is required over two years, is that correct?

Mr BARBOUR: It has changed significantly since that and is now budgeted at significantly more.

CHAIR: It never goes down, does it?

Mr BARBOUR: No. We attached to our questions on notice the documentation from the review that was conducted. It was at the conclusion of that review that the estimate of $250,000 was made by the person who conducted that review. We sought that money in a number of different ways and at different times and, thus far, it has been rejected by Treasury. However, that may well have been fortuitous because, to support a better case, Treasury asked us to do a more detailed analysis to support, if you like, a cost benefit analysis and to look at options in more detail and to focus on that for any further applications made to Treasury. We have now had that undertaken by Deloitte and what we have identified as a result of that is that there are three viable options for an appropriate data system but the options and estimated capital costs are significantly higher. One is adapting the system used in the office, called Resolve and adding a particular reporting tool. The cost for that is estimated at $563,000.

The second option is purchasing and adapting a new system which has been adapted by the Queensland Commission for Children and Young People for child death reviews. The cost of that is estimated to be $579,000. The third option is to develop a purpose-built system from scratch, to meet our needs. The estimated cost for that is $587,000. These costs are estimated to be recovered by efficiency savings but not until eight or nine years down the track. It is a significant difference to what was originally put forward, so Treasury's caution and response back to us asking for more detail may have been helpful to us in the long term. Having said that, whether we will be funded for it, remains in doubt. We will have a meeting and this will be the primary issue we will be putting forward for additional funding. If the committee is able to assist in any way in that regard, I encourage it to do so. As the Committee will be aware, trying to get additional funding for any project at the moment is extremely difficult and notwithstanding the dire need for this work to be done and the real risks associated with it not being done, we are not optimistic that we will be successful in gaining this money. In case we do not get that funding, we will need to look at alternatives to try and support the existing system and to try to reduce the risk of it failing on us.

The Hon. SARAH MITCHELL: Of the three options, do you have a preference? Is the purpose-built one the one you would prefer, given it would be made specifically for your needs?

Mr BARBOUR: At the moment, we are leaning towards using the Queensland one. The reason for that is that, as a result of it already being in place and being introduced, they have already gone through many of the teething problems and difficulties associated with setting up a new system. There may be some considerable advantages in us doing that. We could still use their system but redesign and adapt it for any particular purpose needs that we have that are different to that commission's review role. So we would still be able to have it marry up effectively with what we need. At the moment it appears to be the best option.

The Hon. SARAH MITCHELL: You will communicate that to Treasury, I assume?

Mr BARBOUR: Correct. Fortunately, the dollars are not that different so, at the end of the day, I believe they will be guided by us as to what we think is the best model. If we were putting forward three options and one was several hundred thousand dollars less, Treasury would be trying to secure our agreement to follow that path.

CHAIR: In relation to which system you choose I understand that every State is now following the New South Wales lead, which is to have a review system for child deaths. Are you talking with your counterparts in other States about developing information systems that have a synergy so that national statistics can be easily obtained? It seems to me that, if there are three options, maybe the ones that will be compatible, some importance could be attached to that, to give us better national reporting options in the future.

Mr BARBOUR: We are certainly in discussion with our counterparts in the other jurisdictions. On Monday there is a meeting of the Australia and New Zealand Child Death Review and Prevention Group which Monica will be attending. That group is alive to the sorts of issues that you have just discussed. I think the ongoing challenge is that, notwithstanding the similar focus of each of the different agencies that are involved in this area, the mandate, the legislation, the way in which they do business and what they are required to look at and not look at, is different from jurisdiction to jurisdiction. So it is not just about talking with them and trying to get some commonality in terms of those issues but it is also looking at whether or not those other jurisdictions are likely to legislate to create systems that are more like systems which would make the job far easier.

CHAIR: And the information system needs to be responsive to the legislation.

Mr BARBOUR: Correct.

CHAIR: That is my next question. Is the case study that has been developed by Deloitte—and it is not for us to go into which is the better system and I do not mean to do that—but does that go beyond the legislative requirements of the Child Death Review team or is it a minimalist compliant information system?

Mr BARBOUR: No, perhaps it is best to go back a moment before answering that, to once again reiterate that the recommendations of James Wood which led to the Child Death Review team being located in our office, were predicated on the basis that we already had our child death review function in place. He saw the benefit—and I think that was very sensible—of the synergy between the two functions and the fact that the database, information and register that were needed for both functions could, in fact, be one and the same. Our work is on ensuring that all the functions that we have are appropriately supported, not only in terms of the legislative framework but also in terms of what we have already identified with the existing systems as being problems in terms of data storage, data retrieval, access and a range of other things, so that it will not only support our legislative functions but the design ought to allow us to work far more effectively in the future, in terms of our responsibilities about accessing and using data. That will not only potentially help us to do our work, but it will also be far more helpful when we engage with others, in terms of research projects and the like. The system is very unstable and problematic and has been altered many times in its history. The nature of the information that has been put into it is different over many years and as a result when we do a search and retrieval, we often get different outcomes each time. It causes us to need to do everything manually over the top to make sure that the data is accurate, which is very labour intensive.

CHAIR: How old is the system you are using?

Ms WOLF: Sixteen years, I think.

Mr BARBOUR: It was set up by the Commission for Children and Young People 16 years ago and it has been built on a platform that has been added to progressively. We have split it into two because, even if we get this funding, it is going to be some time before we have got something up and running. We are looking at ways of ensuring that we have the capacity to still use the information and it does not crash completely.
~break/Mendra.

CHAIR: In terms of the future that you are looking at, will that be one that other agencies, such as the Coroner, can access or directly input data into and that sort of thing?

Mr BARBOUR: We will have the capacity to provide information to the Coroner, as we currently do, but they would not have direct access to our system, no.

CHAIR: Because the issue is the collection of data, really.

The Hon. ADAM SEARLE: And the inputting.

CHAIR: Yes, and the inputting. If the Coroner's Office could be inputting directly to your system, I imagine that would save him time as well as you.

Mr BARBOUR: Yes and no. Often we are looking at different issues. Of course, much of the information that the Coroner would focus on would only be part of what we would be looking at, and we would still be wanting to check to make sure that that information was accurate.

CHAIR: How does the Coroner report to you?

Mr BARBOUR: The Coroner does not report in a formal sense.

CHAIR: Report information, I mean.

Mr BARBOUR: We can seek information. Ms Wolf might want to talk about the relationships. It is not just the Coroner but also Births, Deaths and Marriages and other agencies that provide us with information for the database.

CHAIR: Presumably they are doing that proactively.

Ms WOLF: Yes, they are, proactively.

Mr BARBOUR: Yes.

Ms WOLF: We will also identify where we need information from the Coroner, so it is a two-way street, basically. But they do provide us with all coronial cases that they think we require.

CHAIR: Do they just kind of post those to you? Is that what happens?

Ms WOLF: Generally, yes. Some are electronic, but it is different ways.

CHAIR: But that is not part of the current proposal. That is a different issue, is it?

Ms WOLF: I think when we looked at it, we wanted a system that would allow for that in the future so that certain things could be drawn in. At the moment, we get Births, Deaths and Marriages data drawn directly into the system. There are other data sets that could be drawn in, so I think the potential was looked at in those other systems.

CHAIR: It is just quite interesting because I know that the Ombudsman's office already has access to databases that can be interrogated rather than replicating the database, but I guess this is such a specialist case.

Mr BARBOUR: Yes. I am much more comfortable about accessing other agencies' databases than I am about other agencies accessing mine.

CHAIR: I do understand. I was thinking more about putting information into your database.

Mr BARBOUR: But even then we are relying on the accuracy of that, and we have to make sure that it is okay. It is sort of an interesting issue. In terms of risk around the quality of information, we find that often we have to check the quality of information that we get from external agencies and it is often not right. A classic example is around issues, for example, that deal with Aboriginality. Quite often we will get information that fails to identify a child as being Aboriginal.

CHAIR: I know.

Mr BARBOUR: But when in fact we look at all the information, it is quite clear that they are. So that sort of process is very problematic if they are just feeding into our system. I think I would feel uncomfortable not interrogating that to make sure it was actually accurate.

CHAIR: Yes. The work of the committee is incredibly valuable in providing that accurate information. The quality and standards that you have are very important, and thank you for that. So we can be helpful, in terms of the answers, they have been, "It is not successful", "Not successful", but it does sound like Treasury has been trying to engage you in some sort of a value submission process. I am not quite clear on that. Is it possible for you to perhaps update us on where it is at so that we can consider how we might further that?

Mr BARBOUR: Absolutely. We will update you on those negotiations and indicate whether we have been successful or not.

CHAIR: And what it is that they are all asking for. Thank you. I appreciate that very much.

Mr LEE EVANS: I have a question about the computer system. Is there any other jurisdiction in the world that has got a similar system? Has Canada got one?

Ms WOLF: Yes.

Mr BARBOUR: Yes.

Mr LEE EVANS: Are they all about the same?

Mr BARBOUR: Yes. In fact, it is very interesting that you ask that question because we were contacted only recently by a Canadian agency that we think is the only one—the only one that we are aware of—that uses the same system as the Commission for Children and Young People [CCYC] and it is crashing. It wants to come and talk about what it needs to do with the information, so we are well experienced to be able to provide them with some advice.

Mr LEE EVANS: So there is no-one with a whiz-bang buy-off-the-shelf type of system?

Mr BARBOUR: No. The Queensland system seems to probably be.

Mr LEE EVANS: Has that been built up from scratch, though, or has it been adapted?

Mr BARBOUR: They have basically done a lot of work to develop it. I think they have used an initial product that is an off-the-shelf product, but then what they have done is purpose added to it to create something that provides them with what they need. We see it, as I understand, as a vehicle that we can use as well, provided that we add on in certain ways ourselves. I must say initially we had concerns about that, but those concerns after much more careful consideration have largely been evaporated.

CHAIR: I think it is fair to say that the child death review process, across public sectors internationally, is quite innovative and best practice. This is literally an issue that, because we were so early, the information technology infrastructure is now aged and needs to be replaced.

Mr BARBOUR: Yes.

Mr LEE EVANS: My next question is: Once we get it developed, is there a licensing possibility in the future for other jurisdictions around the world?

Mr BARBOUR: Well, there might be for Queensland. I have not even contemplated that. I mean, this will be such a big project that, even if we get the money, it will take some time. Not only do we have to set up this system but we have also got to migrate all the existing data across and we have to confirm the integrity of that data as we go across. So we have got 16 years of information that we have to put onto a new system.

Mr LEE EVANS: We are living through that at the moment here.

Mr BARBOUR: It will be huge. It may make Operation Prospect look like a walk in the park. I do not know yet.

CHAIR: But it sounds like it is urgent, given the lead time that you are faced with.

Mr BARBOUR: It is, but that is also why I think we are being very sensible in getting advice about, if we do not get the funding for the new system, how best to try to deal with the existing issues and create a relative safety net, which at the moment we do not have.

CHAIR: Right.

The Hon. ADAM SEARLE: What risk is there of a system crash?

Mr BARBOUR: We have been living under that risk of that—a genuine risk—for some time.

The Hon. ADAM SEARLE: Okay.

CHAIR: It is going to happen at some stage, from the sounds of it.

Mr BARBOUR: Yes. We had to split the database in two to begin with because it was just so insecure as one system, so we did that reasonably early on—probably within literally months of us getting the jurisdiction. Progressively since then we have been identifying the problems. But, yes, the risk is a high one.

The Hon. ADAM SEARLE: Since getting the jurisdiction, what have been the key challenges in handling it from your perspective?

Mr BARBOUR: The early challenges were the ones that I lamented about and spoke in detail about at the last Committee meeting. We inherited a function that really was just not operating effectively and we needed to do an enormous amount of work in terms of rebuilding the processes that were in place, ensuring the legality of a whole range of issues and looking at the problems associated with the database. Unfortunately, we did not inherit a system that was working particularly well, so the starting point was to fix up all of those issues. What we have been able to do successfully since then is to better engage with the members of the team around how we might approach the issues and responsibilities of the team in a different way and make the team far more innovative and more effective. We are working towards that in a very positive way.

There is a great deal of confidence among the committee members now that there is an opportunity to do very good work, very innovative work and project-oriented work. We are looking to engage more with other agencies external to our own team. There is no doubt that the link between the team's functions and the functions of the Ombudsman in terms of child death reviews works very, very well. Dr Gillis is the deputy convenor. He was on the team before and has come across. He may well have some observations around this.

Dr GILLIS: I think it has probably become one of the most sophisticated teams in the world, actually, because what we have done is expanded it. We have experts. We have an oncologist, a cancer expert, and a paediatric surgeon. There is nothing worse than reinventing those things. We now have experts so we can look at the whole range of deaths, which I think is fairly unique. There also is a lot of good will and absolute engagement. I think over the last few years it has been very exciting. In a sense there is so much excitement that that is why we need the database and things like that. I think it will be incredibly innovative to have wide experts on almost every aspect of child death. It is very unusual, actually.

The Hon. ADAM SEARLE: What is the total budget for the team? How many people are in the team?

Mr BARBOUR: It is not very much. We got about a $500,000 budget increase when the team came across.

The Hon. ADAM SEARLE: So what is the total budget now?

Mr BARBOUR: That is it; for the team, it is $500,000. Added to that was the budget that was available in terms of our existing reviewable death function. We have within the office a combined area, which includes our support for the child death review team, the reviewable child death functions, and the reviewable disability death functions. That area is one area within the office. Really, for budget purposes, what we do is try to put all of that together. But that area, just like any other area of the office, is subject to productivity savings, efficiency savings and so forth. It is one of the reasons why I think that the dollar amount, the quantum, for the database is so significant. It mirrors the total annual budget for the support for the whole team. As Jonathan just said, once we get the database right, and I am optimistic we will get there one way or another, the opportunities really are enormous.

At the moment it is very difficult to engage with researchers and other experts beyond the team who are doing really interesting work or who want to use the team's data, because data is so unreliable and it is so difficult for them to get what they need. Once we are able to do that effectively we will be able to do all sorts of extraordinary things. We have created subcommittees to look at particular issues emphasising the specialities that are brought to the team by members of the team. We are looking at restructuring the staff of the area to make sure we have the highest level of support and research capability internally that we can get to support the team. A number of members of the team that are directly linked to universities and teaching facilities are keen to have postgraduate students and others who are doing research projects working with the team. We are really in the box seat to be doing some very effective work.

The Hon. ADAM SEARLE: How many people comprise the team?

Mr BARBOUR: The Child Death Review Team or the support staff?

The Hon. ADAM SEARLE: The Child Death Review Team.

Mr BARBOUR: It is currently 20.

The Hon. ADAM SEARLE: You mentioned there is an oncologist.

Mr BARBOUR: I will mention some of them. We have the Director of the Division of Surgery and senior staff specialist paediatric general surgeon from Sydney Children's Hospital, Dr Susan Adams; Robyn Bale is one of the departmental; representatives from the Department of Education and Training; Professor Ngiare Brown is one of our Indigenous members; she is the medical officer of the Australian Indigenous Doctors Association; Dr Luciano Dalla Pozza is the head of the department and senior staff specialist oncology at the oncology unit for the Children's Hospital at Westmead; Professor Megan Davis, Director of the Indigenous Law Centre, faculty of law at the University of New South Wales; Dr John Howard, senior lecturer, National Drug and Alcohol Research Centre, University of New South Wales; Professor Ilan Katz, Director of the Social Policy Research Centre, University of New South Wales; Dr Ella Sugo, paediatric pathologist and a specialist in anatomical pathology, Sydney Children's Hospital; and Dr Helen Somerville, Visiting Medical Officer, department of gastroenterology at the Children's Hospital, Westmead. So they go on. It is a very distinguished group.

The Hon. ADAM SEARLE: It is a really impressive group.

Mr BARBOUR: It is. I must also compliment the agencies and Ministers that have put very useful, supportive and interesting agency representatives onto the team. They contribute very positively.

Dr GILLIS: It is a very distinguished group.

The Hon. SARAH MITCHELL: In your opening comments, Mr Barbour, you said that the team met on three occasions in the last six months of the previous year. Is that the standard? Do you have set meetings or is it on an as-needed basis?

Mr BARBOUR: We have set meetings and under the legislation we have to have a minimum of four annually. We try to have more than that. We have also created some subcommittees to give us more flexibility in meeting outside the whole team structure. As you can appreciate, one of the tensions that comes with the incredible expertise and seniority of the people on the team is a very busy work schedule. We try to capture their time as best we can and we have meetings scheduled well in advance.

The Hon. SARAH MITCHELL: Are they all Sydney-based or are there regional members?

Mr BARBOUR: They are all largely Sydney-based. We did have some regional members but we do not at the moment.

CHAIR: I have some questions about the outstanding recommendations. I understand the recommendation on swimming pools has now been implemented.

Mr BARBOUR: The review of the swimming pool legislation is certainly underway. We have made recommendations in relation to what some of those provisions ought to be but we are not aware of whether or not they have found their way into the legislation.

CHAIR: I just recall that we have altered the legislation so now everyone has to register their swimming pool.

Mr BARBOUR: Absolutely, but we made some much more specific recommendations as well about the registration system

Ms WOLF: I think the recommendations made previously have been implemented and we have made new ones.

Mr BARBOUR: And what should be in the legislation. We might be talking slightly at cross-purposes.

CHAIR: I am on page 121.

Mr BARBOUR: Those are the old ones.

CHAIR: Is that one ticked off the list?

Mr BARBOUR: Yes.

CHAIR: Is it correct that the others are still on the list?

Mr BARBOUR: That is correct. We made some fresh recommendations in relation to this new report. They go to very specific issues which we think would support the new system of registration in a much more positive way. That comes from the research we did. We did a review, which is documented in this report, about swimming pool drownings. From that review we were able to identify particular common factors and we have used those common factors to base recommendations that are quite specific in terms of the new legislation. For example, most of the swimming pool drowning deaths are young children under five and they drown in a pool which is normally at their home or the home of a relative that they are visiting. Primarily they are at their home. We have recommended that we not only have a registration system but that that system require people to document if there are children under five living at the premises. If so, they are then bumped to the top of the list and prioritised in terms of the inspection regime. There is no point in resources being spent prioritising inspection of pools at homes where children do not reside and never use the pool. It is much better to focus on the ones where it is clear there is evidence to support the likelihood of that risk.

CHAIR: Very good idea. Has that been included in the legislation?

Mr BARBOUR: Not that we are aware of at this stage, but certainly we have put it out to those who are looking at the review and preparing legislation.

CHAIR: So the system of registration needs to be designed correctly in the first place?

Mr BARBOUR: Correct.

CHAIR: That is pretty pressing, isn't it?

Mr BARBOUR: Yes, that is why we have made the recommendations and as well we put a submission along those lines to the review of the swimming pools legislation. We have covered it in both ways.

CHAIR: I hope they are doing it, but they are not, are they?

Ms WOLF: We will follow up the response to those recommendations in some detail.

CHAIR: Would you mind updating us on that?

Ms WOLF: That happens in March so will be able to get those answers pretty soon after that.

CHAIR: Can I request on notice that you follow it up sooner and let us know how that is going because I think this matter is very current.

Mr LEE EVANS: I remember something in the Chamber about that.

CHAIR: We definitely altered the legislation and everyone has to register their swimming pool. That is happening. The point that is being made by the team is that you want to design the system so you can capture information as to whether there are young children living there now while everyone is registering rather than cobbling it on later, which will entail having to go back and ask every owner. I suppose it can be done through a letter.

Mr BARBOUR: The device for doing that may well be by way of regulation or something like that attached to the legislation. We are happy to engage further and will advise you about what our inquiries uncover. My understanding is that it is still at the bill stage and it has not come back into the Parliament. I think they are looking at a whole range of submissions that came in from that first round. We will certainly follow that up.

CHAIR: Yes, just to make sure they are on top of your suggestion.

Mr BARBOUR: As you would be aware, we also issued our first issues paper on that subject of pool drownings and more recently we have issued an issues paper on low-speed vehicle run-overs.

CHAIR: Excellent. In relation to the other recommendations, the situation is pretty outrageous, isn't it? In some cases these things have been recommended more than a decade ago, particularly the 2008 one relating to births, deaths and marriages and the identification of Aboriginal children and young people who die. There is also one in relation to the lack of paediatric pathology. Is that still the situation with those two recommendations?

Mr BARBOUR: Certainly the response that is listed at the end is the current situation as far as the team is concerned in relation to those recommendations. Two of those matters that we are still actively pursuing and that I can speak about relate to Health and its response and how it is auditing its new policy framework in relation to sudden and unexpected death in infancy [SUDI]. We are actively engaged in that and we have a SUDI subcommittee that is looking at how best to engage Health around those processes. Regarding sudden unexpected deaths in infancy, we have also recommended to community services that they do a cohort examination in relation to that issue in respect of children that have been notified to them. That is underway as well.

The other one we have actively followed up is what I regard as being an appalling mismanagement between the Commission for Children and Young People and the Motor Accidents Authority involving the sum of $50,000 and whether the grant was made. It defies comprehension that two government agencies can go backwards and forwards saying they have received $50,000 and then say they have not and say they are doing work and other things. It is extremely difficult to get to the bottom of that. I wrote to the heads of both agencies, saying that if they did not independently raise the matter with the Auditor-General I would do it for them. They are in the process of raising that. I understand the Commissioner for Children and Young People has raised the matter with the Auditor-General. I have had some contact from him about the matter.

CHAIR: Has the money just vanished?

Mr BARBOUR: I do not think it was ever paid.

CHAIR: In which case it may still be possible to identify funds that can go into this project. It is an important project.

Mr BARBOUR: Issues have now gone beyond that project. The Commission for Children and Young People is focused on an entirely different process. There has not been much work done on that and we are looking to other modalities to support that particular issue. The Commission for Children and Young People has decided to work globally on trying to set up a serious injury prevention team framework rather than specifically look at this. That is what it has been focused on. That is where it went initially from this particular recommendation, so there has not been much done in relation to this work.

CHAIR: There are deaths occurring in State forests as a result of children riding mini bikes and motorbikes. It is completely unregulated. There is also the problem of the quad bike accidents. I realise this is recreational, but there are obviously accidents involving equipment off road, whether it is recreational or working. Are you saying that is going off the boil as a priority?

Mr BARBOUR: No.

Ms WOLF: One thing that the team is doing for this year's annual report is reviewing all off-road fatalities. It is happening now.

Mr BARBOUR: We definitely want to do work on that. There were three off road vehicle deaths in the year we have just reported on. Clearly it is an issue of concern to the team. We have agreed, such as we did this year when focusing on drowning deaths and low-speed vehicles, to look at that issue in the coming report.

CHAIR: Terrific. There is a facility at Moree that has done a lot of work on quad bike issues. Are you familiar with that? I will look up the details.

The Hon. SARAH MITCHELL: It is Farmsafe Australia.

CHAIR: They are cutting edge on this issue and very passionate about it. I turn to some of the other recommendations. One is that the Registry of Births, Deaths and Marriages monitor the identification of Aboriginal children and young people who die, including the number of registrations where Aboriginal identity is not specified. That was made in 2008. Is the registry making any progress on that matter?

Mr BARBOUR: It would be fair to say no. It is literally as we have reported it. I do not think it is any longer a priority. They are pursuing different issues and they have responded as we have quoted. Details of Indigenous status will be reported based on data from our current system and the LifeLink project is currently on hold pending completion of a review. We thought that LifeLink project was going to be more helpful in respect of that.

CHAIR: What was the timing of the LifeLink project? When they say it is currently on hold, has it been on hold for years?

Mr BARBOUR: We got advice in June 2011 that the implementation of LifeLink had been delayed. We were advised in July 2010 that LifeLink would be implemented in late 2011. It has been on/off, on/off over the past two years.

CHAIR: Is that an important initiative in your view?

Mr BARBOUR: It was to be the vehicle with which they were going to deal with the issue that we had identified. As you know, it is extremely important to identify Aboriginality correctly in respect of the information that we get. That is the reason that issue was properly recognised by the team all those years ago. It is a continuing problem. I have personally written to them. We have followed up. The response is what we have received. Unfortunately I do not have any capacity beyond what I have done to get them to focus on it.

CHAIR: It seems to me it has been a problem for 225 years. Now we really struggle on multiple fronts because we have never had clear information about Aboriginality. It would be a significant problem to different agencies for different reasons, to understand what our history was and what has occurred. I am dismayed that New South Wales is still not dealing with this professionally. The information needs to be at a standard whereby you can rely on it. When you are doing your investigations, do you then notify the status of Aboriginality back to them and are they accepting that information from you?

Mr BARBOUR: We do not notify back to them. We use a range of different information and bases to determine Aboriginality compared to what other Government agencies do. That is one dilemma. There are protocols. There is no consistent practice across Government regarding that particular issue. We use all of the information. Even if that information does not formally identify a child as being Aboriginal, if we believe there is sufficient information in there to identify it, then we will classify them as an Aboriginal child for the purposes of our database.

CHAIR: I can see the benefit whereas the individual family may not want that written on the birth certificate, for all sorts of reasons.

Mr BARBOUR: Yes. Health may not get the information at the time of the child's death.

CHAIR: I understand that is the biggest problem.

Mr BARBOUR: That is just one problem in respect of death certificates and the quality of information surrounding that issue, which is another area that the team has investigated.

CHAIR: It sounds like this is a matter for the Attorney General to progress in his budget process.

Mr BARBOUR: It is also about whether or not the registry sees it as a priority issue.

CHAIR: There was a recommendation in 2005 that we do not have adequate paediatric pathologists.

Glebe morgue does not have a paediatric pathologist on staff or a visiting medical officer.

Mr BARBOUR: This has been an ongoing problem that the team has discussed many times. We have received regular advice that it is extremely difficult to get people with the appropriate qualifications in this area. Beyond monitoring it and noting some of the challenges, we have not been able to progress that issue.

Ms WOLF: There may be some progress. I understand that they are bringing in some paediatric support. We need to wait to see how it pans out.

Mr BARBOUR: They are aware of the problem and are anxious to resolve it, but it is a real challenge in respect of getting people with the skill base to do the work.

CHAIR: I understand the morgue faces enormous challenges. I have heard about funeral directors' cars lapping around the block on a Monday. It is resource-challenged. I presume there are other morgues in the same situation. Are you satisfied with the quality of the post-mortems, or is there a plan B that could involve training people, not only at Glebe, but at other morgues? It depends on how much of a problem it is.

Ms WOLF: The ongoing problem has been the slowness of forensic reporting to allow the coroner to finalise the report. It is volume.

Mr BARBOUR: It is not quality of process, it is the process itself that is the problem.

CHAIR: I understand.

Mr BARBOUR: When they are done, they are done to a high standard. There have been no concerns about that, it is more about the delay.

CHAIR: And the resources are causing the delay, not just access?

Mr BARBOUR: Also the particular protocols. There are decisions about how the autopsies are to be conducted.

Dr GILLIS: Paediatric pathology is specialised. I think general adult pathologists would agree with me. It is specialised. There are rare diseases that only paediatric pathologists might recognise. It is true, we do need paediatric pathologists.

CHAIR: What is the solution?

Dr GILLIS: I think Jillian Skinner has begun to use the children's hospitals to help the Coroner's office. That is the plan as I see it. Some of this is not to do with resources but with not having paediatric pathologists. There are not enough of them.

CHAIR: Absolutely. That is the reason for my question. Do we need to create more training positions?

Dr GILLIS: Ms Wolf can speak to this. I think they have tried to recruit from overseas. They have added a training position at Sydney Children's Hospital. They are aware of it and they are tackling it.

CHAIR: I understand that it is a specialised area. Would almost all paediatric post mortems be conducted at Glebe?

Dr GILLIS: Coronial post mortems would be. When a child dies at a children's hospital, if it is not a coronial case and the parents agree to an autopsy, it is done at that hospital. The two children's hospitals are known as the Children's Hospital Network. They do autopsies on children who are not coronial cases. If the death is the result of a car accident or various other causes, the autopsy is done at Glebe. I presume Newcastle does some, but they are primarily done at Glebe. Until recently, Glebe has not had access to paediatric

pathology. I think they are aware of it and on our recommendation they are beginning to use one of the children's hospital pathologists to help. That pathologist is one of the members of our committee.

CHAIR: That is more valuable.

Dr GILLIS: Dr Sugo is head of paediatric pathology at Sydney Children's Hospital, Randwick. On our recommendation she is now advising the Coroner. Members would be aware that it is a unique area. When you need them you need them, but you do not need them all the time. That is a dilemma throughout medicine.

CHAIR: The Army does not have its own doctors; it uses a reserve of doctors from the broader community. That is a fantastic system. Perhaps that concept could be adopted.

Dr GILLIS: We have made many recommendations and they are aware of it. They are taking it seriously and thinking about what to do.

CHAIR: Do you wish to raise any issues with the Committee?

Mr BARBOUR: No.

CHAIR: In relation to both this and the previous hearing, the Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide written replies to any further questions?

Mr BARBOUR: That would be no problem.

CHAIR: Thank you. That is much appreciated. You would have noticed that this hearing has been held earlier in the year than previously. That has been done to avoid everything banking up at the end of the year. We hope that this will set a precedent for the timing of the review of annual reports.

Mr BARBOUR: We are happy to be here and to assist whenever the Committee chooses to have the hearings.

CHAIR: Thank you. It is better than having a hearing about a report a year after it has been tabled.

Mr BARBOUR: I agree. It is easier for us, too.

CHAIR: I am sure it is fresher in your mind.

(The witnesses withdrew)

The Committee adjourned at 3.43 p.m.)