

DEPARTMENT OF

THE ATTORNEY-GENERAL AND JUSTICE

REPORT

Review of Part 3.3 *Care and Protection of Children Act* (Section 222)

22 November 2012

**INDEX**

[**1.**  **Purpose of this Review** 3](#_Toc341196071)

[**2.**  **Executive summary (recommendations)** 3](#_Toc341196072)

[**3.**  **Childs Death Review and Prevention Committee (Part 3.3)** 4](#_Toc341196073)

[**4.** **Childs’ death review committee in other Australian jurisdictions** 6](#_Toc341196074)

[**5.**  **Scope of the review and the consultation process** 10](#_Toc341196075)

[**5.1**  **Object of Part 3.3** 10](#_Toc341196076)

[**5.2** **Composition of the Committee** 11](#_Toc341196077)

[**5.3** **Work undertaken by the Child Deaths Review and Prevention Committee** 12](#_Toc341196078)

[**5.3.1**  **Review of Child Deaths in the Northern Territory** 12](#_Toc341196079)

[**5.3.3** **Research** 15](#_Toc341196080)

[**5.3.4** **The Development of Appropriate Policy** 15](#_Toc341196081)

[5.3.5 Privacy issues 15](#_Toc341196082)

[**5.4** **Consultation** 16](#_Toc341196083)

[**6.**   **Submissions, responses and recommendations** 16](#_Toc341196084)

[**6.1**  **Has the operation of Part 3.3 has met the object of Part 3.3?** 16](#_Toc341196085)

[**6.2**  **Should there be any amendment to Part 3.3?** 18](#_Toc341196086)

[**6.2.1** **The process of appointment and removal of Committee members** 18](#_Toc341196087)

[**6.2.5**  **Provision of Committee Reports to the Minister** 23](#_Toc341196088)

**1. Purpose of this Review**

Section 222 of the *Care and Protection of Children Act* provides:

222 Review of operation of Part

*(1) The Minister must conduct a review of the operation of this Part within 3 years after the commencement of this Part.*

*(2) The review must determine:*

*(a) the extent to which the operation of this Part has met the object of this Part; and*

*(b) whether or not any amendment to this Part should be made.*

The Review had been conducted by the Department of the Attorney-General and Justice (formerly the Department of Justice) in the period since the Department was allocated responsibility for the administering Part 3.3 on 12 April 2011. Under the Act the review was due to be completed by 7 May 2011.

This Review (currently in draft form) has been conducted by the Policy Coordination (Legal Policy) Division, Legal Policy of the Department of the Attorney-General and Justice. This draft report sets out the proposed findings and recommendations for consideration by the Minister for Children and Families.

There is no legislative requirement to table the review in the Legislative Assembly.

**2. Executive summary (recommendations)**

The recommendations are:

**Recommendation 1:** That section 207 of the *Care and Protection of Children Act* be amended to clarify that an object of Part 3.3 is for the Committee to provide recommendations for the development of appropriate policy to deal with child deaths, diseases and accidents.

**Recommendation 2:** That section 218 of the *Care and Protection of Children Act* be amended to allow the Minister to terminate a person’s appointment if the Convenor of the Committee recommends to the Minister that the Minister terminate appointments of Committee members in circumstances where Committee members have left the jurisdiction, or where reasonable attempts to contact an absent Committee member have been unsuccessful.

**Recommendation 3:** That section 209 of the Act be amended to clarify that the Committee continues to operate, despite the absence of at least two Aboriginal Committee members required by section 209(5) of the Act. The amendment should provide for an ongoing obligation on the Committee to recruit suitably qualified Aboriginal members to fill any such vacancies in the membership expeditiously**.**

**Recommendation 4:** That there is no extension of the Committee’s power to conduct individual reviews of child deaths.

**Recommendation 5:** That consideration be given to amending section 211 of the *Care and Protection of Children Act* to include a Chief Executive Officer of a Northern Territory Government agency as a person in which must provide specified information following a request from the Committee. Such an amendment may be drafted in similar terms to section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW)* (“Duty of persons to assist the Team”). Consideration could also be given to prescribing the Committee as an “information sharing authority” for the purpose of section 293C of the Act.

**Recommendation 6:** That section 214 of the *Care and Protection of Children Act* be amended to enable the Committee to give the Minister an amended copy of any reports it prepares or sponsors to remove identifying details of individuals and that the amended copy may be tabled by the Minister to the Legislative Assembly**.**

**3. Childs Death Review and Prevention Committee (Part 3.3)**

Part 3.3 commenced on 7 May 2008. Part 3.3 was intended to create a better capacity to prevent harm to children and young people in the Northern Territory by establishing a Child Deaths Review and Prevention Committee[[1]](#footnote-1).

The object of Part 3.3 is to assist in the prevention and reduction of child deaths through:

* maintaining a database on child deaths; and
* conducting research about child deaths, and diseases and accidents involving children; and
* the development of appropriate policy to deal with such deaths, diseases and accidents.[[2]](#footnote-2)

Part 3.3 provides for the establishment of a Committee[[3]](#footnote-3) to undertake the following functions[[4]](#footnote-4):

1. to establish and maintain the Child Deaths Register;
2. to conduct or sponsor research into child deaths, diseases and accidents involving children; and other related matters (such as childhood morbidity and mortality), whether alone or with others;
3. to raise public awareness about a matter mentioned in paragraph (b), including, for example, any of the following:
   1. the death rate of children;
   2. the causes and nature of child deaths and of diseases and accidents involving children;
   3. the prevention or reduction of such deaths, diseases and accidents;
4. to make recommendations about a matter mentioned in paragraph (b);
5. to monitor the implementation of the recommendations;
6. to contribute to any national database on child deaths in Australia;
7. to enter into an arrangement for the sharing of information with anyone in Australia that has functions similar to those of the Committee;
8. to perform any other functions relating to the object of this Part as the Minister directs.

The Committee is comprised of members who possess qualifications or experience relating to the above functions of the Committee[[5]](#footnote-5). Members are appointed by the Minister, in writing, for a term of up to two years and are eligible for re-appointment[[6]](#footnote-6).

The Minister appoints one member to be the Convenor of the Committee and another member as the Deputy Convenor of the Committee. At the time of this Report, the Convenor of the Committee is Children’s Commissioner, Dr Howard Bath. The Deputy Coroner is also a member of the Committee and is the Deputy Convenor.

The Committee is required, at the end of each financial year, to prepare an annual report detailing its work. It may also prepare additional reports as a result of research undertaken or sponsored relating to issues relevant to child deaths. Reports prepared by the Committee are required to be presented to the Minister. Once provided with the Committee’s annual report and any research reports, the Minister is required to table the documents in the Legislative Assembly.[[7]](#footnote-7)

The Committee, in fulfilling its functions, has power to request information from certain persons listed in section 211 of the *Care and Protection of Children Act.* Those persons include the Commissioner of Police, the Registrar of Births, Deaths and Marriages, a Coroner and a health practitioner.

Since its inception, the Committee has undertaken work to develop a child deaths register, create and improve internal policy and procedures for the management and use of the sensitive information it holds and build relationships with key stakeholders.

Research projects have also been undertaken by the Committee in partnership with other entities regarding Aboriginal fetal and infant death rates and hanging deaths. The research project into youth hangings was completed at the end of 2011. The findings of that research were provided to the Parliamentary Inquiry into Youth Suicides and formed the basis of a report by the Committee to that Inquiry. The former NT Government indicated it was adopting all the recommendations made by the Committee. [[8]](#footnote-8)

Annual reports have been published by the Committee as at 30 June 2009, 2010, 2011 and 2012 and provide further detail in regard to the work undertaken by the Committee.

**4. Childs’ death review committee in other Australian jurisdictions**

| **Jurisdiction** | **Process** |
| --- | --- |
| **New South Wales** | The NSW Child Death Review Team was initially established by the Commission for Children and Young People Act 1998 (NSW). The CDRT operated under the auspices of the NSW Government Office of Communities (Commission for Children and Young People). However, following a recommendation made by Justice Wood’s 2008 Inquiry into Child Protection Services in NSW, the [*Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009*](http://www.legislation.nsw.gov.au/maintop/view/inforce/act+13+2009+cd+0+N) provided for the transfer of responsibility for coordinating the Child Death Review Team from the Commission for Children and Young People to the NSW Ombudsman’s office. The transfer of the Child Death Review Team to the Office of the NSW Ombudsman was completed in 2011. The NSW Child Death Review Team is now established by Part 5A of the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW).*  The NSW Child Death Review Team is tasked with maintaining a register of child deaths, classifying deaths in the register according to cause and other factors, undertaking research to help prevent or reduce the likelihood of child deaths and to make recommendations as to legislation, policies, practices and services. In addition, the NSW Ombudsman has power to conduct individual reviews into certain categories[[9]](#footnote-9) of child deaths, which includes children in care.  Publications[[10]](#footnote-10) of the NSW Child Death Review Team indicate the NSW child death review process allows for the inclusion of information relevant to the underlying causes of children’s deaths (for example, socio-economic classification of the family’s location, whether the child was known to child protection services, substance abuse by the child’s parents and relevant history of the child’s mother), and multiple factors that are relevant to a child’s death (such as, in the case of a drowning, whether there was inadequate supervision, or a pre‑existing medical condition of the child contributing to the drowning).  The NSW Child Death Review Team also collects and records a range of information on the circumstances surrounding the deaths of children. This includes the psychosocial and socio-economic circumstances of children and their families, and where relevant, health services accessed.  It is anticipated, from the Northern Territory’s perspective, access to information and privacy issues would arise. The Committee has indicated that it has experienced reluctance from some NT Government agencies to provide information relating to a deceased child, in the absence of a specific statutory obligation to provide the information, or consent from the deceased child’s parent or guardian. It is noted NT Government agencies are permitted to release information about third parties (provided certain steps have been taken) pursuant to section 30 of the *Information Act;* accordingly it appears that such reluctance to provide information to the Committee relates to the internal policy of some Government agencies, and not as a result of a legislative prohibition.  In NSW, a legislative amendment was introduced providing the NSW Child Death Review Team power to obtain ‘full and unrestricted access’ to information from a wide range of persons and statutory bodies to allow the CDRT to fulfil its functions.[[11]](#footnote-11) The section includes power for the NSW Child Death Review Team to request information from the Director-General, the Department Head, Chief Executive Officer or senior member of any department of the government, statutory body or local authority. The NT *Care and Protection of Children Act* does not contain such a provision.  The NSW Child Death Review Team also analyses categories of deaths. This includes deaths involving motor vehicles, pedestrian deaths, where the deceased was a passenger or driver in the vehicle, risk-taking by deceased persons, and, toxicology factors. This appears useful in terms of analysing behaviours and trends, however, based upon the data reported in the Annual Reports of the Committee, it is noted the number of child deaths in the NT is significantly smaller than the number of deaths considered in NSW which may present a difficulty in the NT in identifying trends of particular types of child deaths in the short term.  The NSW Child Death Review Team, in its publications has also provided comment in respect of the responses by Government Agencies to recommendations made by the NSW Child Death Review Team in prior review periods and publications. |
| **Queensland** | In Qld, the child death review process is monitored by the Commission for Children and Young People and Child Guardian and the independent Child Death Case Review Committee. The Commission for Children and Young People and Child Guardian and the Child Death Case Review Committee are established pursuant to Chapter 6 of the *Commission for Children and Young People and Child Guardian Act 2000 (Qld)*. The Child Death Case Review Committee reviews the deaths of all children known to the Qld child protection system.  The Commission for Children and Young People and Child Guardian is responsible for a number of functions relating to child deaths in Queensland, including:   * chairing and providing secretariat support for the independent Child Death Case Review Committee, which reviews the deaths of all children known to the child protection system (within three years of their death) * maintaining a register of all child deaths in Queensland based on notifications from the Registrar of Births, Deaths and Marriages and details of all child deaths reported to the Office of the State Coroner * researching the risk factors associated with child deaths and making recommendations to prevent such deaths occurring, and * preparing an Annual Report on child deaths.   The Qld child death review system consists of two tiers.[[12]](#footnote-12) The review system applies to those children who die and are known to child protection authorities (within three years prior to their death). The first tier is for the Department of Communities (formerly known as the Department of Child Safety, and is referred to in the 2009-2010 Annual Report as Child Safety Services) to conduct a review into the circumstances of the child’s death. The Child Death Case Review Committee is the second tier in Qld. This committee is responsible for assessing the reviews conducted by the Department of Communities.  The child death case reviews conducted by the Qld Department of Child Safety and the Qld Child Death Case Review Committee involve:   * consideration of complex family factors in the death of children (eg, such as domestic violence, substance misuse); * consideration of the extent of involvement of Child Safety Services during the child’s lifetime (which includes the levels of involvement being grouped into categories); * referral of issues to other Qld Government agencies for consideration of options to strengthen the agency’s involvement in areas relating to improving service responses. Those efforts are aimed at improving cross-agency collaboration and highlight the complexity and multi-disciplinary nature of implementing an effective child protection response; and * comments made on government initiatives and funding with respect to improving child safety. |
| **Western Australia** | Western Australia had a Child Death Review Team up until 30 June 2009. The role for the review of child deaths has since been transferred to the Office of the Ombudsman.  The WA Ombudsman has power to review and investigate certain deaths of children pursuant to section 19A of the *Parliamentary Commissioner Act 1971 (WA)*. The WA Department of Child Protection receives information from the Coroner on all sudden or unexpected deaths of children and notifies the Ombudsman of these deaths and of deaths of children in the Department’s care. The Ombudsman examines all child death notifications received and determines whether the death is an ‘investigable death’.[[13]](#footnote-13)  The WA Ombudsman has established a Child Death Review Advisory Panel (the Advisory Panel) to provide independent advice to the Ombudsman. The Advisory Panel provides advice to the Ombudsman on issues and trends that fall within the scope of the child death review function of the Ombudsman; on contemporary professional practice relating to the wellbeing of children and their families; and about issues that impact on the capacity of public authorities to ensure the safety and wellbeing of children and their families.  The WA Ombudsman reviews the circumstances in which, and why, child deaths occur, identifies patterns and trends arising from child deaths and seeks to improve public administration to prevent or reduce child deaths. |
| **South Australia** | In SA, the Child Death and Serious Injury Review Committee) reviews the circumstances and causes of deaths and serious injuries to all South Australian children.[[14]](#footnote-14) The SA Child Death and Serious Injury Review Committee is established pursuant to Part 7C of the [Children’s Protection Act 1993 (SA)](http://www.cdsirc.sa.gov.au/cdsirc/Portals/9/Child%20Protection%20Act%20Updated%20July%202008.pdf). The SA Child Death and Serious Injury Review Committee may make recommendations to the SA Government suggesting changes in systems, policies, procedures, practices or legislation that may help to prevent similar deaths or serious injuries from occurring again. The SA Child Death and Serious Injury Review Committee’s functions include:   * maintaining a database of the circumstances of and causes of death of children in SA; * reviewing deaths and serious injuries with the aim of identifying and recommending legislative or administrative means to prevent such deaths or injuries re-occurring; * requesting any person to produce a document that is relevant to the review; * entering into arrangements with other government agencies for the release of information relevant to a review; * monitoring the implementation of recommendations; and * maintaining links with similar bodies interstate and overseas.[[15]](#footnote-15)   The SA Child Death and Serious Injury Review Committee also undertakes Reviews of Vulnerable Groups of Children (such as those children who are geographically isolated, Aboriginal, living in poverty or have had contact with Families SA). ‘In-Depth Reviews’ are also undertaken in relation to specific deaths. The object of in-depth reviews is the identification of desirable changes in legislation, policies, practices, or procedures that will reduce the likelihood of deaths or serious injuries in similar circumstances. [[16]](#footnote-16) |
| **Tasmania** | In Tasmania, the Child Death Review process is undertaken by the Department of Health and Human Services. The process is designed to review ‘child protection’ deaths, that is, child deaths attributed to abuse or neglect or deaths of children formally known to the child protection authority, regardless of the cause of death. Whilst Tas Department of Health and Human Services does not publish a formal report, statistics are provided on its website[[17]](#footnote-17), and links are provided to recommendations made in respect of specific reviews. |
| **Victoria** | The Victorian Child Death Review Process is a two tiered system (and is similar to the Qld child death review system).[[18]](#footnote-18) The Office of the Child Safety Commissioner is responsible for conducting individual inquiries into the deaths of children under the age of 18 years, as well as children known to the Victorian Child Protection service pursuant to Part 6, Division 4 of the *Child Wellbeing and Safety Act 2005 (VIC)*. The reports of these inquiries are the primary source material used by the Victorian Child Death Review Committee (as the second tier in the review mechanism.  The Victorian Office of the Child Safety Commissioner provides administrative support to the Victorian Child Death Review Committee. The Victorian Child Death Review Committee is an independent, multidisciplinary Ministerial advisory body. Reviews conducted by the Victorian Child Death Review Committee are confined to the deaths of children and young people who were clients of the Victorian Child Protection service at the time of their death or within 12 months of their death.  The Victorian Child Death Review Committee is responsible for:   * reviewing the deaths of all children and young people who are current or recent clients of the Victorian Child Protection service; * identifying any themes, trends or patterns, which emerge from the review process and advise the Minister for Community Services of their implications for policy and practice in Child Protection and related services; * identifying particular groups of child deaths that may benefit from further investigation and oversee a group analysis process to gain a more comprehensive understanding of the issues involved and best practice responses; and * preparing an annual report for the Minister for Community Services that is tabled in Parliament as part of a transparent and accountable approach to the deaths of children known to Victoria’s Child Protection service[[19]](#footnote-19). |

| **Jurisdiction** | **Process** |
| --- | --- |
| **Australian Capital Territory** | The ACT Children and Young People Death Review Committee were established in 2011 pursuant to Chapter 19A of the *Children and Young People Act 2008 (ACT*). Chapter 19A is a new chapter to ACT legislation.[[20]](#footnote-20)  The ACT Children and Young People Death Review Committee is required to keep a register of deaths of children and young people that occur in the ACT and those child deaths which occur outside of ACT where the subject children and young people normally live in ACT. The register kept must include information that is available to the Children and Young People Death Review Committee. This includes the cause of death; the age and gender; Aboriginal and Torres Strait Islander status; and whether within 3 years before the death occurred, the child or young person or a sibling were the subject of a child protection report.  In addition, the register may contain other demographic data available, information about the circumstances of the death, and any other information the ACT Children and Young People Death Review Committee considers relevant.[[21]](#footnote-21)  Other functions of the ACT Children and Young People Death Review Committee will include:   * identifying patterns and trends in relation to the deaths of children and young people; * undertaking research that aims to prevent or reduce the likelihood of child deaths; * identifying areas requiring additional research that arise from the identified patterns and trends in relation to child deaths; * making recommendations about legislation, policies, practices and services for implementation by the Territory and non-government bodies to help prevent or reduce the likelihood of child deaths; * monitoring the implementation of the committee’s recommendations; and * reporting to the Minister for Community Services. |

**5. Scope of the review and the consultation process**

The Review of Part 3.3 must determine the extent to which the operation of Part 3.3 has met the object of the Part, and whether or not any amendment to the Part should be made.[[22]](#footnote-22)

**5.1 Object of Part 3.3**

Part 3.3 is intended to assist in the prevention and reduction of child deaths through:

1. maintaining a database on child deaths; and
2. conducting research about child deaths, and diseases and accidents involving children; and
3. the development of appropriate policy to deal with such deaths, diseases and accidents.[[23]](#footnote-23)

A ‘child death’ is defined in Part 3.3 as the death of a child who usually resided in the NT (whether the death occurred in the NT or not); or a still birth (as defined in the *Births, Deaths and Marriages Registration Act)* that occurred in the Territory.[[24]](#footnote-24) A ‘still birth’ is defined in the *Births, Deaths and Marriages Registration Act* as meaning the birth of a ‘still born child’, which in turn is defined as meaning a child of at least   
20 weeks' gestation or with a body mass of at least 400 grams at birth that exhibits no sign of respiration or heartbeat, or other sign of life, after birth.[[25]](#footnote-25)

Section 212 of *the Care and Protection of Children Act* provides for a Child Deaths Register. The Register is a database of information concerning child deaths, and can include, but is not limited to, information on incidences of child deaths and the causes, patterns and trends of child deaths.

**5.2** **Composition of the Committee**

The Committee is required to consist of at least 10 but not more than 16 members. Currently, the Committee consists of 14 members from a variety of disciplines. Members include the Children’s Commissioner and Deputy Coroner, as well as representatives from NT Police, Fire and Emergency Services, the Departments of Health, Education and Children and Families and Menzies School of Health and Research. At the time of writing this Report, the names of the Committee members, including each member’s qualifications relevant to the functions of the Committee, are:

1. Dr Howard Bath

Expertise in child protection, children with special needs and research.

1. Ms Kathryn Ganley

Deputy Coroner, Office of the Coroner Northern Territory.

1. Ms Leonie Warburton

Expertise in community welfare, quality and practice framework management.

1. Commander Peter Bravos

Crime Command, NT Police, Fire and Emergency Services.

1. Mr Alan Green

Expertise in education.

1. Dr Charles Kilburn

Expertise in specialist paediatrics.

1. Professor Victor Nossar

Expertise in child population health.

1. Dr Barbara Paterson

Expertise in maternal and child health.

1. Associate Professor Robert Parker

Expertise in Indigenous mental health and suicide in the NT.

1. Ms Bronwyn Thompson

Expertise in child protection and out-of-home care.

1. Dr Jo Wright

Expertise in remote primary health care, health information systems and public health.

1. Dr Steven Guthridge

Expertise in statistical analysis and reporting.

1. Ms Josie Crawshaw

Expertise in child protection.

1. Ms Priscilla Collins

Expertise in Indigenous Advocacy.

The *Care and Protection of Children Act* requires the Child Deaths Review and Prevention Committee to meet at least three times per year.[[26]](#footnote-26)

Membership is based upon a particular person’s qualifications and experience relating to the functions of the Child Deaths Review and Prevention Committee. It is understood that maintaining the Committee membership has presented challenges as a result of members leaving the jurisdiction and being unable to be contacted. This in turn has prevented the Child Deaths Review and Prevention Committee from being able to obtain a resignation from members who move interstate. The Minister must remove a member if there is failure to attend three meetings in a row without a leave of absence.[[27]](#footnote-27) This, however, can take up to one year to occur, given, at a minimum, the Committee is required to meet three times per year.

**5.3** **Work undertaken by the Child Deaths Review and Prevention Committee**

**5.3.1 Review of Child Deaths in the Northern Territory**

The Child Deaths Review and Prevention Committee has specific functions under Part 3.3 relating to the maintaining of the Child Deaths Register, conducting of research and the development of appropriate policy recommendations to deal with child deaths, diseases and accidents. Those functions do not extend to conducting reviews of individual child deaths. That role is specifically allocated to a Coroner.[[28]](#footnote-28)

There is an obligation to report certain deaths to the office of the Coroner where the death occurs in the NT and a Coroner must investigate such a reportable death and must hold an inquest where the deceased was, for example, a person held in care. A ‘person held in care’ is defined in the *Coroners Act* to include a child who is in the CEO's care as defined in the *Care and Protection of Children Act. [[29]](#footnote-29)*

In the NT, there is no formal review process undertaken by the Child Deaths Review and Prevention Committee in circumstances where a child dies and the child was known to the child protection system. That responsibility lies with the Coroner and the Child Deaths Review and Prevention Committee has indicated that the workload of that office can result in a significant period of time between the child’s death and the delivery of findings. Based upon information provided by the Coroner’s office, the listing of an inquest into the death of a child in care is dependant upon the nature and circumstances of the death and level of investigation required. The Child Deaths Review and Prevention Committee has indicated that delays associated with the delivery of some coronial findings can affect the Child Deaths Review and Prevention Committee’s ability to accurately report data, and provide appropriate and timely recommendations or policies to avoid future deaths in similar circumstances.

**5.3.2 Child Deaths Register**

*Obtaining data – date of death registration, interstate deaths, information sharing*

The Child Deaths Review and Prevention Committee has developed a Child Deaths Register. Initially, assistance was received from the NSW Child Death Review Team which provided a de‑populated version of its Child Death Register to assist with the development of the Child Deaths Register for the NT.

It was considered by the Child Deaths Review and Prevention Committee that whilst many of the data fields in the NSW Register were relevant to the NT, they included factors which presented challenges for data collection and analysis in the NT. These factors included:

* the NT has a significant Aboriginal population, many of whom speak, and are named in, languages other than English;
* Aboriginal family relationships are complex and different to what can be considered to that of the majority of the Australian population and did not fit neatly into the NSW CDRT model Child Death Register. These family relationships can include responsibilities assumed by extended family members (such as aunties, uncles, grandparents) that would generally be undertaken by immediate family members in the mainstream Australian population; and
* the addresses of people living in Aboriginal communities are recorded differently to the standard address consisting of a house or building number, street, suburb and town. Further, it is common for Aboriginal people to move frequently between relatives. It is also common for Aboriginal people to have no fixed address.

In light of the above challenges, the Child Deaths Review and Prevention Committee considered it was appropriate to establish its own Child Death Register. In approximately 2010, an IT professional was engaged to design a database with particular specifications, and this work is continuing. A temporary database was also established whilst this work is being undertaken. The information stored on the temporary database includes demographic particulars, cause of death and child protection data.

*Sources of data and collection of information*

The work of the Committee is focussed on data obtained from the following bodies:

* Australian Bureau of Statistics;
* Australian Institute of Health and Welfare;
* National Coroners Information System;
* NT Births, Deaths and Marriages Registry (which also maintains a record of all stillbirths in the NT);
* records from medical practices; and
* Office of the Coroner.

The primary source of data on child deaths in the NT is the Registry of Births, Deaths and Marriages, which includes all coronial findings. The *Births, Deaths and Marriages Registration Act* and Regulations provide the particulars required for the registration of a death.[[30]](#footnote-30)

It is understood there are factors that have affected the Child Deaths Review and Prevention Committee’s analysis and reporting of child deaths data, and they include:

* at times there may be a significant period between the date of the person’s death, findings if the death is subject to an inquest by the Coroner and the registration of the death. These circumstances can affect the amount of data included in analysis and the annual reporting requirements of the Child Deaths Review and Prevention Committee;
* the Child Deaths Review and Prevention Committee would like to consider circumstances of a deceased child that are beyond the information supplied by the Births, Deaths and Marriages Registry. Such circumstances could include but are not limited to, socio‑economic factors, level of education of the child, whether the child was known to child protection services and relevant circumstances relating to the child’s parents; and
* a number of infants and children are transferred interstate for medical treatment. Section 208(a) of the *Care and Protection of Children Act* defines a child death as ‘the death of a child who is usually resident in the Territory *(whether the death occurred in the Territory or not*)’ (emphasis added). It is understood the Committee does not have any formal arrangements for the sharing of information when NT children die interstate, nor is there a formal process of notification to the NT Registry of Births, Deaths and Marriages. There is the possibility that the current data on child deaths does not accurately reflect the number of NT child deaths to include those children ordinarily resident in the NT who die whilst they are interstate.

These issues present challenges to the ability of the Child Deaths Review and Prevention Committee to obtain necessary information on child deaths due to the remote and transient nature of parts of the Northern Territory population. The Child Deaths Review and Prevention Committee currently has power to require information from the following bodies:

1. the Commissioner of Police;
2. the Registrar of Births, Deaths and Marriages;
3. a coroner;
4. a service provider for a vulnerable child;
5. a health practitioner;
6. a person in charge of a facility for health services in which children are ordinarily patients;
7. an operator of child-related services; and
8. an operator of children’s services.[[31]](#footnote-31)

The Child Deaths Review and Prevention Committee has indicated a desire to obtain additional information relevant to the underlying causes of child deaths, such as educational data. Section 211 of the *Care and Protection of Children Act* provides a list of persons who must, on the Committee’s request, give specified information to the Committee for any of its functions. The *Care and Protection of Children Act* does not currently provide an obligation for entities outside of those listed in section 211 to provide information to the Child Deaths Review and Prevention Committee.

It is understood that the Child Deaths Review and Prevention Committee has experienced difficulty obtaining information from entities that fall outside of section 211 despite exemptions under section 30(3) of the *Information Act* which permits disclosure of information by Public Service Organisations. That provision provides that a Public Sector Organisation may provide access to personal information relating to a third party where that third party’s views about providing the information could not be ascertained, or, where the third party expressed the view the information should not be provided (and the provision sets out a complaint procedure for such a decision). The Child Deaths Review and Prevention Committee has indicated that it has encountered reluctance from some bodies to provide information in the absence of a positive obligation for the entity to provide information to the Child Deaths Review and Prevention Committee.

The Qld Child Death Case Review Team noted the merging of the former Department of Housing, Disability Services Qld and Department of Child Safety to become the Department of Communities[[32]](#footnote-32). The Qld Child Safety Services noted a strengthening of relationships between the agencies and a greater willingness to support information sharing across the entire department as a result of this merger.

**5.3.3 Research**

The Child Deaths Review and Prevention Committee has undertaken specific research relating to Aboriginal fetal and infant deaths. It is understood this task was approached in consultation with the Department of Health’s Health Gains Planning branch.

Statistics on the number of hanging deaths were also a matter of concern to the Child Deaths Review and Prevention Committee. Research was undertaken involving a comparison of the hanging deaths in the NT, Queensland and NSW. Similar consideration of this type of death appears to have been undertaken in other jurisdictions. The comparative analysis of hanging deaths by the Child Deaths Review and Prevention Committee resulted in the sponsoring of suicide research being undertaken in conjunction with the Menzies School of Health and Research. This project was completed in late 2011 and formed part of the evidence provided to the Northern Territory Parliamentary Inquiry into Youth Suicide.

**5.3.4 The Development of Appropriate Policy**

The Child Deaths Review and Prevention Committee has developed internal policies for the holding of data on child deaths; however it is yet to develop specific policies for the prevention of child deaths.

The Child Deaths Review and Prevention Committee has indicated an intention to undertake analysis of background factors and social circumstances surrounding child deaths to consider other potentially relevant factors as to why children die and how future deaths in similar circumstances might be prevented. A similar type of analysis was conducted and included in the research report of Menzies School of Health Research[[33]](#footnote-33) and provided by the Child Deaths Review and Prevention Committee to the Parliamentary Inquiry into Youth Suicide (the Inquiry). It is considered the consideration during the Inquiry of the social circumstances of children who had committed suicide provided some context regarding the cause of and contributing factors to these tragedies and likely would have assisted in the consideration and development of recommendations for appropriate preventative strategies to avoid similar deaths occurring in the future. The NT Government has indicated it will accept the recommendations [[34]](#footnote-34) following the Inquiry.

The Child Deaths Review and Prevention Committee is part of the Australian and New Zealand Child Death Review and Prevention Group (ANZCDRPG) and the work of that group has contributed to discussions on national reform agenda items. A meeting of the ANZCDRPG was held in February 2012. The major issues discussed during that meeting were jurisdictional updates, public promotion of the national group and activities (which included preventable infant deaths, transport fatalities, drowning and Sudden Unexpected Deaths in Infancy (SUDI) deaths), a focus on Middle Years: Trends, Issues and Prevention Activities, and a discussion on the national collection of data and the nomination of the next national chair and secretariat.

5.3.5 Privacy issues

The Child Deaths Review and Prevention Committee handles highly sensitive information in carrying out its functions, and has developed policies for the handling of such information in accordance with the *Information Act*. The Child Deaths Review and Prevention Committee has indicated the policies provide for the handling, use and disclosure of information by the Child Deaths Review and Prevention Committee so that an individual’s privacy is not breached.

It is understood that the Child Deaths Review and Prevention Committee has not received any requests for information outside of the current research projects it has conducted in association with other research entities. However, it is noted the Child Deaths Review and Prevention Committee is authorised by the Minister to disclose confidential information, which includes disclosure of information to research entities for research projects, pursuant to section 221(2) of the *Care and Protection of Children Act*.

**5.4 Consultation**

As a statutory review, it is appropriate to conduct consultation with key stakeholders and invite submissions from the general public.

Letters were sent to key stakeholders in September 2011 and a discussion paper inviting submissions was published on the website of the former Department of Justice.

Submissions were received from the Department of Health, the former Departments of Education, Children and Families, the Child Deaths Review and Prevention Committee and the Children’s Commissioner.

**6. Submissions, responses and recommendations**

As required in section 222 of the *Care and Protection of Children Act,* the review is required to determine:

* the extent to which the operation of this Part has met the object of this Part; and
* whether or not any amendment to this Part should be made.

Set out below is a summary of the issues raised in the formal submissions received in relation to the above two objectives of this review. The summary of each issue is followed by a response to the issue, including recommendations where applicable.

* Whether the operation of Part 3.3 has met the object of Part 3.3;
* Whether or not any amendment to Part 3.3 should be made;
* The Process of appointment and removal of committee members;
* Whether to extend the Child Deaths Review and Prevention Committee’s powers to conduct individual reviews of child deaths;
* Whether the data stores on the Child Deaths Register is sufficient;
* Access by the Child Deaths Review and Prevention Committee to relevant information; and
* Provision of Committee Reports to the Minister.

**6.1 Has the operation of Part 3.3 has met the object of Part 3.3?**

Part 3.3 was created to assist in the prevention and reduction of child deaths through:

* 1. maintaining a database on child deaths;
  2. conducting research about child deaths, diseases and accidents involving children; and
  3. the development of appropriate policy to deal with such deaths, diseases and accidents.

The Child Deaths Review and Prevention Committee established and maintained a data base on child deaths, and backdated it to 2006, two years before the Child Deaths Review and Prevention Committee’s establishment date. The Child Deaths Review and Prevention Committee conducted and commissioned research into child deaths and the outcomes of at least one research project (suicide by children and youth) have formed part of the material provided to a Northern Territory Parliamentary Inquiry. The Child Deaths Review and Prevention Committee has indicated the high incidence of youth suicide will continue to be a focus, and it will also monitor the research into Aboriginal infant and fetal deaths.

One submission noted that Part 3.3 has not been in operation for sufficient time to enable a robust and meaningful assessment of whether or not sub-sections (a) and (b) have been met and more importantly, whether those criteria are being met efficiently and effectively.

A further observation was made in relation to sub-section (c) and the development of appropriate policy. It was observed the *Care and Protection of Children Act* does not provide clarity regarding who is responsible for the development of “appropriate policy”. An assumption could be made that the Child Deaths Review and Prevention Committee, using its function at section 210(d) to make recommendations, could make specific recommendations to Ministers, or recommend that one or more government agencies develop policies for promulgation. If this is not the case, and the Child Deaths Review and Prevention Committee is to develop policies, there is no power to direct agencies, or others, to implement the policies.

*Response:*

The object of maintaining a database on child deaths has been met by the Child Deaths Review and Prevention Committee, through the registration of data on a current register, with a view to creating an electronic database.

The Child Deaths Review and Prevention Committee has met the objective of conducting research about child deaths, and diseases and accidents involving children. In particular, the former NT Government had announced that it intended to adopt the 15 recommendations made by the Child Deaths Review and Prevention Committee in its Report on Child and Youth Suicide in the NT

Issues were raised concerning the capacity for the Child Deaths Review and Prevention Committee to make recommendations. The requirement in section 207 [[35]](#footnote-35) of the *Care and Protection of Children Act* for the Child Deaths Review and Prevention Committee to develop appropriate policy to deal with such deaths, diseases and accidents is ambiguous, however it is understood the Child Deaths Review and Prevention Committee was intended to exist in an advisory capacity. It is expected that following completion of research projects by the Child Deaths Review and Prevention Committee, the NT Government will develop appropriate policy, and the role of the Child Deaths Review and Prevention Committee in the development of appropriate policy should be clarified in that its function is to make recommendations to government. Part 3.3 commenced on 7 May 2008 and accordingly has been in operation for 4 years. Research into child deaths, diseases and accidents requires expertise from a multitude of disciplines and will be resource intensive. The research and policy development objectives of Part 3.3 will naturally require time to complete.

| **Recommendation 1: That section 207 of the *Care and Protection of Children Act* be amended to clarify that an object of Part 3.3 is for the Committee to provide recommendations for the development of appropriate policy to deal with child deaths, diseases and accidents.** |
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**6.2 Should there be any amendment to Part 3.3?**

**6.2.1 The process of appointment and removal of Committee members**

Section 209 of *the Care and Protection of Children Act* gives the Minister power to appoint a person a member of the Child Deaths Review and Prevention Committee. Members are appointed by the Minister in writing and the appointment of members is on the basis of personal expertise rather than in a representative capacity. This criteria for appointment received general support from the majority of key stake holders throughout responses to the discussion paper, however one submission noted it would be beneficial for a more specific description of qualifications and or experience to be inserted in the legislation under section 209(3) of *the Care and Protection of Children Act*.

The process for removal of Committee members is found in section 218 of the *Care and Protection of Children Act.* A Committee member’s appointment may be terminated by the Minister in writing if the Committee member, without leave from the Minister, has been absent, from three consecutive meetings of the Child Deaths Review and Prevention Committee. Given that the Child Deaths Review and Prevention Committee must meet at least three times per year, it may take up to one year to remove a Committee member under this procedure. This is problematic in circumstances where a member has left the jurisdiction or is un-contactable. Concerns were noted that the current process of removal does not afford the Child Deaths Review and Prevention Committee sufficient flexibility and autonomy to carry out its functions without the intervention of the Minister to remove an inactive member of the Child Deaths Review and Prevention Committee. One stakeholder suggested legislative amendment to invest greater power in the Convenor of the Child Deaths Review and Prevention Committee with respect to removal of members to enable quick and simple removal of inactive members.

The requirement in section 209(5) of *the Care and Protection of Children Act* that at least two members on the Child Deaths Review and Prevention Committee be Aboriginal persons was also identified as problematic due to the difficulty in expeditiously recruiting suitably qualified persons following the resignation of an existing Aboriginal Committee member. Concerns were noted that the Child Deaths Review and Prevention Committee may not be able to continue carrying out its functions during periods where the requirement for at least two Aboriginal Committee members cannot be met. It is noted that *the Care and Protection of Children Act* is silent on the issue of what will happen to the Child Deaths Review and Prevention Committee if section 209(5) is not fulfilled. Legislative amendment was suggested to stipulate that the Child Deaths Review and Prevention Committee can continue to function if there are less than two Aboriginal persons currently on the Child Deaths Review and Prevention Committee and active recruitment was underway.

Response:

The Department of the Attorney-General and Justice recommends legislative amendment to provide the Convenor of the Child Deaths Review and Prevention Committee the ability to recommend to the Minister the removal of an appointed member of the Child Deaths Review and Prevention Committee, where the Child Deaths Review and Prevention Committee is aware the particular member has left the jurisdiction or where reasonable attempts to contact an absent member have been unsuccessful.

It is also recommended that section 209(5) of *the Care and Protection of Children Act* be amended to allow the Child Deaths Review and Prevention Committee to continue to carry out its functions with less than two Aboriginal Committee members if active recruitment of a suitably qualified Aboriginal person is underway. It is also noted section 219 of *the Care and Protection of Children Act* provides that in a meeting of the Child Deaths Review and Prevention Committee, a quorum is constituted by the number of members that is equal to half of the members plus one. Despite some difficulties in removing inactive members and recruiting suitably qualified Aboriginal Committee members, the Department notes that no concerns were raised by the Child Deaths Review and Prevention Committee about its ability to achieve a quorum at its meetings.

| **Recommendation 2: That section 218 of the *Care and Protection of Children Act* be amended to allow the Minister to terminate a person’s appointment if the Convenor of the Committee recommends to the Minister that the Minister terminate appointments of Committee members in circumstances where Committee members have left the jurisdiction, or where reasonable attempts to contact an absent Committee member have been unsuccessful.** |
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| **Recommendation 3: That section 209 of the Act be amended to clarify that the Committee continues to operate, despite the absence of at least two Aboriginal Committee members required by section 209(5) of the Act. The amendment should provide for an ongoing obligation on the Committee to recruit suitably qualified Aboriginal members to fill any such vacancies in the membership expeditiously.** |
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**6.2.2 Whether to extend the Child Deaths Review and Prevention Committee’s powers to conduct individual reviews of child deaths**

Child death review processes interstate such as in Queensland and Victoria provide for reviews of all deaths of children. The Child Deaths Review and Prevention Committee has indicated a desire to conduct individual reviews of child deaths on the basis that national research has indicated a significant proportion of children who die have had contact with child protection authorities, and that Committees interstate have case review functions. The Child Deaths Review and Prevention Committee has recommended that, where a child who dies, or a sibling of a child that dies, has been the subject of a report to the agency responsible for the administration of the *Care and Protection of Children Act* alleging harm or exploitation within the three preceding years, a formal case review be undertaken by that agency as soon as practicable. The Child Deaths Review and Prevention Committee also recommended that consideration be given to a review process whereby the Children’s Commissioner (who monitors the administration of *the Care and Protection of Children Act* and is charged with ‘ensuring the wellbeing of vulnerable children’) is provided with a copy the administering Agency’s case review for consideration and comment (which is similar to the models in Queensland and Victoria).

The former Department of Children and Families opposed any extension of the Child Deaths Review and Prevention Committee’s power to conduct individual reviews of child deaths, on the basis the current regime in the Northern Territory for the review of children’s deaths meets the Territory’s needs. The former Department of Children and Families suggested that in the alternative, if it was considered *the Care and Protection of Children Act* required amending to provide for review of deaths of children in addition to a coronial review, the ‘two tier approach’, such as in Queensland or Victoria, would be preferred. It was submitted, however, that only if it were established that the current systems were inadequate should an extension of the Child Deaths Review and Prevention Committee’s powers be considered.

Whilst there was opposition to the Committee having extended powers to conduct individual reviews of Child deaths, there was no objection from the former Department of Children and Families to the Committee receiving any reports in regard to the deaths of children that have had contact with former Department of Children and Families

The former Department of Justice wrote to the Office of the Coroner seeking its views on the above issue, however, no submission was received from the Office of the Coroner. The Department notes that a Deputy Coroner is appointed as a Committee member.

*Department response:*

The core functions of the Child Deaths Review and Prevention Committee are particularised in section 210 of *the Care and Protection of Children Act*. The main functions of the Child Deaths Review and Prevention Committee under that section focus on advocacy, data collection and research. There are no specific functions provided that specifically relate to the Child Deaths Review and Prevention Committee exercising reviewing responsibilities, with the exception of section 210(e), which involves monitoring the implementation of the Child Deaths Review and Prevention Committee’s recommendations.

There is a specific process in the NT for the reporting and review of children’s deaths, which is a coronial review. Coronial reporting is required where the death is ‘unexpected, unnatural, or violent’ or where the child was a ‘person in care’. In the second category of death, it is noted the Chief Executive Officer of the agency administering the *Care and Protection of Children Act* would be required to investigate and review the surrounding circumstances of the child’s death as part of the coronial process, and likely appear as a party at the inquest.

It is considered, that in light of the specific functions of the Committee, the already established jurisdiction of a Coroner, and, the investigation and reporting currently required by agency administering the *Care and Protection of Children Act* where the deceased child was known to that agency, the inclusion of a separate legislative review process may unnecessarily duplicate the child death review process in the NT.

The former Department of Children and Families indicated a willingness for the Child Deaths Review and Prevention Committee to be provided with reports generated by agency administering the *Care and Protection of Children Act* involving the deaths of children that have had contact with that agency. Such interagency collaboration is encouraged to assist the Child Deaths Review and Prevention Committee fulfil its functions listed in section 210 of *the Care and Protection of Children Act*.

| **Recommendation 4: That there is no extension of the Committee’s power to conduct individual reviews of child deaths.** |
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**6.2.3 Whether the data stored on the Child Deaths Register is sufficient**

As previously noted, the Child Deaths Review and Prevention Committee reports it maintains a Child Deaths Register. Data collection for the current register has been backdated two years prior to the establishment of the Child Deaths Review and Prevention Committee.

The Child Deaths Review and Prevention Committee also reports that there has recently been a re-design of the database to modify existing data fields. The re-design was commissioned to produce a more appropriate range of data fields to accommodate the unique needs of the Northern Territory. The Committee reports that the new register is now adequately broad to meet future requirements. The fields maintained on the register include:

* Births Deaths and Marriages Registration Number
* Registration Year
* Registration Date
* Surname
* Given Names
* Sex
* Date of Death Indicator
* Date of Death
* Date of Birth Indicator
* Date of Birth
* Age
* Place of Death
* Usual Residence 1
* Usual Residence 2
* Postcode
* Occupation
* Place of Birth
* Aboriginal Indicator
* Torres Strait Islander Indicator
* Marital Status
* Fathers Surname
* Fathers Given Names
* Fathers Occupation
* Mothers Maiden Surname
* Mothers Given Names
* Mothers Occupation
* Cause of Death Data (coded to the International Statistical Classification of Disease and Related Health Problems, Tenth Revision – Australian Modified)
* Underlying Cause of Death
* Cause of Death
* Subject Child known by or had involvement with the agency administering the Care and Protection of Children Act
* Nature of DCF involvement with Subject Child
* Sibling of Subject Child known by or had involvement with the agency administering the Care and Protection of Children Act
* Subject Child and/or Sibling of Subject Child known by or had involvement with the agency administering the Care and Protection of Children Act
* Nature of DCF involvement with Sibling
* Recorded Substantiation on Subject Child
* Recorded Substantiation on Sibling of Subject Child
* Recorded Substantiation on Subject Child or Sibling of Subject Child

Section 212 of *the Care and Protection of Children Act* is broadly drafted with no limitations stipulated as to the content or scope of the database. It was noted amongst stakeholders that the legislative framework creating the Child Deaths Register should remain as broad as possible to enable the Register to adapt to future requirements.

Response:

The current data stored on the Child Deaths Register is reported by the Child Deaths Review and Prevention Committee as sufficient.

Given that the Child Deaths Register has been redesigned and has recently become operational. It would be beneficial to consult with the Child Deaths Review and Prevention Committee in future to confirm that the data on the new register is still considered sufficient. No amendments in respect of this issue are recommended at this time.

**6.2.4 Access by the Committee to relevant information**

The Child Deaths Review and Prevention Committee has indicated it has experienced limitations in respect of access to information, including access to information held by other Northern Territory Government Agencies. An example is when the Committee has indicated that the consideration of educational data would be useful in analysing trends and underlying causes of some child deaths (for example, youth suicide). It is understood the Committee sought access to educational data from the former Department of Educating and Training, however, the request was declined due to the internal policy of that agency which prevented the release of such information without a parent or guardian’s consent. It is understood the request for information from the Committee to the former Department of Education and Training was not declined as a result of any statutory prohibition.

Section 211 of the *Care and Protection of Children Act* lists a number of entities that must, on the Child Deaths Review and Prevention Committee’s request, provide specified information to the Child Deaths Review and Prevention Committee for any of its functions. Section 211 does not list the agency responsibility for the administration of *the* *Education Act* as one of those entities with a positive obligation to provide information to the Child Deaths Review and Prevention Committee when requested to do so. The former Department of Education and Training provided a written submission that supported the provision of information to the Committee, including educational data, where it is necessary to provide important background information.

The Child Deaths Review and Prevention Committee’s functions include the conduct of and sponsoring of research into child deaths, diseases and accidents, and the development of appropriate policy. Educational data, in some circumstances, may be considered relevant in providing some context of a child’s death and the ongoing analyses of trends and underlying causes of child deaths.

Response:

The Child Deaths Review and Prevention Committee must be able to perform its functions effectively and efficiently.

Section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW)* provides a list of persons who have a duty to provide full and unrestricted access by the NSW Committee to information held by that person, and is aimed at similar persons as those listed in section 211 of   
*the Care and Protection of Children Act*. The NSW legislation also directs a ‘Director-General, the Department Head, chief executive officer or senior member of any department of the government, statutory body or local authority’ to produce information to the NSW Committee for the exercise of its functions.

The work undertaken by the Child Deaths Review and Prevention Committee in the nature of significant research projects, the making of appropriate recommendations and involvement in the development of policy would be enhanced by the access to relevant information held by NT Government Agencies outside of those listed in section 211 of the *Care and Protection of Children Act*. This information includes education records held by the NT Department responsible for schools with that Department recognising that it is appropriate for the Child Deaths Review and Prevention Committee to have access to all relevant information.

There are provisions in the *Information Act* that allow NT Government Agencies to release confidential personal information about a third party. On this basis, there is no strict need to amend the   
*Care and Protection of Children Act* to provide positive obligations upon all NT Government Agencies to provide information to the Child Deaths Review and Prevention Committee, however, legislative amendment would avoid any existing doubts regarding an Agency’s obligation to assist the Committee fulfils its functions.

Additionally, in the period since consultation was conducted regarding Part 3.3, the *Care and Protection of Children Act* has been amended by the inclusion of Part 5.1A (*sharing information for safety and wellbeing of children*). Whilst this Part is not designed with the Child Deaths Review and Prevention Committee in mind it does make it clear that information sharing authorities (as defined in section 293C) may give information to another information sharing provider if the information relates to the safety or wellbeing if a child or children as set out in section 293D(c). This purpose includes the provision of a service or the performance of a function. The Child Deaths Review and Prevention Committee could be prescribed (by regulation) as an information sharing authority.

| **Recommendation 5: That consideration be given to amending section 211 of the *Care and Protection of Children Act* to include a Chief Executive Officer of a Northern Territory Government agency as a person in which must provide specified information following a request from the Committee. Such an amendment may be drafted in similar terms to section 34K of the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW)* (“Duty of persons to assist the Team”). Consideration could also be given to prescribing the Committee as an “information sharing authority” for the purpose of section 293C of the Act** |
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**6.2.5 Provision of Committee Reports to the Minister**

Section 214(2)of the *Care and Protection of Children Act* states that the Committee must give any reports it prepares or sponsors to the Minister. The Minister then has an obligation to table a copy of the report in the Legislative Assembly.

The Committee handles sensitive and private information. Concerns were noted that the tabling of the Child Deaths Review and Prevention Committee’s reports may breach a vulnerable person’s privacy if they were named or identified in the report. In order to preserve the privacy of vulnerable individuals it was suggested the Committee be permitted to provide the Minister with an unamended copy of the report marked confidential and an additional amended copy of the report with all identifying details of vulnerable individuals deleted. The amended copy of the report may then be tabled in the Legislative Assembly.

**Response:**

Section 214 of the *Care and Protection of Children Act* provides that the Child Deaths Review and Prevention Committee may prepare reports about research and that the Minister must table a copy of a research report in the Legislative Assembly. Section 214 does not specifically permit reports to be altered to protect an individual’s privacy before tabling or publication.

It is noted that a report has been provided by the NT Ombudsman into the NT Child Protection System (which was tabled in Legislative Assembly), and an edited version of the report published to protect the identity of children featured in the report[[36]](#footnote-36).The *Ombudsman Act* does not provide specific provisions allowing for the editing of reports for tabling or publishing and it is assumed such editing was taken independently to protect the privacy of those individuals subject of the report. Such a step is considered appropriate in the circumstances, particularly in light of the sensitive subject matter of the reports.

It is paramount that the Committee have a legislative framework in place to pursue its functions while protecting the privacy of vulnerable persons. Legislative amendment is recommended to allow the Committee to provide two copies (one with all identifying details of individuals removed, to be tabled in the Legislative Assembly) of any of their reports to the Minister to protect the privacy of individuals.

| **Recommendation 6: That section 214 of the *Care and Protection of Children Act* be amended to enable the Committee to give the Minister an amended copy of any reports it prepares or sponsors to remove identifying details of individuals and that the amended copy may be tabled by the Minister to the Legislative Assembly.** |
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1. Ms Marion Scrymgour, Minister for Family and Community Services, Second Reading Speech, *Care and Protection of Children Act*  [↑](#footnote-ref-1)
2. Section 207 *Care and Protection of Children Act*  [↑](#footnote-ref-2)
3. Section 209(1) *Care and Protection of Children Act* [↑](#footnote-ref-3)
4. Section 210 *Care and Protection of Children Act* [↑](#footnote-ref-4)
5. Section 209(3) *Care and Protection of Children Act* requires Committee members to have qualifications or experience relevant to the functions of the Committee. [↑](#footnote-ref-5)
6. Section 209 *Care and Protection of Children Act* [↑](#footnote-ref-6)
7. Section 213, 214 *Care and Protection of Children Act* [↑](#footnote-ref-7)
8. “Government backs youth suicide report findings” http://abc.net.au/news/2012-05-04/youth-suicide-report-findings-reaction/399207 [↑](#footnote-ref-8)
9. These categories of deaths are called “Reviewable Deaths”, section 36 *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) [↑](#footnote-ref-9)
10. NSW Child Death Review Team (2010) *Annual Report 2009*, NSW Commission for Children and Young People: Sydney; NSW *Child Death Review Team Annual Report 2010*, October 2011, NSW Child Death Review Team; NSW Ombudsman [↑](#footnote-ref-10)
11. Section 34K *Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW)* (“Duty of persons to assist the Team”) [↑](#footnote-ref-11)
12. Queensland Child Death Case Review Committee 2010, *Annual Report: Queensland Child Death Case Review Committee, 2009 – 2010,* Queensland Child Death Case Review Committee, Brisbane. [↑](#footnote-ref-12)
13. <http://www.ombudsman.wa.gov.au/Improving_Admin/CDR.htm> [↑](#footnote-ref-13)
14. Part 7C *Children’s Protection Act 1993 (SA)* [↑](#footnote-ref-14)
15. Annual Report 2009-2010 Child Death and Serious Injury Review Committee [↑](#footnote-ref-15)
16. Annual Report 2010-2011 Child Death and Serious Injury Review Committee [↑](#footnote-ref-16)
17. <http://www.dhhs.tas.gov.au/children/programs_and_strategies/child_death_review> [↑](#footnote-ref-17)
18. Annual Report of inquiries into the deaths of children known to Child Protection 2011, Victorian Child Death Review Committee [↑](#footnote-ref-18)
19. <http://www.kids.vic.gov.au/vcdrc/index.htm> [↑](#footnote-ref-19)
20. *Children and Young People (Death Review) Amendment Act 2011(ACT)* [↑](#footnote-ref-20)
21. <http://www.dhcs.act.gov.au/ocyfs/children_and_young_people_death_review_committee> [↑](#footnote-ref-21)
22. Section 222 *Care and Protection of Children Act* [↑](#footnote-ref-22)
23. Section 207 *Care and Protection of Children Act*  [↑](#footnote-ref-23)
24. Section 208 *Care and Protection of Children Act* [↑](#footnote-ref-24)
25. Section 4 *Births Deaths and Marriages Registration Act* [↑](#footnote-ref-25)
26. Section 219(1) *Care and Protection of Children Act* [↑](#footnote-ref-26)
27. Section 218(1)(b)(i) *Care and Protection of Children Act* [↑](#footnote-ref-27)
28. Sections 14, 15 *Coroners Act* [↑](#footnote-ref-28)
29. Section 12(1) *Coroners Act* [↑](#footnote-ref-29)
30. Regulations 5, 6 *Births Deaths and Marriages Registration Regulations* [↑](#footnote-ref-30)
31. Section 211(1) *Care and Protection of Children Act* [↑](#footnote-ref-31)
32. Queensland Child Death Case Review Committee 2010, *Annual Report Queensland Child Death Case Review Committee, 2009-10,* Queensland Child Death Case Review Committee, Brisbane. [↑](#footnote-ref-32)
33. Robinson, G., S. Silburn, B. Leckning (2011) *Suicide of Children and Youth in the NT, 2006-2010: Public Release Report for the Child Deaths Review and Prevention Committee,* Darwin: Menzies Centre for Child Development and Education. [↑](#footnote-ref-33)
34. Recommendations of the Inquiry are set out in the *“Gone Too Soon: A Report into Youth Suicide in the Northern Territory”*, 11th Assembly Select Committee on Youth Suicides in the NT. [↑](#footnote-ref-34)
35. [↑](#footnote-ref-35)
36. A Life Long Shadow: Report of a Partial Investigation of the Child Protection Authority” C.A. Richards, Northern Territory Ombudsman June 2011. <http://www.ombudsman.nt.gov.au/wp-content/uploads/2009/07/A-Life-Long-Shadow-_web-version_.pdf> [↑](#footnote-ref-36)