PARLIAMENT OF NEW SOUTH WALES

Committee on Children and Young People

REVIEW OF THE 2004 ANNUAL REPORT OF THE CHILD DEATH REVIEW TEAM

Transcript of Proceedings, Written Answers to Questions on Notice and Minutes

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Terms of Reference

The Committee on Children and Young People is constituted under Part 6 of the *Commission for Children and Young People Act 1998*. The functions of the Committee under the Commission for Children and Young People Act are set out in section 28 of the Act as follows:

(1) The Parliamentary Joint Committee has the following functions under this Act:

(a) to monitor and review the exercise by the Commission of its functions,

(b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of its functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,

(c) to examine each annual or other report of the Commission and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,

(d) to examine trends and changes in services and issues affecting children, and report to both Houses of Parliament any changes that the Joint Committee thinks desirable to the functions and procedures of the Commission,

(e) to inquire into any question in connection with the Committee's functions which is referred to it by both Houses of Parliament, and report to both Houses on that question.

(2) Nothing in this Part authorises the Parliamentary Joint Committee to investigate a matter relating to particular conduct.

(3) The Commission may, as soon as practicable after a report of the Parliamentary Joint Committee has been tabled in a House of Parliament, make and furnish to the Presiding Officer of that House a report in response to the report of the Committee. Section 26 applies to such a report.

(4) A reference in this section to the Commission includes a reference to the Child Death Review Team.

Chairman's Foreword

The Child Death Review Team continued its important work in providing information about child deaths in New South Wales during the January to December 2004 reporting period. The Child Death Review Team is also responsible for preventing or reducing the number of deaths of children and young people in New South Wales from birth to 17 years.

It is heartening to note that between 1996 and 2004 the overall death rate for children and young people decreased from 49.6 deaths per 100 000 (777deaths) to 34.1 per 100 000 (545 deaths).

The Child Death Review Team's specific research functions are to maintain a Child Death Register, analyse the data regarding the causes of death, identify patterns and trends relating to these deaths and make recommendations to government and non-government agencies for the prevention of further deaths of children and young people. The Annual Report follows up on the implementation of 14 recommendations made from this Report and previous reports. The Committee is reassured by the action taken by various agencies in implementing and following up on these recommendations.

The Committee is also very interested in the Child Death Review Team's current special research project examining the 10 years of data in the Child Death Register between 1996 and 2005. As Aboriginal and Torres Strait Islander children and young people continue to be over-represented in the deaths of children and young people, the Committee is pleased to hear that this research will, amongst other things, allow for the greater identification of ATSI children and young people amongst the data. This research may also cast light on the potential correlation between the higher rates of death amongst children and young people in remote areas and from ATSI background. The Committee awaits the outcome of this research with interest.

The Committee commends the work of the Child Death Review Team in casting light on this most difficult of subjects.

Barbara Perry MP
Chair

Chapter One – Questions on Notice

1. The Commission's Annual Report also indicates that improvements were made to the Child Death Register in 2004, which improved the register's capacity for data capture, management and reporting. How will the changes to the register assist the Child Death review Team to perform its functions?

2. The CDRT's Annual Report indicates that remote regions in New South Wales have the highest rate of child deaths in the state, on average more than three times that in least remote regions, and that this pattern has been evident since 2000. Does the CDRT have a perspective on the underlying causes of this pattern and does the CDRT raise issues with relevant agencies as part of its ongoing monitoring of this trend?

3. What progress has been made in the CDRT's efforts to convene a national meeting of bodies in relation to options for cross-border reporting of child deaths? (p.64)

4. Nowra-Bomaderry was again identified as having the highest death rate. The Team has indicated that it will conduct detailed reviews of all the deaths and if appropriate refer the issue to NSW Health for consideration (p.68). Is there any preliminary information available from the Team's reviews at this stage?

5. The most common causes of death for 15-17 year olds were transport incidents and suicide and the external deaths were often associated with risk-taking behaviours. What is the CDRT's view of the impact of the recommendations contained in its special report on suicide and risk-taking deaths?

6. The rate of death among Aboriginal and Torres Strait Islander and young people in 2004 is estimated to be more than twice the death rate evidence among all children in New South Wales, and this over-representation has been a consistent finding of the CDRT.

   (a) What factors are associated with this higher incidence of death in Aboriginal and Torres Strait Islander children?

   (b) What agencies does the CDRT liaise with on this trend?

   (c) Have any reductions occurred in the level of over-representation?

7. 48.8% of the deaths among Aboriginal and Torres Strait Islander children resulted from diseases and morbid conditions, and 13 of 20 deaths in this category occurred in respect of children less than 12 months old. What particular factors contributed to this trend?

8. The Annual report indicates that in the coming year the team will be investigating the supervision of children and young people. How does the CDRT plan to focus on this area?

9. *Monitoring recommendations* - What progress has been made since compiling the report towards completing the review of the NSW Suicide Prevention Strategy?

10. Has the CDRT received any further advice as to whether or how the revised strategy is to take into account the findings from the suicide and risk-taking deaths report, in particular, the finding on HSC stress (p.77)?

Chapter Two – Transcript of Proceedings

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

REVIEW OF THE 2004 ANNUAL REPORT OF THE CHILD DEATH REVIEW TEAM

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At Sydney on Tuesday 22 November 2005

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The Committee met at 11.30 a.m.

———

PRESENT

Ms B. M. A. Perry (Chair)

Legislative Council	Legislative Assembly
The Hon. J. C. Burnswoods	Mr J. R. Bartlett
The Hon. A. Catanzariti	Mr S. R. Cansdell
The Hon. K. F. Griffin	Mrs J. Hopwood
Ms S. P. Hale	Ms D. V. Judge

GILLIAN ELIZABETH CALVERT, Commissioner for Children and Young People, Level 2, 402 Elizabeth Street, Surry Hills, on former oath:

CHAIR: In relation to the review report, do you wish to make an opening address?

Ms CALVERT: It might be a better use of my time if I table an opening address, which just restates the summary of the report.

Document tabled.

CHAIR: It has always been an interest to me and to a lot of people in the community about young people of Aboriginal and indigenous background. The rate of death among Aboriginal and Torres Strait Islander young people in 2004 is estimated to be more than twice the death rate evidence among all children in New South Wales, and this overrepresentation has been a finding that has been consistent for the Child Death Review Team [CDRT] since its inception. First, what factors are associated with this high incidence of death in Aboriginal and Torres Strait Islander children? Secondly, what agencies does the CDRT liaise with on this trend? I guess it is implied in that question that there has been enough of a trend for you to determine that answer. Have any reductions occurred in the level of overrepresentation?

Ms CALVERT: If I could take those one at a time, in relation to factors, I am not in a position to talk definitively about the factors although it is likely that access to health services and socioeconomic disadvantage are associated with these deaths. We have not examined the factors in great depth for two reasons: first, identifying Aboriginal and Torres Strait Islander children from the records available has been problematic; and, secondly, on a year-by-year basis in raw number terms the deaths of Aboriginal children are quite small. So we are hopeful that the 10-year study that we have embarked on will enable us to look at Aboriginality and the interaction with death rates in much greater depth because we will have a bigger database on which to draw to conduct some statistical analysis. We are also investigating other data sources that might help us identify Aboriginality in children, again giving us a better data set to work from for our 10-year study. We anticipate that study being released in 2007.

CHAIR: And the study is being done by the Commission itself with the assistance of?

Ms CALVERT: It is a Child Death Review Team study and the Commission is supporting the Child Death Review Team by undertaking the research on the team's behalf. We will be working with the Centre for Injury Risk Management at the University of New South Wales, which has expertise in epidemiological studies, which is just a way of saying studies with large numbers of people and data. So we will be calling on their expertise to help us with some of the statistical analysis.

CHAIR: When you say "problematic" in determining the Aboriginality issue is that because of the data collection sources?

Ms CALVERT: The team relies on administrative records to conduct its research, and therefore our research is only as good as the administrative records. As you can imagine, in hospitals, schools, community agencies and local GP surgeries the records are not always

what a researcher might like. So we have to supplement our administrative records where we can by other ways of identifying Aboriginality. So it may be that they do not enter the field that says Aboriginality. There may be no answer so we do not know. But then if we have a member of the Aboriginal community who is on the Child Death Review Team look at it they can say, "Yes, that family is Aboriginal because I know their family name". So we have to have a range of ways of trying to identify Aboriginality in children.

Mrs JUDY HOPWOOD: The annual report indicates that in the coming year the team will be investigating the supervision of children and young people. How does the team aim to focus on this area?

Ms CALVERT: It was raised as an issue—we are talking about supervision of little kids under four. In the last annual report the supervision of kids and adolescent risk taking were raised as issues that we said we wanted to follow up and see whether or not there was some existing programs that had shown to be effective in reducing risk taking and therefore deaths. We have this year started to focus on adolescent risk taking and we are anticipating holding a forum where we bring together experts from a number of areas to give us advice on what works or what is promising. Once we have done that we will start looking at the supervision of little kids. So it is just a question of resources and getting through one issue and then we will move onto the next issue. There is probably a bit more available on adolescent risk than there is on supervision of young children under four, and it may well be that the 10-year study gives us better data than what we have from an annual report, and that will give us some new directions or some suggestions about what we should pursue in looking at this area of supervision of little kids.

The Hon. KAYEE GRIFFIN: Because the annual report indicates that remote regions in New South Wales have the highest rate of child death in the State, is there any evidence at the moment that there is a correlation between that question and the question asked about Aboriginal children?

Ms CALVERT: It may well be that we are seeing an overrepresentation, that Aboriginality and remoteness are coming up separately but are in a sense acting on each other. Again, I am not prepared to say anything other than we do not know. That is why the team recommended to the Minister that we do a 10-year data study because it is a unique holding in New South Wales and we need to make the most of that unique holding. It should give us sufficient numbers to be able to explore, statistically anyway, questions around that Aboriginality and remoteness to try to identify some of the things that we could then follow-up on in later years or other agencies could then follow-up.

The Hon. KAYEE GRIFFIN: The report states that the patter of a higher rate of child deaths being in remote regions of the State has been in evidence in 2000. Obviously the 10-year study will resolve some of the causes and questions asked about the report. What are the other relevant agencies that you would be looking at in the ongoing monitoring of the trend?

Ms CALVERT: Certainly the Department of Health would be keenly interested because it is interested in issues of mortality and morbidity. The Department of Aboriginal Affairs is clearly very interested, and we liaise with it. Similarly, the Department of Community Services is interested in these issues given it is responsible for providing community-based services, welfare and child and family support services. They are the sorts of government

agencies that we would liaise with. Clearly as well, if you are looking at Aboriginal issues, you would want to look at some of the land councils and rural and remote farming associations. We have liaised with Farm Safe and have done quite a bit of work with them. They are the sorts of agencies we would be liaising with on rural and remote and Aboriginal issues.

The Hon. KAYEE GRIFFIN: I know this question has come up in discussions before, perhaps not in this vein, but what progress has been made in the efforts of the Child Death Review Team to convene a national meeting of bodies in relation to the cross-border reporting of child deaths and other issues?

Ms CALVERT: I think we are making quite good progress. The Hon. Catherine Cusack initially raised this issue with us and it has helped us quite a lot to go down a path we might not have otherwise gone down quite so early. That has been positive. As a result of our discussions with her and our discussions within the team, the New South Wales Commission is hosting a meeting on 2 December of all Australian and New Zealand child death review teams, and all States and Territories will be represented at that meeting. The agenda for the meeting will cover reporting on child deaths across borders, consistency in coding and classification of child deaths, so we can do interstate comparisons—we can compare apples with apples, in a sense—consistency in data collection and reporting so we get agreement on what data is collected and what is reported across all States, and opportunities for future collaboration. We have also asked the Australian Institute of Health and Welfare to the meeting as well, because we think its experience of working nationally will help the States report within a national framework or report in a way that enables us to do good comparisons between States.

The Hon. JAN BURNSWOODS: My question relates to the deaths of Aboriginal children. Given the Federal Government's constitutional role and in particular the way it funds Aboriginal health services, do Federal agencies keep statistics and identify Aboriginality and can they help? I guess my question relates to the Hon. Kayee Griffin's question in that given the presence of Aboriginal people in a number of border regions, I guess they also might be highly represented in those deaths where the child may live in one state and the death may occur in another State. If you think of places like along the Murray River, Broken Hill, the Moree area, et cetera?

Ms CALVERT: Absolutely.

The Hon. JAN BURNSWOODS: I just wonder what role the Federal Government may play in trying to pin some of that down?

Ms CALVERT: Partly that is why we have approached the Institute of Health and Welfare because it is the Federal agency. Also the Australian Bureau of Statistics [ABS] is another data source we use as well. We have approached Centrelink to see whether it can help us identify Aboriginality amongst our cohort of New South Wales children as well as about strategies to help to identify Aboriginal children. I think there is a role for Commonwealth agencies and I hope they will participate. I am sure the Institute of Health and Welfare and ABS will be more than happy to work with us because they are already working with us on other matters.

The Hon. JAN BURNSWOODS: They are participating in the meeting on 2 December?

Ms CALVERT: We have certainly invited the Institute of Health and Welfare to the meeting on 2 December and we are awaiting a reply, but informal discussions are that it is very interested.

Mr JOHN BARTLETT: Can I change topic? Can I ask three questions on the figures on suicide? I get the feeling that compared to last year numbers of have come down. Is it still the figure of about 50 per cent of suicides that there was nothing on the record anywhere to give any indication that it was likely to occur with these young people? You said last time there was one time they always tell one person, or some person gets to know about it and there is one time you do dob. Do you run any activity or campaign when that was mooted, that there was one time when you tell someone else?

Ms CALVERT: In relation to the rate going down, I would be reluctant to make comments about trends based on the small numbers that we have. Certainly we have a graph on page 52 of the report. If you look at that from the year 2000 it varies whether you are a male or female. Males went up and then came down. Females went down and they have come up little bit. If you just look at the rate itself, it has remained fairly constant since 1998. There was a spike in 1997 but in 1998 to 2004 it has remained fairly constant. This is where the value of the 10-year data study will be useful because we will be able to say what has happened over 10 years, and probably that is more reliable than that five-year figure. In respect of 50 per cent having no record—

CHAIR: Where did you get that from?

Mr JOHN BARTLETT: Last year's. We had a discussion last year about it. The only report you had was the colonial record, nothing in schools.

Ms CALVERT: My memory of what we talked about last year was that 50 per cent of the kids who were in the suicide study had only one administrative record or did not have an extensive record. This year we did not have time to access the records. So we cannot tell you whether or not they did, but we do not think that there was a problem. We actually think the kids did have records. Yes, they did have records.

In relation to always telling one person, I guess that was a key message from last year. If someone does tell you that they are thinking of suicide, it is, as you say, the one time you do dob. That was a recommendation that we made or that was an aspect of the recommendation that we made out of the suicide report. As I understand it, the New South Wales Suicide Prevention Advisory Group has been given carriage of the implementation of the recommendations in relation to the suicide and risk-taking report. They are preparing a revised draft strategy for the next advisory group meeting, although no date has been set for that meeting. We will continue to monitor the progress of that recommendation.

Mr JOHN BARTLETT: What is that group you refer to?

Ms CALVERT: That group is supported by NSW Health.

Ms SYLVIA HALE: At page 110 in the appendices of your report, in terms of the raw figures provided, under "P07 Disorders related to short gestation and low birth rate not elsewhere classified" you have a total of 515 deaths over the five-year period. That far outweighs any other category, yet there appears to be no breakdown. Will you try to break down those figures? Presumably, it could be attributable to the mother smoking, general poor health or a whole range of reasons. The total figure over that period at the very end of the report shows 2,338 deaths, and 515 is at least 20 per cent of that figure. It seems to be a very significant category that needs further attention.

Ms CALVERT: Really you are talking about babies born prematurely and having low birth weight. That is a leading cause of death of babies. There is significant research activity undertaken by the health system around the causes of those deaths. One of the things that we would want to look at is what value the Child Death Review Team could add to that understanding. Again, it may be that the more in-depth analysis that we are dealing with in the 10-year study suggests that there are some trends or patterns that have not been considered that we think need to be followed up. This is the subject of quite significant research activities by health professionals. How do we stop babies being born prematurely and how do we keep them alive if they are? There is a lot of work existing in that area.

The Hon. JAN BURNSWOODS: I may have missed your answers on this issue when I was briefly out of the room. As to negotiations you have had with NSW Health in relation to ethics and the way ethics can get in the way of research, is that an issue?

CHAIR: Ms Sylvia Hale has asked that question.

The Hon. JAN BURNSWOODS: Does it also relate to the questions just asked by Ms Sylvia Hale and your answers as to what NSW Health is doing?

Ms CALVERT: We think there has been some progress in that area. We anticipate there will be a positive outcome next year some time. That will help us significantly.

The Hon. JAN BURNSWOODS: I was broadening it out from infancy to the whole study.

Ms CALVERT: Yes, any sort of study, because it will enable us to do multi-site studies without having to go through multi-ethics committees, which is what the problem was.

Ms SYLVIA HALE: When you compile statistics on death, say, as a result of a road accident, does the death have to occur within a particular time frame to be attributable to the accident? Do you take statistics on people who die, say, 12 months after an accident?

Ms CALVERT: A person might have had a car accident in January and died in December or in January the following year. We would take that death in January and it would then be coded according to the ICD 10 method of coding. That is how we would determine the cause of death. If it was related to the motor vehicle accident that would be captured. You could die from a stroke. The cause of death was the stroke but a contributing factor might be the motor vehicle accident that gave you the blow on the head.

Ms SYLVIA HALE: If there are multiple causes of death, are they recorded in the statistics under one heading or can they be recorded under multiple headings?

Ms CALVERT: For the first time in this report we have talked about the primary cause of death and contributing causes of death. The primary cause of death is what we refer to in the report. When we talk about a motor vehicle accident, that is where it has been the primary cause of death. On page 24 we talk about primary causes. On page 29 we talk about contributing causes.

CHAIR: In these statistics it is just the primary cause.

Ms CALVERT: Yes, our statistical analysis is based on primary cause.

CHAIR: Commissioner, the annual report indicates that in the coming year the team will investigate the supervision of children and young people. How does the Child Death Review Team plan to focus on that area?

Ms CALVERT: I talked about that earlier when I said that we had spent the last year looking at adolescent risk-taking and we will be holding a forum on adolescent risk-taking. We have delayed looking at the supervision of young kids until we have sorted out the adolescent risk-taking issue.

CHAIR: If there are no other questions we will finalise this section. There is one further section on the built environment. You were previously supplied with questions and I am sure you have prepared some answers. Would you be willing to table those answers at some stage to be part of the transcript of this hearing?

Ms CALVERT: Of course, Madam Chair.

CHAIR: Again, I thank you. It is very evident from both hearings how much work—including the surrounding framework and philosophies—goes into this very significant area of children and young people. It is good to know there is an objective analysis of issues. I thank you and your staff once again for attending the hearing and providing the information.

(The witness withdrew)

The Committee adjourned at 12.10 p.m.

Chapter Three – Written Answers to Questions on Notice

Question 1:
The Commission's Annual Report also indicates that improvements were made to the Child Death Register in 2004, which improved the register's capacity for data capture, management and reporting. How will the changes to the register assist the Child Death Review Team to perform its function (CCYP Annual Report, p.19)?

The NSW Child Death Review Team has maintained the Register since 1996. It contains data on all deaths of children and young people less than 18 years of age who die in New South Wales.

The data collected in the Register has been expanded to reflect both the knowledge gained by the Team through its research, and current national and international literature in the area of child death.

We can now systematically record information on:

- the demographic details of the child (e.g. age, sex, family, details, socio-economic disadvantage, geographic location, indigenous status);
- the cause and manner of death of the child; the quality of supervision at the time of the incident;
- the physical environment at the time of death;
- the use of safety equipment;
- the health of the child prior to the incident; and
- any behaviours of the child and others which contributed to the death.

These improvements help the Team identify prevention issues and allow us to complete data management and reporting functions more efficiently.

Question 4:
Nowra-Bomaderry was again identified as having the highest death rate. The Team has indicated that it will conduct detailed reviews of all the deaths and if appropriate refer the issue to the NSW Health for consideration. Is there any preliminary information available from the Team's reviews at this stage? (p.68)

Twenty-three children and young people from the Nowra-Bomaderry area died over the 2001 to 2004 period. Our preliminary examinations did not reveal any unusual pattern.

Of the 20 children and young people reported in the 2004 Annual Report who died in the Nowra-Bomaderry area over the 2001 to 2003 period, 10 were male (50%) and the majority were infants less than one year (12 deaths, 60%). Eleven children and young people died from diseases or morbid conditions, six from external causes and three from ill-defined or unknown causes.

We are currently waiting to receive the medical and coronial records we require to conduct our detailed review.

Question 5:
The most common causes of death for 15-17 year olds were transport incidents and suicide and the external deaths were often associated with risk-taking behaviours. What is the CDRT's view of the impact of the recommendations contained in its special report on suicide and risk-taking deaths? (p.xi)

The NSW Suicide Prevention Advisory Group was convened in late 2004, with representation from the Commission. We have twice made presentations to the Group on the CDRT Report's findings and their implications. The Advisory Group has now set prevention of suicide in young people as a focus area for the new Strategy.

NSW Health has advised that they will develop a revised draft strategy for the next Advisory Group meeting. This date has not been set.

The Team has noted the initiatives undertaken by NSW Health to address risk factors and enhance resilience in the 2004 Annual Report and will continue to monitor action of the recommendations of the report on suicide and risk-taking deaths.

Question 7:
48.8% of the deaths among Aboriginal and Torres Strait Islander children resulted from diseases and morbid conditions, and 13 of 20 deaths in this category occurred in respect of children less than 12 months old. What particular factors contributed to this trend? (pp.19-20).

We know, from our Sudden Unexpected Deaths of Infants research, that households where the mother is Aboriginal or Torres Strait Islander are more likely to smoke in pregnancy and live in smoking households. Both of these are risk factors for Sudden Unexpected Deaths of Infants. At this stage we are unable to comment further, although the delivery of pre and postnatal care are likely to be factors.

We haven't examined this issue further because identifying Aboriginal and Torres Strait Islander infants from the records has been problematic, and on a year by year basis there are a relatively small number of Aboriginal and Torres Strait Islander infant deaths.

We are further investigating data sources that may help identify Aboriginal and Torres Strait Islander children.

Aboriginal and Torres Strait Islander deaths are one group the Team will examine as part of our 10 year study. We expect the findings of this study to be available in mid 2007.

Question 9:
Monitoring recommendations – What progress has been made since compiling the report toward completing the review of the NSW Suicide Prevention Strategy? (pp.77-79)

The NSW Suicide Prevention Advisory Group was convened in late 2004, with representation from the Commission. We have twice made presentations to the Group on the CDRT Report's

findings and their implications. The Advisory Group has now set prevention of suicide in young people as a focus area for the new Strategy.

NSW Health has advised that they will develop a revised draft strategy for the next Advisory Group meeting. The date has not been set yet. We will continue to monitor action of the recommendations of the report on suicide and risk-taking deaths.

Question 10:
Has the CDRT received any further advice as to whether or how the revised strategy is to take into account the findings from the suicide and risk-taking deaths report, in particular, the finding of the HSC on stress (p.77)

The NSW Suicide Prevention Advisory Group will look at HSC stress as part of their considerations.

Appendix 1 – Committee Minutes

Minutes of Proceedings of the Committee on Children and Young People
Thursday 1 December 2005 at 1.15pm
Room 1108, Parliament House

Members Present
Mrs Perry (Chair), Mr Bartlett, Mr Cansdell, Mr Daley, Ms Griffin, Ms Hale, Mrs Hopwood, Ms Judge and Ms Pavey.

Also in Attendance:
Helen Minnican, Pru Sheaves, Hilary Parker, Lluwannee George

The Chair opened the meeting at 1.20pm.

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1. Inquiry Program
Reviews of CDRT and CCYP Annual Reports
Resolved on the motion of Ms Griffin, seconded by Ms Judge, that:

i. in relation to the review of the 2004 Annual Report of the Child Death Review Team:
   a) the Committee's report shall consist of:
      - the questions on notice to the Commissioner;
      - the corrected transcript of the evidence given by the Commissioner during the public hearing on 22 November 2005;
      - answers to the questions on notice, not provided during the hearing by the Commissioner but taken on notice;
      - relevant information (that is not confidential) as provided by the Commissioner in response to matters taken on notice during the hearing.
   b) the report, so comprised, be adopted as the report of the Committee and that it be signed by the Chair and presented to the House, together with the minutes of evidence;
   c) the Chair and Committee Manager be permitted to correct stylistic, typographical and grammatical errors.

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Appendix 2 – Commissioner's Opening Address

Child Deaths Review Team report[1]

The good news from the most recent report of the Child Death Review Team, is that the number of child deaths overall continues to decline.

In 2004, the number of deaths among children and young people up to 17 years of age, was the lowest for nearly a decade.

In 1996 there were 777 deaths in total, but this figure had fallen to 545 by 2004.

The infant mortality rate has also fallen. In 2004, there were 299 infant deaths, which means 3.5 deaths per 1,000 live births. This is one of the lowest rates since 1996.

While we are pleased the numbers are going in the right direction, it's important to recognise the sadness behind each one of these deaths. Every individual child's death is a tragedy that impacts on their families, friends and community.

It's a reminder to keep working to reduce the number of child deaths in NSW. One of the ways we can do that is by continuing our work researching the causes.

External causes of death

The figures for external causes of death also show a reduction since 1996, although the number of transport related deaths has changed little.

External causes represent around 1 in 5 of total child deaths (21.5%). In 2004, there were 117 deaths from external causes, the lowest numbers since 1996.

The main external causes of death in 2004 were transport incidents (which were responsible for almost 1 in 10 of all deaths), drownings, suicide, assault and house fires.

The Child Death Review Team found the main external death causes in 2004 were:

- Transport incidents (53 deaths; or 9.7% of all deaths)
- Drowning (16 deaths; or 2.9% of all deaths)
- Suicide (16 deaths; or 2.9% of all deaths)
- Assault (8 deaths; or 1.5% of all deaths)
- House fires (8 deaths; or 1.5% of all deaths)

This pattern has been consistent since 1996.

Transport-related deaths

Although the overall rate of deaths from external causes is falling, one area in which progress has been tough is in transport-related deaths, where the rate has changed little since 1996.

[1] Opening address received by Committee 28/3/06

More than half the transport fatalities are passengers (30 deaths or 56.6% of total transport deaths) and 1 in 5 are pedestrians (11 deaths or 20.8% of total transport deaths).

In recent years the high number of male deaths in transport incidents has dropped, while the relatively low number of female deaths is on the rise.

In 2002, male transport death rates were 5.7 per 100,000, dropping to 3.7 by 2004. At the same time female rates rose from 2 to 3 per 100,000.

We don't know all the reasons for this trend. It is possible safety messages are getting through to males but not females. It is also possible there are increasing risk taking behaviours amongst young women.

Rural and ATSI

While there is good news, there are ongoing areas of concern as well. Higher death rates in remote areas and for Aboriginal and Torres Strait Islander children and young people, have also been raised in previous reports of the Child Death Review Team.

Aboriginal and Torres Strait Islander children and young people make up 3.5 per cent of the population, yet they account for 7.5 per cent of all deaths.

The rate of death for kids in remote areas of NSW is three times higher than in highly accessible areas of NSW, and this has been the case since 2000.

We are working to better understand why this is, through a 10 year data study. It may help us find out how to reduce death rates amongst these groups of young people.

Another issue raised in this report concerns the high child death rates in the Nowra-Bomaderry area.

The rate in Nowra-Bomaderry is 80 deaths per 100,000 children. This is more than twice the rate for similar regions, which are an average of 30 per 100,000.

The Child Death Review Team is responding with a detailed review of all deaths in the region from 2001-2004.

We hope the review will identify some of the causes of such a high death rate in a particular region so we can work towards helping to reduce the number of child deaths.

Conclusion

The ongoing reduction in the rates of deaths of children in NSW is good news.

The NSW Child Death Review Team should be commended for their work.