



**SPECIAL COMMISSION OF INQUIRY INTO  
CHILD PROTECTION SERVICES IN NEW SOUTH WALES**

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**PUBLIC FORUM  
ROLE OF OVERSIGHT AGENCIES  
28 MARCH 2008  
AGENDA**

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1. In relation to the reviews of child deaths:
  - a. do each of the reports produced by DoCS, the Ombudsman, the Coroner and the Child Death Review Team contribute to our understanding of systemic issues?
  - b. should one agency be responsible for overseeing the review of and research into all child deaths?
  - c. is the mode of inquiry and of reporting variously used by the several agencies appropriate?
2. How appropriate are the existing procedures for reviewing the situation of children in care by the Ombudsman or Children's Guardian?
3. Do the Quality Improvement and Case File Audit Programs of the Children's Guardian deliver value commensurate with the resources required for their implementation. If not, could they be modified in any way?
4. The management by DoCS of allegations against employees, service providers and authorised carers, including:
  - a. the time taken to investigate and the procedures followed
  - b. the reasons children are removed from carers who are the subject of allegations
  - c. the role of the Ombudsman in overseeing the investigations or conducting investigations directly
  - d. the use made of allegations which are not substantiated and the consequences for carers, service providers and employees
  - e. the possible involvement of NGOs or mediation in such cases.
5. Would outcomes for children and young people be improved if the functions of the Children's Guardian and the Commission for Children and Young People were combined?