PeakCare Queensland Inc.

Submission to the

Queensland Parliament

Education, Employment and Small Business Committee

Child Death Review Legislation Amendment Bill 2019

8 October 2019

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INTRODUCTION

PeakCare Queensland Incorporated (PeakCare) welcomes the opportunity to provide information in response to the Queensland Parliament's Education, Employment and Small Business Committee's invitation calling for submissions in response to the *Child Death Review Legislation Amendment Bill 2019*.

ABOUT PEAKCARE

PeakCare is a not for profit peak body for child and family services in Queensland, providing an independent and impartial voice representing and promoting matters of interest to the non-government sector.

Across Queensland, PeakCare has around 60 members which are a mix of small, medium and large, local and statewide, mainstream and community controlled Aboriginal and Torres Strait Islander non-government organisations that provide prevention and early intervention, generic, targeted and intensive family support to children, young people, adults and families. Member organisations also provide child protection services, foster and kinship care and residential care services for children and young people and their families who are at risk of entry to, or who are in the statutory child protection system.

A network of registered Supporters made up of individuals and other entities with an interest in child protection and related services and who are supportive of PeakCare's policy platform around the safety, wellbeing and connection of children and young people, also subscribe to PeakCare.

ABOUT PEAKCARE'S SUBMISSION

PeakCare's primary concern is child protection and related services and as such, PeakCare has an interest in reforms relating to child death review processes.

Overall, PeakCare welcomes the proposed legislative changes to system reviews following child deaths connected to the child protection system, including proposals for broadening the scope beyond the Department of Child Safety, Youth and Women (Child Safety) to include other agencies involved in providing services to the child and the stated intention of ensuring independence of these processes.

PEAKCARE'S RESPONSES TO THE PROPOSED AMENDMENTS

The following responds to the proposed legislative amendments and their apparent intentions.

Expanding the requirement for government agencies to conduct internal reviews

PeakCare supports measures to expand the requirement to conduct internal reviews, following the death or serious injury of a child known to Child Safety, to other relevant government agencies involved in providing services to the child.

This will include Queensland Health, Department of Education, Queensland Police Service and the Department of Youth Justice. The additional focus on collaboration and joint learning, reflecting the shared responsibility for child protection, is welcomed.

Establishment of a Child Death Review Board

PeakCare supports measures to increase the impartiality and independence of child death review processes. However, PeakCare holds concerns that the proposed placement of the new Child Death Review Board within the Queensland Family and Child Commission (QFCC) may not achieve the level of independence required.

PeakCare suggests further independence could be attained by placing this function with the Queensland Coroner, given judicial officers act independently and without interference from the parliament or the executive. The review process must be inquisitorial, not a method of apportioning guilt and conducted in accordance with the principles of procedural fairness. The effective administration of child death review processes is important for public confidence generally (and in particular, for affected families and staff).

The Domestic and Family Violence Death Review and Advisory Board sits with the Queensland Coroner and is responsible for the systemic review of domestic and family violence deaths and identifying issues with service systems in Queensland. This function is well aligned with the investigation of the deaths of vulnerable children known to the child protection system.

Placing the Child Death Review Board with the Coroner would also avoid unnecessary duplication of investigations.

The proposed increase in functions and powers of the Child Death Review Board to include undertaking reviews relating to the child protection system, research, analysis of data, making recommendations, monitoring recommendations and reporting, with the broad purpose of continuous improvement, are supported.

There is an opportunity to improve respect for the rights of children and families through the inclusion of family members in the child death review process. While families experiencing such tragedy should always be met with empathy and compassion, they also want to understand what happened to their child and be assured that any learning arising from their child's death will help prevent future children's deaths.

PeakCare suggests processes could be included which:

- acknowledge the distress of families and their need for support
- recognise different cultural beliefs and practices surrounding death, and
- keep affected family members informed (where appropriate) of the progress of the review

PeakCare commends the commitment to strengthening child death review practices and through continuous improvement from these learnings, strengthening the child protection service system overall.

Thank you for the opportunity to provide information in response to Queensland Parliament's *Child Death Review Legislation Amendment Bill 2019*.

Yours sincerely

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