AASW Queensland Branch

Queensland Branch response to Child Death Review Legislation Amendment Bill 2019

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Queensland Branch Office– Brisbane
5/43 Vanessa Boulevard, Springwood
BRISBANE, QLD 4127
PO Box 1024
SPRINGWOOD QLD 4127
T 07 3090 3718
E aaswqld@aasw.asn.au www.aasw.asn.au

Enquiries regarding this submission can be directed to:
Queensland Branch President:
Ellen Beaumont
Email: qld.branchpresident@aasw.asn.au

Queensland Branch Manager
Ms Mere Vitale
Email: aaswqld@aasw.asn.au

Introduction

Who we are

The Australian Association of Social Workers (AASW) is the professional body representing more than 12,000 social workers throughout Australia. We set the benchmark for professional education and practice in social work, and advocate on matters of human rights, social inclusion, and discrimination.

The social work profession

The social work profession is committed to maximising the wellbeing of individuals and society. We consider that individual and societal wellbeing is underpinned by socially inclusive communities that emphasise principles of social justice and respect for human dignity and human rights, including the right to be part of a loving and understanding family.

The social work profession supports and enacts the United Nations Declaration on the Rights of the Child, particularly Principle 9 which states that 'The child shall be protected against all forms of neglect, cruelty and exploitation.' Drawing on knowledge of social work practice, social sciences, humanities and Indigenous knowledge, social workers focus on the interface between the individual, their family and the environment and recognise the impact of social, economic and cultural factors on the health and wellbeing of individuals and communities. Accordingly, social workers maintain a dual focus in both assisting with and improving human wellbeing and identifying and addressing any external issues that may impact on wellbeing, such as inequality, injustice and discrimination.

Significant numbers of social workers practise in child wellbeing and protection settings in a range of roles including direct case work, management and policy. No other professional discipline is so immersed in the areas of knowledge that are essential for quality relationship-based child protection practice. As a result, social workers are recognised throughout the world as the core professional group in child protection policy, management and practice. Social workers offer a unique and valuable contribution in providing appropriate and targeted child-centred services as well as facilitating referral pathways that ensure the linking of services, access and equity.

Submission

The AASW Queensland Branch (herein the 'AASW'), welcomes the opportunity to contribute to the consideration of the *Child Death Review Legislation Amendment Bill 2019* (herein 'the Bill').

As stated in the Explanatory Notes, the policy objective of the Bill is to implement the recommendation of the Queensland Family and Child Commission (QFCC) report, *A systems review of individual agency findings following the death of a child* (QFCC report), and give effect to the Government's commitment to develop a new, independent model for reviewing child death cases.

The QFCC report identified several best practice benchmarks that must be considered in designing a contemporary child death review model, including:

1. extending the scope to include other government and non-government organisations;
2. extending the powers and authority of Child Death Case Review Panels, including the power to make recommendations;
3. reporting to government and public audiences on outcomes of child death reviews;
4. reconsidering panel governance, such as selection and appointment of members and period of membership; and
5. providing appropriate resourcing for secretariat, panel operation and agency reviews.

The AASW agrees in principle with these recommendations by the QFCC. The focus has previously been on Child Safety without commensurate responsibility and accountability of other organisations. The current review process depends on the goodwill of organisations to participate and how they

participate, but there are insufficient mechanisms to make recommendations to support more holistic service provision. The current system also places the onus on Child Safety when it is evident that a whole-of-systems approach is needed. Moreover, multiple systems are involved, and thus it is important that these systems and relevant services have some level of accountability in terms of appropriately considering and implementing feedback and recommendations.

The Bill proposes to establish a new child death review model by:

1. *expanding the requirement to conduct an internal systems review following the death or serious physical injury of a child known to Child Safety, to other relevant government agencies involved in providing services to that child (in addition to Child Safety and the Director of Child Protection Litigation);*

The AASW agrees with this requirement. Services funded by Child Safety are not included here, yet much of the service provision occurs by non-government organisations (NGOs) and community services. We suggest that this requirement needs to be applicable to the whole service. Furthermore, we recognise that a child's death or serious injury can itself be a very stressful and sensitive matter for all involved. As such, a review can potentially add to this stress, and so we recommend that a clear and non-blaming learning-focused framework should be adopted to improve opportunities for services to meaningfully consider feedback and recommendations. Additionally, whilst it is important to learn from NGOs and community services, this should not come at the cost of diluting the responsibility of government services.

2. *establishing a new, independent Child Death Review Board, located within the Queensland Family and Child Commission, responsible for carrying out systems reviews, following child deaths connected to the child protection system, to identify opportunities for continuous improvement in systems, legislation, policies and practices; and to identify preventative mechanisms to help protect children and prevent deaths that may be avoidable.*

The AASW agrees with the establishment of a new independent Child Death Review Board located within the QFCC. We also agree with the purpose and focus of the Board (as articulated on page 7 of the Explanatory Notes). It would be important that the Board establishes and maintains a collaborative rather than adversarial relationship with services as the previous iteration of the Board under the QFCC could be characterised as having an adversarial disposition, which was counter-productive for the Commission and Child Safety departmental staff. An important step toward a collaborative approach is ensuring a non-blaming stance that also avoids duplication of the review process where possible.

What is not clear and needs further clarification is if the Board would have the ability to seek and request information from private organisations. It is important that there should be parity in seeking information from all services regardless of their public/private status. If there were to be a disparity, this potentially would create a situation where the Board may have far more information than Child Safety. This has relevance for how streamlined the review process is, and how we achieve the best outcomes for children and young people.

The Explanatory Notes state:

> *Given the broad purpose of the new model is about systems and practice improvements, and not about individual accountability or blame, the Bill makes it clear that the scope of reviews (for internal reviews and by the Board) must not include considering whether disciplinary action should be taken against an individual.*

In line with our previous comments, the AASW agrees with this, as it will support a collaborative approach and improve opportunities for meaningful implementation of recommendations.

The AASW also agrees with changes to Chapter 7A pertaining to Internal Agency Reviews. Furthermore, the AASW supports changes to section 246AB(2) and 246BA of the Child Protection Act (per page 5 of the Explanatory Notes). Furthermore, the AASW supports expanding information sharing as described on page 6 of the Explanatory Notes.

Finally, the requirement for agencies to fund internal reviews through their existing budget is problematic as this does not support undertaking a significant review process, which itself can be quite time consuming and requires dedicated and skilled people to do this. Without allocating appropriate resources to the internal review, there is risk that the review process will be surface level or become blame oriented because they have not been allocated sufficient staff with appropriate skills and resources. This is a significant change and addition to workload and requires appropriate and dedicated funding.

Conclusion

The AASW thanks the Queensland Government for the opportunity to contribute to the consideration of the *Child Death Review Legislation Amendment Bill 2019*. The AASW supports the Bill in principle, and the opportunity it hopefully brings to improve outcomes for children and young people. There are some areas for clarification and consideration, particularly with respect to ensuring the Board and the review process are collaborative, and work toward improving information sharing. Furthermore, the AASW recommends that the government support agencies to meet the financial and resource burden associated with internal reviews, so as to enable these agencies to engage in the review process effectively.

The AASW welcomes the opportunity to work with the government to implement these changes.