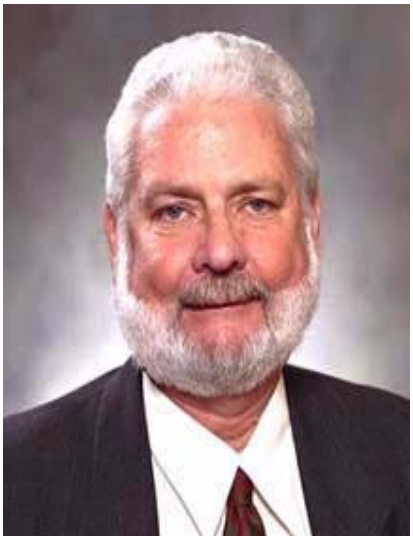

Speech by

Hon. Mike Reynolds

MEMBER FOR TOWNSVILLE

Hansard 11 May 2004

MINISTERIAL STATEMENT

Child Death Review Committee

Hon. M.F. REYNOLDS (Townsville—ALP) (Minister for Child Safety) (10.12 a.m.): I believe it is important to bring the attention of the House to the significant reform work of my department in the area of child death case reviews and how the Beattie government intends to legislate to enhance this work and consequently enhance accountability.

These case reviews have become more rigorous since June 2002 and are governed by departmental procedures. As part of our reforms to the child protection system in Queensland, we will soon amend the Child Protection Act to ensure these reviews not only provide a legislative link for the new Child Death Review Committee but also provide even more rigour and more transparency. These reviews examine whether the Department of Child Safety responded appropriately to notifications of abuse and whether the department's work with other agencies like Health, Police and Education was sufficient.

The new Child Death Review Committee will be independent and its primary function will be to review Department of Child Safety case reviews of its interventions with any child who has died within three years of contact with the Department of Child Safety. This statutory committee will have the power to make recommendations, and when these are not met within a reasonable time the committee will be able to report on this to both myself as the Minister for Child Safety and the Premier.

When the department's Review of Significant Incidents Committee considers the nature of the department's contact with children who have died, its inquiries apply to a very wide range of children. They include those who are or have been in the care of the department through various orders, and all children about whom a notification of abuse has been made. The cases, for example, could include children whose parents have been accused of abuse by a neighbour, with just one phone call having been made to the department. The child may have died as the result of an accident or terminal illness.

Of the 14 deaths of children between 1 January and 30 April 2004 that are subject to review, two deaths were from suspected suicide, four were from sleeping accidents, possibly sudden unexplained infant death, three were non-accidental or infanticide, one was from a fall, one was from inhalant use, one was from multiple medical conditions and the cause of death of the remaining two have yet to be determined. This figure of 14 deaths of children compares with 15 deaths in the six months to December last year and I am advised the details of those 15 cases will be published as usual on my department's information gateway website in a few weeks time.

As minister I am determined that the new Department of Child Safety, which will be fully functional by December this year, is open, transparent and accountable. The implementation of this key CMC recommendation enshrines in legislation that key principle. Our most vulnerable children in the state deserve nothing less.