Speech By

Hon. Yvette D'Ath

MEMBER FOR REDCLIFFE

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CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL

Introduction

Hon. YM D'ATH (Redcliffe—ALP) (Attorney-General and Minister for Justice) (11.17 am): I present a bill for an act to amend the Child Protection Act 1999, the Director of Child Protection Litigation Act 2016 and the Family and Child Commission Act 2014 for particular purposes. I table the bill and the explanatory notes. I nominate the Legal Affairs and Community Safety Committee to consider the bill.

Tabled paper: Child Death Review Legislation Amendment Bill 2019 [1501].

Tabled paper: Child Death Review Legislation Amendment Bill 2019, explanatory notes [1502].

I am pleased to introduce the Child Death Review Legislation Amendment Bill 2019. In introducing this bill, I acknowledge the death of 21-month-old toddler Mason Jett Lee, who on 11 June 2016 died tragically at his Caboolture home. The death shocked the community. Following Mason's death, the Premier requested the Queensland Family and Child Commission, QFCC—

Mr DEPUTY SPEAKER (Mr Kelly): Pause the clock. I ask those leaving the chamber to please exit the chamber quietly. The minister is addressing sensitive matters in her introductory speech.

Mrs D'ATH: Following Mason's death, the Premier requested the Queensland Family and Child Commission, QFCC, to oversee the reviews being undertaken by the Department of Child Safety, Youth and Women and Queensland Health about the services provided to Mason before he died. Child Safety and the Director of Child Protection Litigation, the litigation director, are currently the only agencies required to undertake a review of their involvement following the death or serious physical injury of a child who is known to Child Safety. Government accepted the single recommendation from the QFCC's report, *A systems review of individual agency findings following the death of a child*, to 'consider a revised external and independent model for reviewing the deaths of children known to the child protection system'. The Palaszczuk government also publicly committed to introducing legislation requiring expanded key government agencies—such as health, education and police—to conduct internal systems reviews in child death cases. This bill, if passed by the House, will fulfil that commitment.

Naturally, there is significant public interest in government's ability to safeguard our most vulnerable children, ensure cases are appropriately examined and identify opportunities for policy, practice and system improvements. While the QFCC found Child Safety's internal reviews are effective at an agency level, an important finding of the QFCC report was that Queensland's system of reviewing deaths of children known to Child Safety is not sufficiently independent and not delivering whole-of-system changes required to protect vulnerable children. The QFCC report also found that the current model does not apply to other government agencies that may have also been involved. The QFCC identified the need for key government agencies to better work together, with a particular concern being the lack of information sharing and collaboration, a key learning from the Mason Jett Lee case.

The QFCC report concluded that when it comes to child death reviews Queensland can do better. The proposed new model, established under the bill, will do this in two ways. Firstly, it will expand the current requirement to conduct an internal systems review when a child known to Child Safety dies or

suffers serious physical injury to other relevant government agencies—Queensland Health, including hospital and health services, the Department of Education, the Queensland Police Service, and the Department of Youth Justice in addition to Child Safety and the litigation director. Secondly, it will establish a new, external and independent Child Death Review Board to carry out systems reviews following child deaths connected to the child protection system.

Importantly, the child death review model is focused on promoting continuous improvement of systems, legislation, policies and practice. It is not about individual blame or disciplinary action. Provisions in the bill ensure that the scope of internal agency reviews or reviews by the board must not include whether disciplinary action should be taken against any person.

The bill amends the Child Protection Act 1999 to expand the existing internal agency review process, which will continue to focus on children known to Child Safety who have died or suffered a serious physical injury in the past 12 months; require relevant government agencies to undertake a systems review of their involvement with the child if they have provided a service to the child; continue to focus on improvements to services and accountability, with an added purpose of promoting collaboration and joint learning; in exceptional circumstances, enable responsible ministers to request their agency to conduct a review outside of the usual scope; require agencies to decide the extent of, and terms of reference for, their review; introduce provisions to enable the sharing of information while protecting confidentiality so relevant agencies can carry out reviews and share outcomes; and require all agencies undertaking an internal review to prepare a review report and provide a copy of these reports relating to child deaths to the new board within six months. Requiring these key agencies to review and critically reflect on their involvement recognises that child protection is a shared responsibility.

The bill establishes the new Child Death Review Board under the Family and Child Commission Act 2014. Independence of the department of child safety is critical to the board and is central to the QFCC's recommendation and government's commitment. The independent board, and its ability to consistently make public systems recommendations, will increase transparency and improve public confidence. The bill provides that the board will sit within the QFCC, given its many synergies and opportunities for streamlining with QFCC's existing functions, including oversight of the child protection system and management of the Child Death Register in Queensland. Though the board will receive secretariat support from the QFCC, it is important to note that the board will be independent and operate as a separate entity from the QFCC with distinct functions and powers.

Likewise, while the board will be chaired by the principal commissioner or a commissioner of the QFCC, the bill makes it clear that they will not be subject to ministerial direction in their role as chair of the board. Under the bill, the board must also act independently and in the public interest. The independence of the board is further ensured because its primary focus is to review deaths of, or serious injury to, children known to the child protection system. The board sits outside the bodies that will have had the necessary contact with the child to trigger a review.

The new board is modelled on common elements from other death review models, particularly Queensland's Domestic and Family Violence Death Review and Advisory Board and other states and territories, in particular Victoria, New South Wales and Western Australia. Other existing mechanisms in Queensland that review the deaths of children have different purposes and scope, can be limited in their ability to produce timely results and are not consistently undertaken. For example, reviews by the Queensland Ombudsman are largely complaints driven and limited to government agencies. While certain 'reportable deaths' are subject to coronial investigation, only a small number proceed to inquest—sometimes several years following the death. The QFCC currently conducts systems level reviews prompted by the death of a child, as in the case of Mason Jett Lee; however, in practice this only occurs by ministerial request.

Accordingly, the new board complements, not duplicates, these existing processes. The board will consistently consider all deaths of children known to Child Safety and will make whole-of-systems recommendations that are timely and public facing. The board's focus will not be investigating the death of a particular child. Whilst the board may examine the circumstances of a death and the contact various government agencies may have had with the child, the responsibility of investigating the specific circumstances and causes of the death will remain with the relevant expert agencies such as the Queensland Police Service and the Coroner.

The board will replace the current Child Death Case Review Panels and replace the QFCC's current function of conducting systemic reviews following the death of a child. The QFCC will continue to have a broader statutory systemic review function about the child protection system and will also retain responsibility to maintain the Child Death Register, which records information on all child deaths in Queensland. The purpose, scope, functions and powers of the new board are significantly broader

than existing Child Death Case Review Panels. The board's focus will be to carry out systems reviews across a range of government and non-government entities, funded or private, following the deaths of children connected to the child protection system.

In exceptional circumstances, as the responsible minister for the board, I will be able to request the board to conduct reviews outside of its usual scope. This will ensure reviews can be conducted where there is a significant public interest—for example, a serious physical injury case that, while not within the board's usual scope, presents clear systems issues and requires a more in-depth review.

The board will have the ability to look at a child's involvement across a range of systems and services that may be provided by government, non-government or private entities and in turn make recommendations to these entities. A broad systems focus is necessary to allow opportunities for improvements to be identified across the spectrum of service delivery. The board will also have supporting functions relevant to its whole-of-systems reviews to analyse data and apply research to identify patterns, trends and risk factors, and to carry out or engage persons for research.

A key source for the board's systems reviews is the internal review reports that relate to child deaths that relevant agencies must provide to the board. Beyond this, the board will also have the power to request confidential information from any entity—government, non-government or private—that is required to support its whole-of-systems focus. For example, the board could request confidential information from a public entity, a non-government agency that provides a service to children or families, a private hospital, a medical practitioner, the principal of a school or an early childhood education and care provider. The bill makes it clear that entities may give confidential information to the board for the purpose of its functions, and this information can be provided to the board despite any other law that would otherwise prohibit or restrict the giving of the information. Provisions in the bill maintain existing protections to ensure privacy and the confidentiality of information obtained.

An important difference from the current system is that the board will be able to make public systems recommendations and publicly monitor implementation of these recommendations. The bill provides that the board produce an annual report on its operations, including whole-of-systems recommendations, which may highlight themes from a collection of cases or from individual cases, as well as progress made on implementation of previous recommendations of the board. The report will be tabled annually in parliament.

The board will, in addition, have the ability to prepare and publish other systemic reports relevant to its functions. These other systemic reports will not always, as a matter of course, be published. The bill makes it clear that the board must not publish a systemic report if it contains identifying information or information that may prejudice an investigation or recommendations, unless as the responsible minister I have decided to and in fact tabled the report. In making a decision about whether to table the report I am required to consider a number of factors, including whether the tabling of the report is in the public interest. Given the highly sensitive nature of these cases, these provisions balance independence and the need to ensure that privacy and confidentiality is maintained.

Under the bill, the board must have a multidisciplinary membership, balanced by government and non-government members, from a range of experience and disciplines relevant to the work of the board, including Aboriginal or Torres Strait Islander representation. Specifically, the bill provides that the board's membership must not include a majority of persons who are Public Service employees. This will promote independent decision-making and also allow members to effectively understand patterns and trends, build a collective knowledge of key issues and develop expertise over time. To complement this mix of members, the bill provides that the board may invite guests or subject matter experts to attend a meeting to advise or inform the board about a particular matter, theme or issue.

The bill is a further commitment on the part of the Palaszczuk government to protect some of our most vulnerable, our children. We have taken great steps to meet government's obligation. This includes significant investment in the child and family support system; wideranging reforms to improve the blue card system; and implementing recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. Finally, I would like to thank the QFCC for their extensive review and recommendation and the many stakeholders who have informed this important work. I commend the bill to the House.

First Reading

Hon. YM D'ATH (Redcliffe—ALP) (Attorney-General and Minister for Justice) (11.30 am): I move—

That the bill be now read a first time.

Question put—That the bill be now read a first time.

Motion agreed to.

Bill read a first time.

Referral to Legal Affairs and Community Safety Committee

Mr DEPUTY SPEAKER (Mr Kelly): Order! In accordance with standing order 131, the bill is now referred to the Legal Affairs and Community Safety Committee.