Speech By

# Corrine McMillan

## MEMBER FOR MANSFIELD

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## CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL

**Ms McMILLAN** (Mansfield—ALP) (2.27 pm): I rise to make my contribution to the Child Death Review Legislation Amendment Bill currently before the House. In speaking to this bill I acknowledge the death of a 21-month-old toddler, Mason Jett Lee, who died tragically at his Caboolture home on 11 June 2016. His death shocked the community. It was Mason's death that prompted the Premier to request the Queensland Family and Child Commission to oversee reviews being undertaken by the Department of Child Safety, Youth and Women and Queensland Health regarding the services provided to Mason prior to him passing away. This review amounted to the QFCC providing a single recommendation to the government in their report titled *A systems review of individual agency findings following the death of a child*. The sole recommendation was for the government to consider a revised external and independent model for reviewing the deaths of children known to the child protection system.

The Palaszczuk government has also publicly committed to introducing legislation requiring expanded key government agencies to conduct internal systems reviews in child death cases. Child protection, as we know, is a complex matter and, like the rest of the world, Queensland can do better. We know that the Palaszczuk government is committed to improving past practices.

This bill aims to implement the QFCC's recommendation through two mechanisms. 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. Secondly, it will establish a new external independent Child Death Review Board to carry out systems reviews following child deaths connected to the child protection system. I will make comment about each of these mechanisms separately.

Initially, the bill amends the Child Protection Act 1999 to expand the existing internal agency review process. This amendment will keep in force the standard review processes but will also require relevant agencies to undertake a systems review of their involvement with the child if they have provided a service to the child and introduce provisions to enable the sharing of information while protecting confidentiality so relevant agencies can carry out reviews and share outcomes. It will also 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, as well as creates a more uniform and aligned review process.

Further, 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 the 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—under the guidance of Cheryl Bardon, a great leader within our government organisations—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. The new board will be consistent with other state practices as it is modelled on common elements from 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. Consequently, the new board complements but does not duplicate existing review processes, thereby allowing for a far more efficient review system.

As a former principal and administrator of a large organisation, I know the importance of improving and upholding excellent standards of review, particularly for matters relating to children. I am therefore confident that these two mechanisms implemented through this bill will restore the public's confidence in Queensland's child death review system, as well as create a far more efficient system. I also commend the Palaszczuk government for upholding its public commitment to introduce such a bill that will conduct internal systems reviews in child death cases and move us closer to ensuring that every child is safe in Queensland. I commend this bill to the House.