Speech By

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MEMBER FOR NINDERRY

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CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL

Mr PURDIE (Ninderry—LNP) (3.05 pm): The child safety system in Queensland has been broken for a long time. I have had more than my fair share of professional encounters, struggles and challenges working in the system. Too many lives have been unnecessarily lost. Too many lives have been destroyed. Too many Labor reviews and recommendations have come and gone. Attempts at reform in this state to date have been encumbered by a raft of clumsy laws, protocols, policies, procedures, reporting constraints, red tape and poor accountability.

I would like to acknowledge the devastating and unconscionable death of 21-month-old Mason Jett Lee on 11 June 2016 which is the genesis of these reforms. I extend my sympathies to the many staff across many agencies who, despite their efforts, found themselves unwittingly involved in what can only be described as a catastrophic systemic failure. Unfortunately, tragically, the story of Mason Jett Lee is not unique. Staff in these agencies are still swimming against the tide, doing their utmost in a broken system.

I would like to acknowledge the Education, Employment and Small Business Committee for their examination of the bill. I would also like to acknowledge the work of the Australian Association of Social Workers, Bravehearts, the Queensland Law Society, Sisters Inside and PeakCare Queensland for making submissions to the committee and for the work they do in the child protection space. They all support in principle the amendments in this bill.

Child protection is without doubt the most complex of frameworks to take the stick of common sense to, but that is, it seems, what the Queensland Family and Child Commission are calling for. The commission oversaw the review of Mason Jett Lee's death and subsequently released their report *A systems review of individual agency findings following the death of a child*, the findings of which underpin this bill. Cheryl Vardon, principal commissioner, said in the report's foreword—

> We must remain vigilant. Every person, every community and every organisation has a role in protecting our children. In memory of Mason, I ask that we all do everything we can to keep Queensland's children more than safe.

Queensland's child protection system under Labor has been the subject of reviews for the past 15 years, yet vulnerable Queensland children remain less than safe. As evidenced in the current commission's report and many reviews prior, the multiple and different parts of what should comprise an effective Queensland child protection system fail to work together to deliver the safety net for our children in care that they are charged to provide. It is with utter despair that the community rightfully demands urgent policy and procedural changes to be implemented to prevent further child deaths and overhaul the process of investigating them so as to identify and close operational gaps and, in doing so, save lives.

The commission found that one of the key learnings from the review of the contributing factors to Mason's death was a lack of information sharing and collaboration across agencies. The commission reported that in 2015-16 alone Mason was one of 45 children known to the child safety department who died in Queensland. Of the 385 child deaths in Queensland in 2017-18, 48 were known to the child protection system. The report elaborated to say that some of these children attended school and some

younger ones, like Mason, had been in contact with health and hospital services while others were receiving support from non-government organisations. In most cases, there were potentially many eyes on the children in otherwise innocuous settings before they tragically died and there were many missed opportunities to check on their safety which may have prevented their deaths.

Despite the long established internal and agency restricted child death case review process being subjected to a number of reforms under Labor since 1999 and the commission's recommendations nearly three years ago to overhaul it, shamefully Queensland still does not have a contemporary best practice child death review model. The truth is Labor dropped the ball. The commission had done the work and handed the solution to it back in March 2017. Labor took two years to draft the bill, two months to garner stakeholder support and, at long, long last, in February 2020—nearly three years since the commission recommended urgent changes to prevent more deaths like Mason's—we are here in readiness to support what was needed three years ago.

The crux of the reforms provided for in the bill are twofold and include the creation of a new, independent Child Death Review Board located at the commission that will carry out system reviews following child deaths connected to the child protection system and extending the requirement to conduct an internal system 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. The new Child Death Review Board, unlike previous incarnations, will be truly independent from the child safety department and will be able to monitor and report on the implementation of its recommendations. It will also be responsible for identifying 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.

In exceptional circumstances the minister may ask the board to carry out a review in circumstances where the child is not connected to the child protection system but the death or injury is relevant to the child protection system. In particular, the reviews consider matters relating to the provision of services to, and other interactions with, children and their families by government and non-government entities. This is an important provision in order to remove bureaucratic silos and improve transparency. After all, we are all responsible for child safety and moving forward we must all be committed to keeping Queensland's children more than safe. In order to improve service provisions and accountability, the bill also stipulates that Queensland Health, the Department of Education, the Queensland Police Service and the Department of Youth Justice will also be required to conduct internal reviews in addition to Child Safety and the litigation director. In the case of a child death, reports are given to the board, which carries out further reviews of relevant systems.

While the establishment of an external and independent review board will strengthen the investigative process of a child death that is directly or indirectly connected to the Child Safety system, it is important to note that the commission's report raised the issue of individual accountability and the legislative requirement for child death case review panels in determining the need for disciplinary action. The commission highlighted that panels often do not have enough information to determine individual accountability and noted that in designing the new child death review model consideration should be given to legislative amendments removing this requirement because decisions on accountability are the responsibility of the employer and/or the Coroner. This may help to break down barriers in the reporting process.

The department stated that the requirement of government agencies to conduct an internal review in the first place rather than having an independent party conduct a review enables the agency to critically reflect on its involvement, support learning and continuous improvement and, importantly, recognise that child protection is a shared responsibility. This philosophy does, however, speak to Commissioner Vardon's overarching statement and appeal for us all to make all Queensland children more safe and to put our insecurities aside as personnel involved in a child's life in order to improve the lives of children in our care.

There is no place for egos and there is no place to hide when the responsibility for our children is shared on a personal, organisational and systemic level, but—and there is a big but—this sector must be adequately resourced if real change is to be achieved. Only 39 per cent of investigations into child safety breaches were completed in the 60-day time period last year, meaning that child safety officers are clearly overburdened. Since 30 June 2015, the number of children subject to child protection orders increased by 14.2 per cent and 17.8 per cent for ATSI children. Sadly, we are living the legacy of a generation of Labor governments in Queensland that have failed to adequately protect the most vulnerable and innocent members of our society—our children. The LNP has a good record in dealing with crime and protecting the vulnerable. The LNP government efficiently and effectively targeted child protection resources following the adoption of the 2013 Carmody inquiry recommendations which lead to the reduction of Child Safety notifications and substantiated cases of harm.

In closing, I want to remind the House of my staunchly held view that there is no excuse for killing a vulnerable, innocent, defenceless child; there is no worse crime; there is no worse offender; and there is no punishment harsh enough to fit this crime. Monsters who kill innocent, defenceless young kids should feel the full force of the law and we must make every effort to prevent these crimes from occurring. I will work every day with my LNP colleagues to fight to protect our children and I will honour Commissioner Vardon's plea to remain vigilant in memory of Mason Jett Lee and many others to keep Queensland's children more than safe. I commend this bill to the House.