Speech By
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MEMBER FOR NUDGEE

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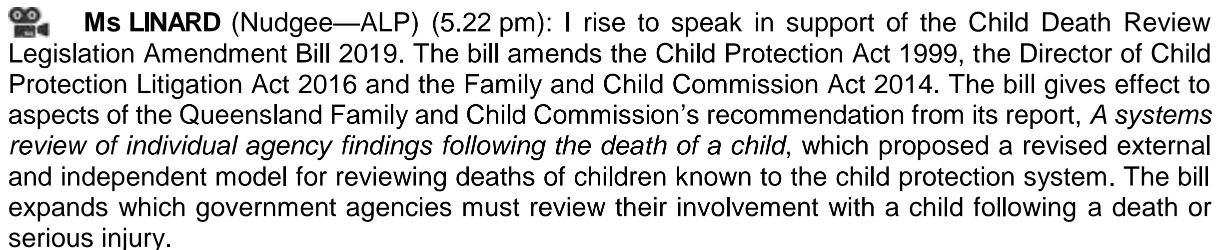
CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL



Ms LINARD (Nudgee—ALP) (5.22 pm): I rise to speak in support of the Child Death Review Legislation Amendment Bill 2019. The bill amends the Child Protection Act 1999, the Director of Child Protection Litigation Act 2016 and the Family and Child Commission Act 2014. The bill gives effect to aspects of the Queensland Family and Child Commission's recommendation from its report, *A systems review of individual agency findings following the death of a child*, which proposed a revised external and independent model for reviewing deaths of children known to the child protection system. The bill expands which government agencies must review their involvement with a child following a death or serious injury.

The bill establishes a new Child Death Review Board to review systems, identify opportunities for continuous improvement and mechanisms to protect children, and prevent deaths that may be avoidable. Queensland's current child death review system is a two-tiered system established under the Child Protection Act 1999. This involves: an internal systems and practice review of service provision by Child Safety and the Director of Child Protection Litigation; and the convening of external multidisciplinary child death case review panels, located in Child Safety, by the Minister for Child Safety to conduct an independent review. The QFCC report focused on system-level issues arising from the agencies' child death reviews.

As I said, Queensland has a two-tier system for reviewing departmental involvement with children and young people who have died or suffered serious physical injury. Tier 1 is the internal review process conducted by Child Safety, known as a systems and practice review. Tier 2 is an external review of Child Safety's internal review by an independent child death case review panel.

The QFCC report identified several significant strengths of Queensland's current child death case review model, including that everyone involved was passionate and committed to improving outcomes for children; systems and practice reviews were guided by clear documentation and effective practice; and there were good working relationships between external child death case review panels and the secretariat. The review of the current model also found that Child Safety's internal review processes are comprehensive and effective at an agency level. In addition, child death case review panels are established under legislation and members are drawn from a variety of disciplines.

The QFCC report noted that both tier 1 and tier 2 reviews examine serious injuries and not just death, and both are 'empowered to consider learning and system improvements'. This has proven problematic in practice. However, Queensland's current system for reviewing deaths of children known to Child Safety does not consider or identify systems changes required to protect vulnerable children, or 'encourage verification of key points of agency interaction and service delivery'.

The QFCC identified several best practice benchmarks to be considered in the design of a contemporary child death review model. In concluding its review, the QFCC made a single, overarching recommendation that the Queensland government consider a revised external and independent model for reviewing the deaths of children 'known to the child protection system'. Our government accepted

this recommendation and committed to introducing legislation requiring additional agencies involved in providing services to children in the child protection system—Health, Education and Police—to conduct internal reviews which are already undertaken by Child Safety and the litigation director. The bill before us gives effect to that single, overarching recommendation of the QFCC and our commitment as a government.

The bill amends the Child Protection Act to expand the requirement to conduct an internal review when a child known to Child Safety dies or suffers serious physical injury to other key government agencies and amends the Family and Child Commission Act to establish a new, external and independent Child Death Review Board located within the QFCC. The board will replace existing child death case review panels within Child Safety.

The key issues raised in submissions included the expansion of agencies required to conduct internal reviews; information-sharing provisions, both for internal agency reviews and systems reviews conducted by the new Child Death Review Board; the issue of individual accountability; and the collaborative function of the new Child Death Review Board. While submitters raised issues with particular aspects of the bill, all published submissions acknowledged the importance of advocating for and protecting Queensland's most vulnerable children.

In respect of internal reviews, Sisters Inside supported the expansion of agencies required to conduct an internal review because—

... all organisations concerned with children should work towards the wellbeing and safety of children and in particular, government departments should always ensure that children are properly cared for and protected from harm.

Bravehearts' submission affirmed this view noting that 'through a thorough, effective and independent review process, government will be better placed to protect our most vulnerable children'. Submissions from PeakCare, the Queensland Law Society and the Australian Association of Social Workers also supported measures to expand the conduct of internal reviews to other relevant agencies involved in providing services to children to enhance the safety of children and young people who have contact with the child protection system.

With respect to other relevant agency reviews, although Sisters Inside supported the purpose of internal reviews, its submission raised concerns about the conduct of an internal review by the agency head. While it recognised an agency 'may be in the better position to provide a review of its particular involvement', Sisters Inside suggested there may be a possible lack of independence. The submission proposed that in order to improve independence, internal reviews be conducted by an independent party. In response to this, the department highlighted the requirement of nominated agencies to review their involvement with children known to the child protection system who have died or suffered serious injury forms part of the QFCC's recommendation, which the government accepted. The purpose is to promote learning and analysis of internal decision-making, consideration of systems issues and collaboration with other agencies.

Further, the department added—

Requiring relevant government agencies to conduct an internal review, rather than having an independent party conduct the review, enables these agencies to critically reflect on their involvement, supports learning and continuous improvement, and, importantly, recognises that child protection is a shared responsibility.

I support this notion. In respect of information sharing, a number of submitters raised concerns with regard to relevant protection from liability for the giving of relevant information. I will not expand on this point any further as I appreciate the Attorney-General provided further clarification in this regard in her second reading speech.

Any improvements to the protections and the systems that afford those protections to our most vulnerable are to be supported. We can never do enough to prevent such deaths and we certainly should never shy away from shining a light on the issue.

I thank the Attorney-General and her department for their assistance during the committee's inquiry, submitters for their valuable contributions as part of the inquiry, my fellow committee members, our committee secretariat and Hansard. The committee made one recommendation—that the bill be passed. Accordingly, I commend the bill to the House.