Speech By

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MEMBER FOR MACALISTER

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CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL

Mrs McMAHON (Macalister—ALP) (2.12 pm): I rise to speak in support of this bill. I acknowledge the work of the Education, Employment and Small Business Committee in examining this bill and their detailed report. The objective of this bill is to implement the recommendation of the Queensland Family and Child Commission report. The single recommendation in that report was that the Queensland government consider a revised external and independent model for reviewing the deaths of children 'known to the child protection system'. This bill identifies relevant agencies subject to this bill which include the Department of Child Safety, Youth and Women; the Department of Education; Queensland Health; the Department of Youth Justice; and the Queensland Police Service.

The establishment of a separate and independent board, the Child Death Review Board, within the QFCC to provide for the conduct of reviews is the cornerstone of this bill. The board's functions as listed in the bill include carrying out reviews relating to the child protection system following child deaths connected to the system; analysing data and applying research to identify patterns and trends relevant to reviews; making recommendations about improvements to systems, policies and practices; and monitoring the implementation of the recommendations.

On the composition of the board, I note that the legislation outlines requirements of membership of the board as well as limits on the make-up of certain subgroups. I commend the onus of ensuring that the board's composition reflects the social and cultural diversity of the Queensland community, but note at the same time the requirement to ensure appropriate criminal history checks and ongoing disclosure of any offences which may deem a board member ineligible for membership. At the heart of this bill is improving safety for children, and we must ensure that board members appointed are appropriate for the task.

I note clause 23, which outlines the reporting requirements of the board which are line with similar other boards in terms of annual reporting, but I also note the discretion of the board to prepare other reports to the minister as appropriate, accompanied by a recommendation as to the tabling of that report in this House. While the establishment of the board is the cornerstone of the bill, the bulk of the work to be generated by this bill will be in the conduct of relevant agency internal reviews as required.

Clause 6 of the bill provides that, when a child dies or suffers serious physical injury after a relevant agency has been involved with the child, the agency head must carry out a review of its involvement. The purpose of the reviews are to promote safety and wellbeing of children who come into contact with the child safety system. In order to facilitate these reviews there are a number of provisions that facilitate information sharing between relevant agencies to ensure that siloed approaches are avoided because, as we know, it is very unlikely that a child subject to an internal review would have been involved with just one relevant agency.

While some submitters still had concerns about internal reviews and a possible lack of independence, it is noted that all internal agency reviews relating to the death of a child are provided to the Child Death Review Board, which may request further information. It should be noted that it is not

the role of either the agency internal reviews or the Child Death Review Board to determine culpability or consider disciplinary action against an employee of an agency. The review process is to focus on improvement to services and systems, not to assign blame.

The QFCC report, which is the genesis of this bill, noted in designing the new child death review model that decisions on accountability are the responsibility of the employer and the Coroner. Just on that, I would like to make a final point in closing. Notwithstanding the important role that government agencies have in monitoring the welfare of vulnerable children and intervening when necessary, I cannot discuss child safety related death and blithely ignore the failings of people in lieu of finding a department head or officer responsible. I do not give a free pass to murderers and abusers of children and their enablers so that I can kick a public servant who is trying to do their job.

I am of the view that, whilst it is important to identify any shortcomings in government processes or procedures, we should not minimise the role of an offender. I have yet to encounter a child death where those who were primarily responsible for the care and safety of those children—whether that be the family, immediate or extended, community or others who were trusted to care for that child—did not have concerns. Why can we not or why do we not intervene when we fear for the safety of a child? What stops us? When did our first response to concerns about the safety of a child become a phone call to an automated phone service in the city and then walking away thinking, 'Well I've done my bit. It's up to someone else now'? Yes, government has a vital and ever-increasing role to play in child safety, but that is because everyone has failed that child. We have all failed that child. Let us not lose sight of that.

I certainly recall, having been a frontline officer, being contacted and advised that someone I had been involved with as part of my day-to-day duties had been murdered. Members in this House must be aware that when someone becomes aware of this it does cause people to stop and pause and consider what their involvement was. Could it have been better? Could I have done a better job? Every single person who works on the front line makes those considerations. Unfortunately we are now in an environment where that concern also then turns to 'How are they going to blame this on me? What could I have done differently? What could I have done better?'

Every single person who is on the front line doing their best to protect Queenslanders, particularly to keep our children safe, is doing what they can at that first point of contact, as well as when they go on and investigate and do their case management. I want to see more responsibility in the community at large for the safety of our children, not just in government departments. That is what is missing in many of the things we discuss.

Like I said in this House, I am more than happy to discuss how we can improve systems, policies and procedures, but at the end of the day we are all Queenslanders and we all have a responsibility to look after our kids and not palm the responsibility off to a government department. When we can do that, I am more than happy to sit down and point fingers at public servants. Until we all take responsibility for every child in our community, let us try to keep this in perspective.