Speech By

Stephen Bennett

MEMBER FOR BURNETT

Record of Proceedings, 5 February 2020

CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL

Mr BENNETT (Burnett—LNP) (2.02 pm): The LNP considers the objectives of the bill to be fundamental in enhancing child safety and that is why we will not be opposing the bill. As stated in the explanatory notes, the policy objective of the bill is to implement the recommendation of the Queensland Family and Child Commission report. The commission's report identified several best practice benchmarks that need to be considered in designing a contemporary child death review model. These included: extending the scope to include other government and non-government organisations; extending the powers and authority of child death case review panels, including the power to make recommendations; reporting to government and public audiences on the outcomes of child death reviews; reconsidering panel governance, such as the selection and appointment of members and the period of membership; and providing appropriate resourcing for secretariat, panel operation and agency reviews.

It is a sad reality that some children in Queensland are killed by the people who should have their best interests at heart. Given this is a reality which we are faced with, it is fundamental that the most effective measures are in place to help build better policies and practices going forward. This bill will strengthen the investigative process of child deaths connected to the child safety system, which will hopefully act as a proactive measure to prevent further tragic deaths in the future.

I agree in principle with the recommendations of the commission. The focus has previously been on Child Safety without the appropriate responsibility and accountability of other organisations. The current review process depends on the goodwill of organisations to participate and how they participate, but there are insufficient processes to make recommendations to support more appropriate service provision. The current system also places the onus on Child Safety when it is evident that a whole-of-system approach is needed. Multiple systems are involved, and thus it is important that these systems and relevant services have some level of accountability in terms of appropriately considering and implementing feedback and recommendations.

The bill proposes to establish a new child death review model by expanding the requirement to conduct an internal systems 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—that is, in addition to Child Safety and the Director of Child Protection Litigation. I note the submissions to the committee agree with this requirement. Submissions also highlighted that services funded by Child Safety are not included, yet much of the service provision occurs with non-government organisations and community services. It has been suggested that this requirement needs to be applicable to the whole service. In respecting the submitters to the committee, it is important to learn from NGOs and community services, but this should not come at the cost of diluting the responsibility of government services.

I note the concerns around the length of time it has taken those opposite to introduce this bill. It has been articulated in this debate already that in June 2016, after the death of Mason Jett Lee, the government requested the commission oversee the reviews being undertaken by the department of

communities, child safety and disability services and the child death case review panel, and the investigation conducted by Queensland Health about the services provided to Mason Jett Lee before his death.

The commission tabled its report on 30 March 2017. It made an overarching recommendation to 'consider a revised external and independent model'. It was not until 18 September 2019, some two and a half years later, that the bill was introduced. It is concerning that it has taken this long. We have heard many explanations for that in the course of this debate. While the department of justice related the delay to the need to undertake consultation, it was noted by committee members that two and a half years was a lengthy period and earlier introduction of this bill may have benefitted our most vulnerable.

The new, independent Child Death Review Board, located within the Queensland Family and Child Commission, will be responsible for carrying out systems reviews, following child deaths connected to the child protection system, to identify opportunities for continuous improvement in systems, legislation, policies and practices and to identify preventative mechanisms to help protect children. I note submissions to the committee also highlighted it would be important the board establishes and maintains a collaborative rather than adversarial relationship with services as the previous iteration of the board under the commission could be characterised as having an adversarial disposition which was counterproductive for the commission and Child Safety staff. An important step toward a collaborative approach is ensuring a non-blaming stance.

What is not clear to some in the sector and needs further clarification is whether the board would have the ability to request information from private organisations. I do not need to go over that as I note the minister and other contributors to the debate have touched on that. Perhaps during consideration in detail that can be expanded upon.

There is wide support for the expansion of information sharing. This is a significant change and an addition to the workload and it requires appropriate and dedicated funding. There have been questions raised by submitters to the committee concerning the appointment of a Queensland family and child commissioner to the role of chairperson of the board. I am sure the minister will address that issue. It is reasonable that submissions to the committee recommended that the government consider the appointment of the chairperson be made with bipartisan support. We would welcome that.

Given some of the rhetoric I have heard in the debate so far, I think it is important we establish some facts about this government's ability to protect people in our community. Two recent articles highlighted the Labor government's inability to attend to vulnerable children within the recommended time frames. It is deeply troubling that almost 6,400 reports of child abuse and neglect were not addressed on time. The failure to react on time to 126 of the most serious cases is just shocking.

In a recent question on notice it was noted that for a case requiring a five- or 10-day commencement, an investigation and assessment will be counted as having commenced once work on the case has started. This could mean that a child safety officer could open and save a Word document in the office for a case to commence instead of going outside to see the child or the family with their own eyes in order for the commencement to begin.

The member for Bulimba seems to be more interested in protecting weak decisions than protecting those most vulnerable. This is further evidence that the government is more interested in protecting itself. The information articulated just before lunch was really damning. These are not numbers on a spreadsheet; these are real children with real issues. Of the 58 deaths known to the child protection system in 2018-19, 29 deaths were from external sources. Of those 29 deaths, 14 were from suicide and six were from fatal assault and neglect. Those numbers, as I said, are not just statistics in a spreadsheet; they are young people in our communities whose lives we are talking about.

I was quite offended by what the member for Bulimba said before lunch and her excuse for not attending to vulnerable children within the recommended time frames being the complexity of family needs and the community changing. I think the words used were 'ice', 'alcohol', 'drugs' and 'domestic violence'. I would argue that those issues have been prevalent in our community for a long time. To use that as an excuse I think is quite shocking. Family needs were and will always be complex. We need to make sure that the government and the minister spend less time finding excuses and weakening the reporting guidelines and more time protecting the kids.

In the time left it is important that I talk about a few more statistics that have shocked us as we have continued along this path. We would argue that over the last five years we have not seen amazing results from reform. The lives of Queensland kids are at risk while urgently needed reforms to the system are delayed year after year. According to the latest statistics on child safety, children living away from home skyrocketed to 10,535 by the end of September 2019. This was nearly 750 more than the previous year. In just one year there was an increase of 405 ATSI children living away from home—an

increase of almost 10 per cent. Meanwhile, there was an increase of six per cent for non-ATSI children over the same period. The number of children subject to a protective order had jumped to 10,769 by the end of September 2019. This is 719 more than 12 months earlier.

The number of notifications—all concerns received that suggest a child is in need of protection—received had jumped up to 25,572 by the end of September 2019. When we consider that this is 1,200 more than 12 months earlier and 3,200 more than in 2015, I would argue that blaming everyone else for the failings in Child Safety is not fair and not reasonable. More importantly, it is not fair to those people who rely on the department and the government to provide that mechanism.

Only 39 per cent of investigations were completed within the 60-day time period. This is down from 47.5 per cent the year before. This means that child safety officers are clearly overburdened and are not given the support they need. The number of children subject to child protection orders increased by 6.4 per cent, from nearly 10,000 as at September 2018 to 10,500 as at September 2019. Since 30 June 2015, the number of children subject to child protection orders has increased by nearly 15 per cent. Over this period the number of Aboriginal and Torres Strait Islander children subject to child protection orders increased by nearly 18 per cent. The number of non-Aboriginal and Torres Strait Islander children increased by nearly 12 per cent.

There is a lot more to do. We welcome the reforms in child safety, and we look forward to better results for those most vulnerable.