Speech By
# Hon. Yvette D'Ath

## MEMBER FOR REDCLIFFE

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## CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL

### Second Reading

**Hon. YM D'ATH** (Redcliffe—ALP) (Attorney-General and Minister for Justice) (4.30 pm): I move—

That the bill be now read a second time.

The Child Death Review Legislation Amendment Bill 2019 was introduced on 18 September 2019 and referred to the Education, Employment and Small Business Committee for examination. I thank the committee for its thoughtful consideration of the bill. I also thank the stakeholders and organisations who took the time to make submissions on and attend the public hearing in relation to the bill. I am pleased to inform the House that on 18 November 2019 the committee tabled report No. 25 and made one recommendation: that the bill be passed. I welcome the recommendation of the committee. In doing so, I note the statement of reservation from the opposition members of the committee and I will address this in my contribution to today's debate of the bill.

This bill reflects the Palaszczuk government's ongoing commitment to protecting Queensland's most vulnerable children. The Palaszczuk government has significantly invested in the child protection and family support system after the cuts and divestment we saw when the opposition was last in government. The Palaszczuk government has also implemented wideranging reforms in the blue card system to better protect children and commenced implementing recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse.

The loss of a child in any circumstances is a tragedy. When a child who is known to a child protection system dies, it is imperative that we learn from these tragedies to ensure that we as a government are doing everything that we can to protect children and, where possible, help prevent future deaths. Consistent with the recommendation of the Queensland Family and Child Commission, QFCC, the bill establishes a contemporary best-practice model for reviewing the deaths of children known to the child protection system. The bill requires key government agencies to critically reflect on their involvement with particular children who have died or suffered a serious physical injury and will establish a new independent Child Death Review Board to examine child death cases at a whole-of-systems level to identify opportunities for continuous improvement across the broader child protection system.

While currently only Child Safety and the Director of Child Protection Litigation are required to conduct internal systems reviews, the bill will expand this requirement to Queensland Health, the Department of Education, the Queensland Police Service and the Department of Youth Justice where these agencies have also had involvement with a child who has died or suffered a serious physical injury. This expanded system of internal reviews will promote ongoing learning and improvement, accountability and collaboration across these key government agencies that have a high degree of contact with children known to the child protection system. While ultimately agencies will determine the extent of and the terms of reference for their internal reviews, the bill provides that agencies may

consider the adequacy of their involvement with a child or their involvement with other entities in providing services to the child and the adequacy of legislative requirements and the agencies' policies. The bill provides a process for internal agency reviews, including when an agency must commence a review and when a review must be completed and a report prepared.

The bill recognises that these reviews may overlap with other established review processes that agencies have in place, for example, root cause analysis or health services investigations undertaken by Queensland Health. It is not the intent of this model to replace or duplicate these existing processes which will continue to apply alongside the new internal review requirement. The bill provides that where there is overlap in relation to a matter, agencies are required to work together to coordinate reviews and avoid unnecessary duplication.

A consistent theme in previous child protection systems reviews and other death review processes, including in the 2018-19 annual report of the Domestic and Family Violence Death Review and Advisory Board, is the importance of open exchange of relevant information across government and non-government agencies. To this end the bill includes new information-sharing provisions which will enable agencies to share information with each other. This is important not only for the coordination of reviews but also to ensure that agencies can identify a child's touchpoints across multiple government and non-government service providers. The bill also allows agencies to request information from an entity, with requests largely expected to be directed to funded and contracted services. This recognises that often children receive services directly from these agencies, particularly given government's continued investment in the non-government sector to provide early intervention and intensive family support services.

After completing reviews the bill allows agencies to share any relevant findings or learnings with each other. This provides an opportunity for agencies to share not only areas of improvement but also examples where things have worked well, such as policies or procedures that have been helpful or effective or an integrated service response across agencies that has a successful outcome. This exercise is not about assigning blame across agencies. Rather, this is about working together towards shared improvements as part of a unified response to achieving better outcomes for children. Child protection is a shared responsibility and these information-sharing provisions are integral to ensuring ongoing learning and improvement across government. The new Child Death Review Board established under clause 23 of the bill will receive all internal agency review reports relating to child deaths to inform its whole-of-systems reviews. These reports will form a valuable evidence base for the board's reviews which are carried out in relation to the broader child protection system following child deaths connected to the child protection system.

The bill also enables the board to conduct reviews in relation to an issue about a particular system that may have presented in an internal agency review. However, it is important to note that the board's reviews will not necessarily focus on an individual child, as is currently the case for reviews carried out by current child death case review panels. Rather, the internal agency review reports will provide an evidence base for systems reviews by the board for further in-depth analysis. Under the bill the board will conduct systemic reviews of child deaths that extend beyond reviewing key government agency service provision to an individual child, to look across the range of government and non-government services and systems, such as health, education, community and justice services that support vulnerable children and families.

As I have indicated, the board's review could, for example, be based on an individual case or a collection of cases with a similar theme or issues. In exceptional circumstances, as the responsible minister I can also ask the board to carry out a systemic review or to consider a stated system or issue outside its usual scope. Ultimately, however, the board will be independent in performing its functions, including determining the extent of and the terms of reference for its reviews and in the way it conducts its proceedings. In this regard I note that some submitters to the committee raised concerns regarding the independence of the board.

Strengthening the independence of Queensland's child death review model is a key objective of this bill. The QFCC found that Queensland's current child death review system is not sufficiently independent. For example, currently secretariat support for child death case review panels is provided from within Child Safety. This is why the board is located within the QFCC, consistent with the approach in Victoria and other jurisdictions whereby the child death review function is independent from the government department responsible for child protection services.

A number of other measures have also been taken to ensure the board's independence from government. The bill explicitly requires the board to act independently and in the public interest. While the board is located in the QFCC to enable the QFCC to provide secretariat support, it will operate independently with separate and distinct functions and powers.

Consistent with other states and territories, whereby the head of the child death review body is also the head of the agency in which it is located, the bill provides that a commissioner of the QFCC, whom I note is appointed by the Governor in Council, must be appointed as chairperson of the board. While the role of chairperson is certainly an important one, I wish to emphasise that the decisions of the board will be made collectively by the multidisciplinary group of board members.

Importantly, under the bill the board must reflect the diversity of the Queensland community and cannot include a majority of public service employees. This is central to ensuring independent and robust decision-making in which the public can have faith and confidence. The bill makes clear that the board is not subject to my direction, or the direction of anyone else, in performing its functions. While as responsible minister for the QFCC I am able to provide directions to the commissioner in performing functions under the Family and Child Commission Act 2014, this will not extend to the board or to a commissioner in their capacity as chairperson of the board.

Importantly, the bill requires the board to produce annual reports, which must be tabled and can include recommendations about improvements to systems, policies and practices, and legislative change, as well as reporting on progress made on the implementation of previous recommendations. In addition, the board can, at any time, prepare a report about the outcomes of a review or another matter arising from the performance of its functions, such as research. These reports may be published or, if they contain certain sensitive information or recommendations, be provided to me as the responsible minister, with considerations and requirements for tabling as outlined in new section 29K of the Family and Child Commission Act as inserted by the bill.

I will turn now to an additional matter raised by submitters in relation to the ability of the board to request and share information. Consistent with the QFCC recommendation, a key objective of the new model is strengthening the powers of the board to request information from a broad range of government and non-government entities. Some submitters noted the need to ensure that the board cannot compel entities to provide information in certain circumstances, for example, where consent has not been given by a relevant party or where information may be subject to legal professional privilege. I note, too, that similar information requesting provisions are included for internal agency reviews, which enable agencies to request information from entities that may be relevant to internal reviews. This concern of submitters is understandable given the highly sensitive nature of the information that the board is likely to receive.

For public entities, the bill includes an underlying principle that information should be given to the board on request, in a timely way and to the extent that is appropriate having regard to the relevance of the information to the board's functions and the effect of giving the information on the safety, wellbeing and best interests of children. This establishes the clear expectation that public entities, including government agencies, will be collaborative and provide information as requested to support the board's functions. However, I wish to clarify that there is nothing in the bill that requires that any entity hand over information on request or be compelled to hand over information.

The bill enables the sharing of information and addresses any legislative barriers by making clear that entities may give confidential information to agencies and the board, despite any other law that would otherwise prohibit or restrict the giving of the information. However, there is no requirement for entities to comply with a request and no penalty attached to the provision. If the information is provided, there are provisions in the bill ensuring that confidentiality of information is protected, as well as protection from liability for giving information. This framework strikes a balance between enabling and encouraging the sharing of information, critical for the board to perform its functions, while still allowing entities the discretion to determine what is appropriate to be shared.

Finally, I would now like to turn to the statement of reservation by the opposition members of the committee. Opposition members have questioned the time it has taken, since the release of the QFCC report, for the bill to be introduced. It is of the utmost importance that we get this new model right. That is why, following the release of the QFCC report, significant work was undertaken by the Department of Justice and Attorney-General, in collaboration with the Department of Child Safety, Youth and Women, the QFCC and other relevant agencies, to establish a contemporary, best-practice child death review model for Queensland. Consultation was undertaken across government to resolve policy, operational and resourcing issues to best give effect to the model.

To build on the work of the QFCC in developing the model, departmental officers undertook targeted consultation with New South Wales, Victoria and Western Australia counterparts to explore the strengths of their individual child death review models and identify key opportunities for Queensland. This is consistent with the QFCC recommendation that provided that best-practice benchmarks and experiences of other Australian jurisdictions be considered. These processes take time, but were necessary to ensure that this model delivers on public expectations and meets the key elements of the

QFCC report. Rushing to introduce a model without proper consideration of best-practice benchmarks and interstate models does nothing to properly protect vulnerable Queensland children.

I also remind the opposition that the current system whereby Child Safety reviews itself is the system that the LNP themselves introduced while in government. As such, it is a bit rich for the opposition to be calling on the government to rush to get rid of their own model.

Collaboration, not just across government but also across all services in contact with vulnerable children, will be key to the success of this model. This model is not about blame and disciplinary action. The bill makes clear that apportioning blame is outside of scope. This model is about ensuring that we are all doing our part to embrace opportunities for systems and practice improvements, for the benefit of our most vulnerable children.

In conclusion, I would like to again thank the Education, Employment and Small Business Committee for its consideration of the bill and acknowledge the valuable contribution of all those who made submissions and participated in the public hearing. I would also like to thank the QFCC for their report and their continued leadership in the oversight of the child protection system. The amendments made by this bill will enhance the protection of children in line with the Palaszczuk government's strong ongoing commitment to keep our communities safe. I commend the bill to the House.