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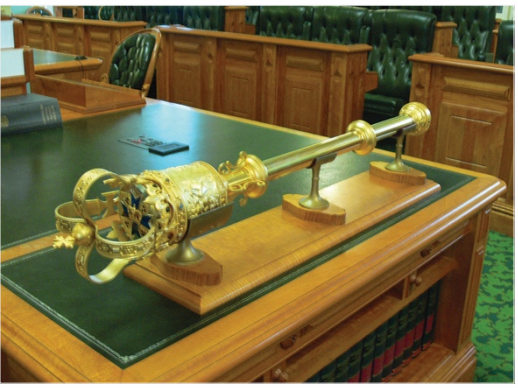
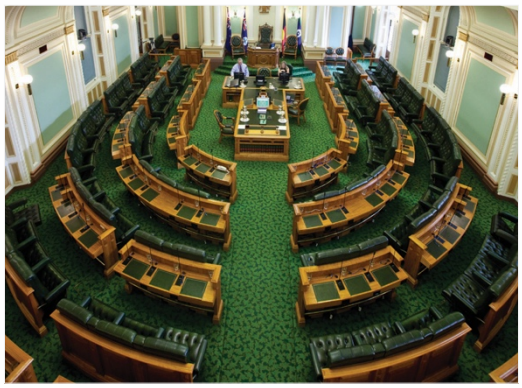
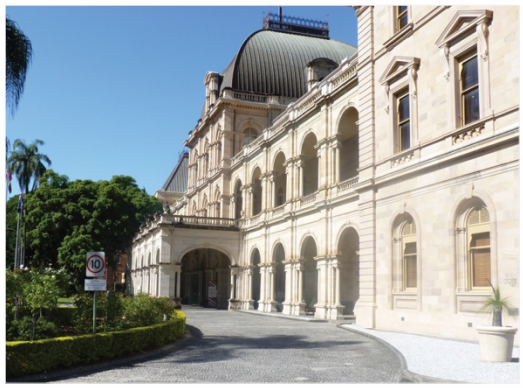

Child Death Review Legislation Amendment Bill 2019

Report No. 25, 56th Parliament
Education, Employment and Small Business Committee
November 2019

Education, Employment and Small Business Committee

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Acknowledgements

The committee acknowledges the assistance provided by the Department of Justice and Attorney-General.

Contents

Abbreviations

AASW	Australian Association of Social Workers, Queensland Branch
Bill	Child Death Review Amendment Legislation Bill 2019
Board	Child Death Review Board
committee	Education, Employment and Small Business Committee
CPA	*Child Protection Act 1999*
DCSYW	Department of Child Safety, Youth and Women
DFVDRAB	Domestic and Family Violence Death Review and Advisory Board
DJAG	Department of Justice and Attorney-General
DoE	Department of Education
DYJ	Department of Youth Justice
FACC Act	*Family and Child Commission Act 2014*
litigation director	The Director of Child Protection Litigation or litigation director is an independent statutory agency in DJAG established to conduct child protection legal matters. The litigation director works with Child Safety to manage child protection order applications and proceedings.
LSA	*Legislative Standards Act 1992*
QFCC	Queensland Family and Child Commission
QFCC report	*A systems review of individual agency findings following the death of a child* (March 2017)
QH	Queensland Health
QLS	Queensland Law Society
QPS	Queensland Police Service
ToR	Terms of Reference

All Acts are Queensland Acts unless otherwise specified.

Chair's foreword

This report presents a summary of the Education, Employment and Small Business Committee's examination 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 (QFCC) 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.

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

On behalf of the committee, I thank those organisations which made written submissions on the Bill. I also thank our Parliamentary Service staff and officials from the Department of Justice and Attorney-General.

I commend this report to the House.

Leanne Linard MP

Chair

Recommendations

The committee recommends the Child Death Review Legislation Amendment Bill 2019 be passed.

1 Introduction

1.1 Role of the committee

The Education, Employment and Small Business Committee (committee) is a portfolio committee of the Legislative Assembly which commenced on 15 February 2018 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The committee's primary areas of responsibility include:

- education
- industrial relations
- employment and small business, and
- training and skills development.

Section 93(1) of the *Parliament of Queensland Act 2001* provides that a portfolio committee is responsible for examining each bill and item of subordinate legislation in its portfolio areas to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles, and
- for subordinate legislation – its lawfulness.

The Child Death Review Legislation Amendment Bill 2019 (Bill) was introduced into the Legislative Assembly and referred to the committee on 18 September 2019. The committee was required to report to the Legislative Assembly by 18 November 2019.

1.2 Inquiry process

On 24 September 2019, the committee invited stakeholders and subscribers to make written submissions on the Bill. Six submissions were received.

The committee received a written briefing about the Bill from the Department of Justice and Attorney-General (DJAG) on 30 September 2019. A copy is published on the committee's web page. DJAG provided a further oral briefing on 14 October 2019 and responded to committee questions. A transcript is published on the committee's web page; see Appendix B for a list of officials.

The committee received written advice from DJAG in response to matters raised in submissions on 15 October 2019.

The committee held a public hearing on 21 October 2019 (see Appendix C for a list of witnesses).

The submissions, correspondence from DJAG and transcripts of the public briefing and hearing are available on the committee's webpage.

1.3 Policy objectives of the Bill

The objectives of the Bill are to:

- implement the single recommendation of the Queensland Family and Child Commission (QFCC) report, *A systems review of individual agency findings following the death of a child* (QFCC

[1] *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

report)[2] to 'consider a revised external and independent model for reviewing the deaths of children known to the child protection system,'[3] and

- give effect to the Government's commitment to develop a new, independent model for reviewing child death cases.[4]

The Attorney-General and Minister for Justice Hon Yvette D'Ath MP stated at the Bill's introduction that the proposed child death review model 'is focused on promoting continuous improvement of systems, legislation, policies and practice'.[5]

1.4 Government consultation on the Bill

The explanatory notes state the QFCC was consulted in the development of the Bill.[6] The explanatory notes also note stakeholder information sessions and/or a fact sheet on the proposed changes were provided to key stakeholders, including:

> *Queensland Law Society; Bar Association of Queensland; Aboriginal and Torres Strait Islander Legal Service (Queensland) Ltd; Legal Aid Queensland; Community Legal Centres Queensland; Sisters Inside Inc.; Human Rights Law Centre; Hub Community Legal (formerly The South West Brisbane Community Legal Centre); PeakCare Queensland Inc.; CREATE Foundation; Griffith University School of Human Services and Social Work; Queensland Foster and Kinship Care; Family Inclusion Network South-East Queensland; Micah Projects; Queensland Aboriginal and Torres Strait Islander Child Protection Peak; Queensland Council of Social Service; Youth Advocacy Centre; YFS Legal; Youth Affairs Network Queensland; Bravehearts; Protect All Children Today Inc.; Child Protection Practitioners Association of Queensland; Family Matters Queensland; Queensland Teachers' Union; Queensland Association of State School Principals Inc.; Queensland Secondary Principals Association and Queensland Association of Special Education Leaders Inc.; Queensland Police Union of Employees; and the Queensland Police Commissioned Officers' Union*.[7]

The explanatory notes stated, in finalising its report the QFCC 'undertook a broad consultation process. This included working with key government agencies and agencies in other states and territories'.[8]

1.5 Estimated cost of the Bill

The explanatory notes outline that as part of the 2019-20 Budget, the Government allocated $2.521 million net over four years ($0.825 million net ongoing, 3.8 new full time employees) to establish and operate the new Child Death Review Board (Board). The requirement for agencies to conduct internal reviews will be met from within their existing resources.[9] Concerns were raised about costs in some

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2 The Queensland Family and Child Commission (QFCC) report, *A systems review of individual agency findings following the death of a child*, tabled in the Legislative Assembly on 20 April 2019, (QFCC report): https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2017/5517T555.pdf

3 Explanatory notes, p 3.

4 Explanatory notes, p 1.

5 Hon Yvette D'Ath MP, Attorney-General and Minister for Justice, Queensland Parliament, Record of Proceedings, 18 September 2019, p 2913.

6 Explanatory notes, p 15.

7 Explanatory notes, p 15.

8 Explanatory notes, p 15.

9 Explanatory notes, p 12.

submissions,[10] for example the Australian Association of Social Workers Queensland Branch (AASW) suggested funding internal reviews through existing budgets could be problematic.[11]

In response to concerns raised by AASW, DJAG advised that the QFCC will work with other government agencies to implement the new model, including the development of operational guidelines. DJAG noted continuous improvement and capacity building in relevant government agencies can be supported by the Board which, if the Bill passes, will have the ability to provide comments directly to these agencies on their internal agency review reports, where a need is identified, (clause 23, new section 29M of the FACC Act).[12]

1.6 Should the Bill be passed?

Standing Order 132(1) requires the committee to determine whether or not to recommend that the Bill be passed.

After examination of the Bill, including consideration of the policy objectives to be implemented, stakeholders' views and information provided by DJAG, the committee recommends that the Bill be passed.

Recommendation 1

The committee recommends the Child Death Review Legislation Amendment Bill 2019 be passed.

10 Submissions 2 and 6.

11 Submission 6, p 4.

12 Department of Justice and Attorney-General (DJAG), correspondence dated 15 October 2019, pp 15-16.

2 Queensland Family and Child Commission report

This section provides a brief overview of the policy context to the Bill. In particular it summarises the key findings and recommendation of the QFCC report.

2.1 Overview

On 11 July 2016, the Premier, the Honourable Annastacia Palaszczuk, requested the QFCC oversee the internal and external reviews of the Department of Communities, Child Safety and Disability Services (Child Safety); and the health service investigation conducted by Queensland Health into the death of 21-month-old Mason Jet Lee on 11 June 2016.[13] The QFCC was asked to consider whether the reviews were timely and thorough; and to ensure all reviews were able to deliver outcomes and guidance to make systems changes where required.

2.2 Current child death review process

Queensland's current child death review system is a two-tiered system established under Chapter 7A of the *Child Protection Act 1999* (CPA). This involves:

- *an internal systems and practice review of service provision by Child Safety and the Director of Child Protection Litigation (litigation director); 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.*[14]

2.2.1 Review of current system and findings

The QFCC report focused on system level issues arising from the agencies' child death reviews.[15] Queensland has a two-tier system for reviewing departmental involvement with children and young people who have died or suffered serious physical injury. Tier one is the internal review process conducted by Child Safety, known as a systems and practice review. Tier two is an external review of the Child Safety's internal review by an independent child death case review panel.[16]

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.[17]

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 one and tier two reviews examine serious injuries and not just death, and both are 'empowered to consider learning and system improvements', this has proven problematic in practice.[18]

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'. [19] The QFCC report also found

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13 QFCC report, p 11.

14 Explanatory notes, p 1.

15 QFCC report, p 7.

16 QFCC report, p 50.

17 QFCC report, p 32.

18 QFCC report, p 34.

19 QFCC report, pp 34; 29.

despite several reforms of the child death review process since 1999, Queensland does not have a contemporary, best practice child death review model.[20]

The explanatory notes summarise a number of issues identified by the QFCC in relation to current Child Death Case Review Panels, including:

> *… that they are not truly independent of Child Safety (noting governance and secretariat support is provided by Child Safety); they are not able to undertake own-motion reviews of systemic issues arising from child deaths; and there is no public reporting process outside of an annual report produced by Child Safety. The QFCC report also noted that Child Death Case Review Panels can only make recommendations to Child Safety and cannot monitor or report on the implementation of their recommendations.*'[21]

The QFCC's report also raised the issue of individual accountability and the legislative requirement for Child Death Case Review Panels in determining the need for disciplinary action relating to public servants involved in child deaths or serious injury.[22] Despite being in the terms of reference for panel reviews, the QFCC report highlighted panels often do not have enough information to determine individual accountability or the resources to pursue questions arising from staff conduct. The QFCC report noted 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 coroner.' [23]

2.2.2 Best practice benchmarks

The QFCC identified several best practice benchmarks to be considered in the design of a contemporary child death review model. These are summarised in the explanatory notes:

- *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 outcomes of child death reviews;*
- *reconsidering panel governance, such as selection and appointment of members and period of membership; and*
- *providing appropriate resourcing for secretariat, panel operation and agency reviews.*[24]

2.3 Report recommendation and Government response

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'.[25] The recommendation includes consideration of the best practice benchmarks; and requires legislation to compel nominated agencies which have provided service delivery to a child who has died or been seriously injured to undertake an internal review.[26]

The explanatory notes state the Government accepted this recommendation. It committed to introducing legislation requiring additional agencies involved in providing services to children in the

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20 QFCC report, p 8.

21 Explanatory notes, p 2.

22 QFCC report, p 33.

23 QFCC report, p 33.

24 Explanatory notes, p 2.

25 QFCC report, p 36.

26 QFCC report, pp 36-7.

child protection system – Health, Education and Police – to conduct internal reviews which are already undertaken by Child Safety and the litigation director.[27]

[27] Explanatory notes, p 3. The Director of Child Protection Litigation or litigation director is an independent statutory agency in DJAG established to conduct child protection legal matters. The litigation director works with Child Safety to manage child protection order applications and proceedings.

3 Examination of the Bill – amendments to Child Protection Act and Family and Child Commission Act

This section summarises the main policies proposed to be implemented, and discusses issues raised during the committee's examination of the Bill. While submitters have raised issues with particular aspects of the Bill, all published submissions acknowledge the importance of advocating for and protecting Queensland's most vulnerable children.[28] On the importance of the welfare of the child, Ms Cheryl Vardon, Principal Commissioner of the QFCC, stated that 'the death of every child is a tragedy'[29] and further submitted to the committee:

> *The key issue to remember is that, of the 385 children who died right across Queensland in 2017-18 … 48 were known to the child protection system. … That overrepresentation of those children is very key for the work of the Board, we think.*[30]

Mr Bill Potts, President of the Queensland Law Society (QLS) concurred, by stating:

> *The death of a child may be entirely explicable, for example, as we have heard from Ms Vardon, with respect to diseases and the like, but when they are statistically overrepresented by those people who are known to [Child Safety], looking into each single death—life, of course, is something we hold as valuable, priceless effectively.*[31]

The key issues raised in submissions discussed in this chapter are: the expansion of agencies required to conduct internal reviews (3.1.1.1); information sharing provisions both for internal agency reviews (3.1.5.1) and systems reviews conducted by the new Child Death Review Board (3.3.3.4); the issue of individual accountability and the collaborative function of the new Child Death Review Board (3.2.1.1); and, its operational location and independence (3.2.2.2).

Clause 6 proposes to insert definitions of key terms used in the Bill (new section 245B). New section 245B proposes a ***relevant agency*** is any of the following entities:

- the department responsible for administering the *Child Protection Act 1999* (CPA) (Department of Child Safety, Youth and Women (DCSYW))
- the departments mainly responsible for:
    - education (Department of Education (DoE))
    - public health (Queensland Health (QH))
    - youth justice (Department of Youth Justice (DYJ))
- a Hospital and Health Service (HHS), and
- the Queensland Police Service (QPS).

Clause 6 also proposes to insert a definition of an ***agency head***, which is defined as the head of a relevant agency, and in accordance with the above definition means: the chief executive for departments listed above, a health service chief executive for a HHS, or the commissioner of the QPS.[32]

In determining whether a relevant agency must conduct an internal review, consideration is given to whether the agency is or was ***providing a service to a child***. Under clause 6, new section 245C proposes

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28 Submissions 1, 3, 4, 5 and 6.

29 Public hearing transcript, Brisbane, 14 October 2019, p 3.

30 Public hearing transcript, Brisbane, 14 October 2019, p 6.

31 Public hearing transcript, Brisbane, 14 October 2019, p 7.

32 DJAG, correspondence dated 30 September 2019, p 6.

that providing a service to a child includes 'interacting with a child, or a member of a child's family, in relation to a matter relevant to the child's safety and wellbeing'.[33]

3.1 Amendments to the *Child Protection Act 1999*

3.1.1 Internal reviews following a child death or serious injury

Currently, Child Safety and the litigation director are required to complete an internal systems and practice review following the death or serious injury of a child known to the child protection system. Clause 6 proposes to omit existing Chapter 7A from the *Child Protection Act 1999* (CPA) and replace it with new Chapter 7A 'Internal agency reviews following child deaths or injuries'.

Proposed new Chapter 7A provides for an internal agency review system whereby, if a child dies or suffers serious physical injury after a 'relevant agency' has been involved with the child, the agency's head must carry out a review of its involvement.

DJAG acknowledged that the DYJ was not named in the Government response to the QFCC report however, 'due to the particular vulnerability of children known to the youth justice system and that a significant number of children involved in the youth justice system are also known to Child Safety' they are included in the Bill.[34]

The Bill proposes that the purpose of the reviews (new section 245(3)) is to promote the safety and wellbeing of children who come into contact with the child protection system by:

- facilitating ongoing learning and improvement in the provision of services and the litigation director
- promoting the accountability of the agencies and the litigation director, and
- supporting collaboration and joint learning by the agencies.

The proposed principles underlying new Chapter 7A provide that relevant agencies should work collaboratively to achieve the purpose of internal agency reviews. New section 245A states that if a relevant agency is carrying out a review, other relevant agencies should share information with that agency, and that relevant agencies should share the outcomes of reviews with other relevant agencies.

Under clause 6, proposed new section 245A also suggests that the sharing of information and outcomes should be timely and to the extent that is appropriate, have regard to: the relevance of the information and the extent to which it would advance the purpose of the review; and, the effect of information sharing on the safety, wellbeing and best interests of children.

3.1.1.1 Submitters' views and department's response

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 to ensure children are properly cared for and protected from harm.* [35]

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'.[36]

Submissions from PeakCare, the Queensland Law Society (QLS) and the Australian Association of Social Workers (AASW) also supported measures to expand the conduct of internal reviews to other relevant

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33 DJAG, correspondence dated 30 September 2019, p 6.

34 DJAG, correspondence dated 30 September 2019, p 5.

35 Submission 3, p 2.

36 Submission 1, p 1.

agencies involved in providing services to children to enhance the safety of children and young people who have contact with the child protection system.[37]

However AASW submitted, in addition to requiring additional government agencies to conduct internal reviews, services funded by Child Safety should also be required to conduct internal systems reviews following the death or serious physical injury of a child known to Child Safety. The AASW stated:

> *… much of the service provision occurs by non-government organisations (NGOs) and community services. We suggest that this requirement [to conduct internal reviews] needs to be applicable to the whole service.'*[38]

In response to the AASW, DJAG advised:

> *The QFCC report recommendation and Government commitment extended to relevant government agencies only. However, these services [non-government and community services] will be captured in internal agency review processes by the ability for relevant government agencies to request information from other entities that may be relevant to the review (clause 6, new section 245T of the CPA).*
>
> *… Further, non-government organisations that provide services to, or otherwise interact with, child and families known to the child protection system will be captured in whole-of-systems reviews by the Board, who will have the ability to request information from these entities (clause 23, new section 29P of the FACC Act), as well as make recommendations about improvements to systems, policies and practices for implementation by non-government entities (new section 29D(d)(i) of the FACC Act).*[39]

3.1.2 When reviews must be carried out

Clause 6 inserts proposed new Part 2 'When reviews must be carried out'. Proposed new sections 245E and 245J set out when Child Safety and the litigation director, respectively, must conduct an internal review. As these agencies already conduct internal reviews, proposed new sections 245E and 245J replicate the existing sections of the CPA with minor technical changes.[40] The events that trigger a review by Child Safety or the litigation director are also replicated from existing provisions of the CPA (proposed new section 245M).

3.1.2.1 Notification about review to other relevant agencies

DJAG advised that to 'trigger' a review by another relevant agency (QH, DoE, QPS and DYJ), clause 6 inserts proposed new section 245G(2)(a) to (b), introducing the new requirement for the chief executive (Child Safety) to give written notice to the heads of other relevant agencies and the litigation director.[41] The litigation director receives a notice if they are performing or have performed a litigation function in relation to the child.[42]

Under clause 6, proposed new section 245G(2) excludes the heads of HHS from receiving written notices because proposed new section 245G(4) provides the chief executive (Queensland Health) must first determine whether a HHS may have provided a service to the child within one year before the child's death or serious physical injury. The chief executive (Queensland Health) must then provide a

37 Submissions 4, 5 and 6.

38 Submission 6, pp 2-3.

39 DJAG, correspondence dated 15 October 2019, pp 14-15.

40 Explanatory notes, p 19; 21.

41 DJAG, correspondence dated 30 September 2019, p 6.

42 DJAG, correspondence dated 30 September 2019, p 6.

copy of the notice to the head of each HHS which may have provided a service to the child. The DJAG notes this is required to enable a coordinated response within Queensland Health.[43]

In accordance with proposed new section 245G(3), the notice must state:

- a child has died or suffered a serious physical injury
- the chief executive (Child Safety) is required to carry out a review and the agency head may also be required to carry out a review
- details about the child (name, date of birth, date of death or injury), and
- any other relevant information held by the chief executive (Child Safety) that may determine whether a relevant agency is required to conduct a review.[44]

3.1.2.2 Other relevant agency review (QH, DoE, QPS, DYJ)

Under clause 6, proposed new section 245H requires, as soon as practicable after receiving a notice other agency heads must determine whether the agency provided a service to the child. If an agency provided a service within one year before the child's death or serious physical injury, it must conduct a review.

Proposed new section 245H(3) provides that the heads of relevant agencies (DCSYW, QH, DoE, QPS, DYJ) can provide information to an agency head who has received the notice to assist in determining whether a review is required. For example, this might include the child's address during the year before their death or injury.[45]

3.1.2.3 Submitters' views and department's response

Although Sisters Inside supported the purpose of internal reviews (proposed new section 245), 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 in order to improve independence, that internal reviews be conducted by an independent party.[46]

In response to this, the DJAG 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.[47] The purpose of this is to promote learning and analysis of internal decision-making, consideration of systems issues and collaboration with other agencies'. Further, the DJAG 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.*[48]

Agencies are also required to provide all internal agency review reports relating to the death of a child to the Child Death Review Board (new section 245O of the CPA); and the Board will have the ability to

43 DJAG, correspondence dated 30 September 2019, p 6.

44 DJAG, correspondence dated 30 September 2019, p 6.

45 DJAG, correspondence dated 30 September 2019, p 6.

46 Submission 3, p 2.

47 DJAG, correspondence dated 15 October 2019, pp 2-3.

48 DJAG, correspondence dated 15 October 2019, p 3.

directly request further information from any entity, including relevant agencies (clause 23, proposed section 29P of the FACC Act – refer section 3.2.4 of this report).[49]

3.1.2.4 Ministers of other relevant agencies to request review

In exceptional circumstances, the Minister of another relevant agency may, under proposed new section 245I, ask the agency's head to carry out a review if they consider it would be appropriate having regard to the circumstances of the child's death or serious physical injury and the purpose of review.[50] The Bill states this request can be made in circumstances where no notice under section 245G has been given to the agency head; or, no review is required under section 245H.

DJAG stated that:

> *… this is intended to capture matters where a child may have had multiple or ongoing interactions with a relevant agency and was not known to Child Safety, but the nature and circumstances of the child's case suggest they perhaps should have been.*[51]

3.1.3 Scope of internal reviews

The suggested scope for internal reviews conducted by relevant agencies and the litigation director is provided in proposed new Chapter 7A, Part 3. The DJAG stated the proposed ToR for reviews are largely based on existing provisions for Child Safety (existing section 246B(2) of the CPA).[52] Proposed new section 245L provides the ToR for the litigation director which will also replicate existing sections of the CPA.[53]

In accordance with proposed new section 245K, guidance is provided on what the terms of reference may include:

- whether the agency's involvement with the child complied with legislative requirements and the agency's policies
- considering the adequacy and appropriateness of the agency's involvement
- the adequacy of the agency's involvement with other entities in the provisions of services to the child
- the adequacy of legislative requirements and the agency's policing relating to the child
- making recommendations on such matters and suggesting strategies to implement recommendations.

The ToR, under proposed new section 245K, must not consider disciplinary action against an employee of the agency. The DJAG advised excluding disciplinary action reinforces the QFCC report finding that child death review processes should focus on improvement to services and systems and not assigning blame.[54]

3.1.4 Conduct of reviews and reporting

Clause 6 inserts proposed new Part 4 (sections 245M to 245R) which set out when internal reviews are to be carried out and the suggested process for preparing and sharing review reports. Consistent with

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49 DJAG, correspondence dated 15 October 2019, p 3.

50 DJAG, correspondence dated 30 September 2019, p 7.

51 DJAG, correspondence dated 30 September 2019, p 7.

52 DJAG, correspondence dated 30 September 2019, p 7.

53 DJAG, correspondence dated 30 September 2019, p 7.

54 DJAG, correspondence dated 30 September 2019, p 7.

current practice and the QFCC report recommendation,[55] as soon as practicable and not more than six months after the 'triggering event' for an internal review, relevant agencies must:

- decide the extent of, and ToR for, the review
- complete the review and prepare a report about the review, and
- for internal reviews relating to the death of a child, give a copy of the review report and copies of any documents obtained by the agency head or litigation director and used for the review, to the Board.[56]

For reviews relating to a reportable death under the *Coroners Act 2003* (i.e. a child in care), the Bill would also require that reports must also be provided to the Queensland Coroner (proposed new section 245P).[57] This is consistent with current practice for Child Safety and the litigation director.[58]

Where two or more relevant agencies conduct reviews in relation to the same child, the Bill also provides under proposed new section 245R(2) they may also provide reports to each other. The existing requirement for Child Safety and the litigation director to share reports with each other continues to apply (proposed new section 245Q).[59] Proposed new section 245N also provides an agency head must collaborate across other relevant agencies and avoid unnecessary duplication in the completion of reviews and their reports.[60]

3.1.5 Information sharing

Clause 6 inserts proposed new Part 5 (new sections 245S to 245W) to enable information sharing, while protecting confidentiality, so relevant agencies can effectively carry out internal reviews and share the outcomes. In accordance with proposed definitions provided at new section 245B, the Bill defines outcomes to include: findings, recommendations, and information considered in forming findings and recommendations.

New section 245T provides that relevant agencies can share confidential information for the purpose of a review and to share outcomes of reviews.[61] Recognising that other relevant agencies have legislation that may restrict information sharing, proposed section 245U ('Interaction with other laws') states these provisions apply despite any other law (with the exception of information about the identity of the notifier which continues to be protected under existing section 186 of the CPA).[62]

To ensure confidentiality, proposed new section 245T(5) provides information given to the head of a relevant agency for the purpose of an internal review does not apply to information about the identity of a notifier. Additionally, new section 245T(6) states that existing section 186(2)(a) of the CPA (enabling the identity of a notifier to be disclosed in certain circumstances, including in the course of performing functions under the CPA) does not apply to the head of a relevant agency (other than Child Safety) in the course of carrying out an internal agency review.[63]

Clause 6 inserts proposed new section 245V which provides protection from liability if a person, acting honestly, gives information under Part 5 of the Bill. Under proposed new section 245V(2), a person is not liable, civilly, criminally or under an administrative process for giving information. The Bill also

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55 QFCC report, p 37.

56 Explanatory notes, p 6; DJAG, correspondence dated 30 September 2019, p 7.

57 DJAG, correspondence dated 30 September 2019, p 7.

58 Explanatory notes, p 6.

59 Explanatory notes, p 6.

60 DJAG, correspondence dated 30 September 2019, pp 7-8.

61 DJAG, correspondence dated 30 September 2019, p 8.

62 DJAG, correspondence dated 30 September 2019, p 8.

63 DJAG, correspondence dated 30 September 2019, p 8.

provides (at section 245V(3)) merely giving information does not mean a person has breached any code of professional etiquette or ethics; or departed from accepted standards of professional conduct.

3.1.5.1 Submitter's view and department's response

In its submission, the QLS noted:

> *Proposed section 245V provides protection from liability for giving information. The provision applies, "if a person, acting honestly, gives information under this chapter." However, it is the view of the Society that the Bill should not enable the compulsion of the provision of any privileged document. A practitioner who discloses a privileged document has the protection of any privileged of proposed sections 29T and 245V. However, these provisions offer no protection to a client. Therefore, we propose the provision be amended so it specifically preserves privileged documents from the requirements of disclosure.*[64]

In response to the QLS's proposed amendment, the DJAG advised that given there is no compulsion to provide requested information, it is not considered necessary to amend information sharing provisions to specifically preserve documents subject to legal professional privilege from the requirements of disclosure.[65] The Bill also attaches no penalty for non-compliance with a request for information.[66] DJAG also advised there are appropriate safeguards if the information is provided for the purpose of internal agency reviews or to the Child Death Review Board, under the CPA and FACC Act, respectively. For example:

> *…the Bill maintains existing confidentiality provisions around the use and disclosure of confidential information (sections 186 to 188 of the CPA and section 36 of the FACC Act). The Bill also maintains protections for persons if the information is disclosed (clause 6, new section 245V of the CPA and clause 23, new section 29T of the FACC Act).*
>
> *The Bill also provides that if a person may claim privilege in relation to information under another Act or law, the privilege is not affected only because the information may be, or is, disclosed under the relevant information sharing provisions for the purposes of internal agency reviews (clause 6, new section 245U(3) of the CPA) or to the Board (clause 23, new section 29S(3) of the FACC Act).*[67]

This matter was raised again by QLS Chair of the Children's Law Committee, Mr Damian Bartholomew, at the public hearing in Brisbane on 21 October 2019. Mr Bartholomew stated:

> *… there is a similar use of this type of the wording in this legislation [in reference to proposed new section 245V] in the child protection legislation, where there is also a compulsion to provide material and there is some uncertainty that has already been raised in relation to how that provision is interpreted, what the society is concerned about is the potential for a lack of clarity and some uncertainty that might arise around the drafting of the legislation as it is. A simple statement in 245V that says that there is nothing that compels for a privileged document to be provided would overcome any of those concerns.*[68]

On 21 October 2019 the committee requested additional information from the DJAG considering the QLS's additional evidence provided at the hearing. In response, the DJAG advised the committee:

> *… DJAG's view continues to be that given there is no compulsion to provide requested information, it is not considered necessary to amend these provisions to specifically preserve*

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64 Submission 5, p 2.

65 DJAG, correspondence dated 25 October 2019, p 1.

66 DJAG, correspondence dated 15 October 2019, p 10.

67 DJAG, correspondence dated 25 October 2019, p 2.

68 Public hearing transcript, Brisbane, 21 October 2019, pp 7-8.

documents subject to legal professional privilege from the requirements of disclosure, as entities would be entitled to withhold them.

DJAG's current thinking is that the Bill already strikes the appropriate balance by establishing a permissive framework for sharing confidential information supported by the guiding principles, while at the same time making it clear there is no requirement on entities to provide requested information.[69]

3.2 Proposed amendments to the *Family and Child Commission Act 2014*

Clause 23 of the Bill proposes to amend the *Family and Child Commission Act 2014* (FACC Act) by inserting new Part 3A 'Child Death Review Board'. New Part 3A would establish a separate and independent Board within the QFCC and provides for the conduct of reviews. DJAG noted, 'the Board represents a significant shift in scope, functions, powers and governance from the existing panels, which will be dissolved upon commencement'.[70]

In accordance with proposed new section 29A(4), the purpose of the Board's reviews are to:

- identify opportunities for continuous improvements in systems, legislation, policies and practice, and
- identify preventative mechanisms to help protect children and prevent deaths that may be avoidable.

DJAG stated, 'the Board will be focussed on reviewing child deaths 'connected to the child protection system' as defined under new section 29B – namely, following deaths of children for whom relevant agencies have conducted an internal review under the CPA.'[71] DJAG also stated the Board will not routinely consider serious physical injuries because:

Experience from the current Child Safety process and other jurisdictions suggests learnings from serious physical injury reviews are similar to those from reviews of child deaths; and have the added complexity of ongoing case management for the particular child and family, more relevant to internal agency reviews.[72]

However, under new section 29I, on exception and at the request of the responsible Minister (currently the Attorney-General), the Board may consider serious physical injury cases.[73]

3.2.1 Board functions and powers

Clause 23 also inserts proposed new section 29G to provide the Board's functions. The explanatory notes stated these are consistent with the best practice benchmarks identified in the QFCC report[74] and other comparable death review models,[75] most notably New South Wales, Victoria and Western Australia.[76]

In accordance with proposed new section 29D, the Board's functions are to:

- carry out reviews relating to the child protection system following child deaths connected to the system

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69 DJAG, correspondence dated 25 October 2019, p 1.

70 DJAG, correspondence dated 30 September 2019, p 8.

71 DJAG, correspondence dated 30 September 2019, p 8.

72 DJAG, correspondence dated 30 September 2019, p 9.

73 DJAG, correspondence dated 30 September 2019, p 9.

74 QFCC report, pp 36-37.

75 Explanatory notes, p 7.

76 Explanatory notes, p 8.

- analyse data, and apply research, to identify patterns, trends and risk factors relevant to reviews; and to carry out, or engage persons to carry out, research relevant to reviews
- make recommendations about improvements to systems, policies and practices for implementation by government and non-government entities that provide services to, or otherwise interact with, children and their families, and legislative change, and
- monitor the implementation of these recommendations.

The Board can also provide comments and information to relevant agency heads and the litigation director in response to internal review reports at proposed new section 29M. The DJAG noted this is to 'support continuous improvement and must not be published or included in a report of the Board'.[77]

In carrying out its functions, the Bill provides the Board may engage appropriately qualified people to conduct research, provide legal advice and prepare reports to assist the Board's work (proposed new section 29E). The Board must also avoid unnecessary duplication of processes carried out in other entities and, to the extent it considers appropriate, coordinate its reviews and the reviews carried out by other entities (proposed new section 29G).

3.2.1.1 Submitters' views and the department's response

In its submission, the AASW emphasised the importance of ensuring the Board maintained a collaborative rather than adversarial relationship with services and that an important step toward ensuring this is 'a non-blaming stance'.[78] PeakCare's submission supports this sentiment and suggested Board review processes 'be inquisitorial, not a method of apportioning guilt and conducted in accordance with the principles of procedural fairness.'[79]

To ensure collaboration, as discussed above at section 3.1.5.1, there is no requirement for entities to comply with a request for information (clause 23, new section 29P of the FACC Act), and no penalty provisions for non-compliance with a request.[80] DJAG also advised:

> *Collaboration is further supported by new section 29L of the FACC Act, which requires the Board, where it proposes to recommend in a report that a particular entity take action, to consult with the entity, and any other entity likely to be affected, about the recommendation before finalising the report.*[81]

The QLS raised a related concern about individual accountability and the functions of the Child Death Review Board under proposed section 29D. The QLS submission considered section 29D 'broadly drawn' and noted it anticipated this will allow the Board to maintain 'the ability to review individual cases and examine whether a particular officer has acted appropriately.'[82]

In response to issues regarding individual accountability raised by submitters, DJAG stated:

> *The Bill specifically provides that consideration of individual accountability, such as whether disciplinary action should be taken against a person, is out-of-scope for both internal agency reviews (clause 6, new section 245K(4) of the CPA); and systems reviews by the Board (clause 23, new section 29H(5) of the FACC Act). This approach is consistent across all Australian jurisdictions.*

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77 DJAG, correspondence dated 30 September 2019, p 9.

78 Submission 6, p 3.

79 Submission 4, p 3.

80 DJAG, correspondence dated 15 October 2019, p 16.

81 DJAG, correspondence dated 15 October 2019, p 16.

82 Submission 5, p 2.

… This does not mean that if inappropriate behaviour or misconduct is identified it will not be dealt with. Rather, it will not be dealt with as part of the child death review process.[83]

The DJAG further advised if matters concerning individual accountability are identified either by a department through an internal review, or through the systems review process of the Board, that matters be 'referred appropriately and dealt with under separate processes'.[84]

3.2.2 Independence of the Board

Existing section 22 of the FACC Act provides that a commissioner is subject to the direction of the responsible Minister in performing the commissioner's function under the Act. Under clause 23 of the Bill, new section 29F requires the Board act independently and in the public interest when performing its functions. If the Bill passes, QFCC commissioners will not be subject to direction by the responsible Minister or anyone else in performing the Board's functions.[85]

3.2.2.1 Membership of the Board

Proposed Division 6 of the Bill also sets out the membership of the Board. The DJAG's written briefing states the QFCC report[86] recommended Government 'reconsider selection, appointment of members and period of membership, and ongoing support, guidance and strong governance to members'.[87] New Division 6 establishes membership of the Board, which provides:

- *a chairperson, appointed by the responsible Minister, who must be the Principal Commissioner or another Commissioner of the QFCC;*
- *a requirement that the chairperson or deputy chairperson be an Aboriginal or Torres Strait Islander person;*
- *a maximum of eleven other members (also appointed by the responsible Minister) based on relevant expertise, with specific requirements regarding eligibility. Members are to be appointed for up to three year terms and may be reappointed;*
- *a requirement that the responsible Minister ensure the Board membership reflects the social and cultural diversity of the Queensland community; includes at least one Aboriginal or Torres Strait Islander member; includes persons with a range of relevant experience, knowledge or skills relevant to the Board's functions; and must not include a majority of persons who are public service employees;*
- *circumstances under which the office of a member becomes vacant, including if the Minister ends the member's appointment; and*
- *appropriate conditions of appointment, including provisions regarding remuneration and allowances for members of the Board, including that a member who is a State Government employee is not entitled to remuneration.*[88]

The DJAG advised that appointing the principal commissioner, or another commissioner, of the QFCC is consistent with other states and territories in that the head of the child death review body is also the head of the agency in which it is located.[89]

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83 DJAG, correspondence dated 15 October 2019, p 11.

84 DJAG, correspondence dated 15 October 2019, pp 11-12.

85 DJAG, correspondence dated 30 September 2019, p 10.

86 QFCC report, p 37.

87 DJAG, correspondence dated 30 September 2019, pp 11-12.

88 DJAG, correspondence dated 30 September 2019, p 12.

89 DJAG, correspondence dated 30 September 2019, p 12.

3.2.2.2 Submitters' views and department's response

A number of submitters raised concern about the Board's operational location and independence from government.[90] While PeakCare supported measures to increase the impartiality and independence of child death review processes, it was concerned the placement of the new Child Death Review Board within the QFCC may not achieve the level of independence required. PeakCare suggested greater independence could be attained by situating the Board with the Queensland Coroner because:

> *… judicial officers act independently and without interference from the parliament or the executive. The review process must be inquisitorial, not a method of apportioning guilt and conducted in accordance with the principles of procedural fairness.*[91]

In its submission, PeakCare referenced the Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) which sits with the Queensland Coroner and is responsible for the systemic review of domestic and family violence deaths, and identifying issues with service systems in Queensland. PeakCare proposed this function is 'well aligned with the investigation of the deaths of vulnerable children known to the child protection system.'[92]

Sisters Inside and the QLS supported clause 23 in its establishment of a singular, professional and independent Board with its own powers and functions.[93] However submissions from both of these organisations raised concerns about the independence maintained by the Board if the chairperson appointed by the responsible Minister is the principal commissioner or another commissioner of the QFCC.

The QLS submission questioned whether the appointment of a QFCC Commissioner to the role of chairperson (proposed section 29W) would maintain the independence of the Board from government, which is 'essential' as the chairperson is responsible for leading the board, and directing its activities, to ensure it appropriately performs its functions.[94] Sisters Inside concurred, proposing in its submission that the chairperson should be independent from government but given the same power and responsibility prescribed to the chairperson in the Bill.[95]

In response to concerns about the operational location and independence of the new Board, DJAG advised that Commissioners of the QFCC, including the Principal Commissioner, are Governor in Council appointments (existing section 11(2) of the FACC Act). Further, the appointment of the Principal Commissioner or a Commissioner of the QFCC as chairperson of the Board 'is consistent with other states and territories, where the head of the child death review body is also the head of the agency in which it is located (for example, the Ombudsman in New South Wales and Western Australia, the Children's Commissioner in Victoria).'[96]

Independence of the Board is strengthened by new section 29F of the FACC Act, which requires the Board to act independently and in the public interest. Further, despite existing section 22 of the FACC Act (providing a Commissioner is subject to the directions of the responsible Minister in performing the Commissioner's functions under the Act), a Commissioner is not subject to direction of the Minister in their role as chairperson of the Board or other Board member.[97]

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90 Submissions 3, 4, and 5.

91 Submission 4, p 3.

92 Submission 4, p 3.

93 Submissions 3 and 5.

94 Submission 5, p 2; Bill, clause 23, proposed section 29W(2).

95 Submission 3, p 3.

96 DJAG, correspondence dated 30 September 2019, p 7.

97 DJAG, correspondence dated 30 September 2019, p 7.

3.2.3 Conduct of Board reviews

Clause 23 inserts new Division 3 of the Bill in respect to the conduct of Board reviews. If the Bill passes, proposed new section 29H provides the Board must decide the extent of, and ToR for, each review. The Bill also provides guidance on the matters the Board may consider in a review (proposed new sections 29H (4)(a-d)). Consistent with provisions in the Bill for internal agency reviews and the intent of systems reviews generally, section 29H(5) provides the ToR for a review must not include consideration of disciplinary action.

In exceptional circumstances, the Minister responsible for the QFCC may ask the Board to carry out a review, or consider a particular issue or system as part of a review, 'for a matter that would ordinarily fall outside the Board's scope' (proposed new section 29I).[98] For example, it may be an issue arising from the serious physical injury of a child, or a death not connected to the child protection system. The DJAG advised the Board must comply with the request, but it will determine the extent of, and ToR for, the review.[99]

3.2.3.1 Reporting

Clause 23 also inserts proposed new Division 4 which sets out the Board's reporting requirements and protocols. Proposed new section 29J provides that the Board's annual report of its financial operations must be given to the responsible Minister by 31 October after the end of each financial year. Annual reports must be tabled in the Legislative Assembly within 14 sitting days after the report is received (proposed new section 29J(3)).

Proposed new section 29K also provides that, if the Bill passes, the Board may prepare other reports about outcomes of a review or another matter arising from its functions at any time. The Board can give other reports to the Minister and must make a recommendation to the Minister about whether the report should be tabled in the Legislative Assembly.

In accordance with proposed new section 29K(3), in deciding whether to table, the Minister must consider whether the report includes:

- *personal information about an individual; or*
- *information that may prejudice the investigation of a contravention or possible contravention of the law; or*
- *anything else relevant to whether tabling the report would be in the public interest.*

3.2.4 Information sharing

Clause 23 also inserts proposed new Division 5 (proposed new sections 29N to 29U) relating to the sharing of information and protection from liability. The DJAG stated this supports the Board's whole-of-systems focus and consideration of systems that may have been involved with a child or child's family prior to the child's death.[100] Proposed new section 29O sets out the underlying principle of this part. If the Bill is passed, information requested from entities should be provided in a timely way, and have regard to the relevance of the information for the Board's functions and the effect of the information on the safety, wellbeing and best interests of children.

Under proposed new section 29P, the chairperson of the Board may request information from any entity for the purpose of its functions. To provide for the broadest application, the term 'entities' relies on its meaning under the *Acts Interpretation Act 1954*, covering persons and unincorporated bodies. In practice, the DJAG suggested:

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98 DJAG, correspondence dated 30 September 2019, p 10.

99 DJAG, correspondence dated 30 September 2019, p 10.

100 DJAG, correspondence dated 30 September 2019, p 10.

> *… it is envisaged the Board will predominantly request information from public entities, but the Bill enables information to be requested from a range of entities, such as a non-government agency that provides a service to children or families, a private hospital, medical practitioner, the principal of a school, or the approved provider of an early childhood education and care service.*[101]

The Bill maintains existing protections relating to confidentiality of information by amending (under clause 24) section 36 of the FACC Act to extend confidentiality requirements to a member of the Board. Under proposed section 29Q, the chairperson may disclose confidential information to an entity for the performance of the Board's functions, including for requests for information from entities (under new 29P); and to avoid duplication of processes carried out in other entities and coordinate its reviews and those of entities (under new 29G).[102]

Proposed new section 29R provides the Board may enter into information sharing arrangements with entities, including the QFCC, the DFVDRAB or the Queensland Coroner for the purposes of sharing or exchanging confidential information. Proposed new sections 29S to 29U provide protections for persons in the event of the disclosure of confidential information. Sections 3.1.5 and 3.1.5.1 above, provide an explanation of the protections offered to individuals, who acting honestly, share information for the purposes of an internal systems review or in providing information to the Board.

3.2.4.1 Submitter views and department's response

In its submission, Sisters Inside raised concerns in relation to maintaining client confidentiality when providing information to the chairperson of the Board for the purposes of a systems review. Sisters Inside, 'strongly oppose handing over any of our confidential records unless the woman agrees for this information to be provided to the Board'. Sisters Inside suggested they, and other non-government organisations, should not be compelled to provide any information to the Board.[103]

In response, DJAG stated, 'consistent with the Board's intended collaborative approach, there is no requirement for entities to comply with a request for information (clause 23, new section 29P of the FACC Act), and no penalty attached to the provision.' It will ultimately be a decision for individual entities to determine how they respond to requests for information.[104]

3.2.5 Proceedings of the Board

Clause 23 also inserts proposed new Division 7 to provide for the proceedings of the Board under new sections 29ZE to 29ZK. These provisions set out administrative aspects of meetings including planning, quorum (which requires at least half of the broad members, including one member who is Aboriginal or Torres Strait Islander), the conduct of meetings, disclosure of interests and attendance by proxy. The Board also has the power to invite people other than members to attend a meeting to advise the Board about any matter (proposed new section 29ZH(7)).

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101 DJAG, correspondence dated 30 September 2019, p 10.

102 DJAG, correspondence dated 30 September 2019, p 11.

103 Submission 3, p 3.

104 DJAG, correspondence dated 30 September 2019, p 4.

4 Compliance with the *Legislative Standards Act 1992*

4.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (LSA) states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals, and
- the institution of Parliament.

The committee has examined the application of the fundamental legislative principles to the Bill. The committee brings the following to the attention of the Legislative Assembly.

4.1.1 Rights and liberties of individuals

Section 4(2)(a) of the LSA requires that legislation has sufficient regard to the rights and liberties of individuals.

4.1.1.1 Criminal history check for Child Death Review Board Members

Clause 23 inserts new provisions in the *Family and Child Commission Act 2014* to establish the Board. Under new section 29X(5), a person cannot be appointed to the Board unless the person consents to a criminal history check before appointment. A person with a conviction for an indictable offence is ineligible for appointment under clause 23, proposed section 29X(4)(a).

Members of the Board are required to disclose new indictable offence convictions imposed during their term of appointment as a Board member (proposed section 29ZD). The clause requires such a person to 'immediately' give notice of the conviction to the chief executive, unless the person has a reasonable excuse. The notice must include information about when the offence was committed, details adequate to identify the offence, and the sentence imposed. A failure to so notify attracts a maximum penalty of 100 penalty units.

In requiring a criminal history check before appointment to the Board, and requiring a serving Board member to disclose indictable offence convictions imposed while in office, proposed sections 29X(5) and 29ZD involve a potential breach of the fundamental legislative principle that legislation should have sufficient regard to the rights and liberties of individuals, including the right to privacy and confidentiality of personal information.[105]

The potential breach of fundamental legislative principle is heightened here, given that spent convictions are required to be disclosed.[106] In the Bill, the term 'criminal history' (clause 28) extends to spent convictions as well as charges without conviction. Additionally (though not mentioned in the explanatory notes), the information included in a criminal history also extends to any disqualification orders and offender prohibition orders made under the *Working with Children (Risk Management and Screening) Act 2000* or the *Child Protection (Offender Reporting and Offender Prohibition Order) Act 2004*.[107]

The following safeguards in the Bill can be noted:

- a person's criminal history can only be obtained with their consent
- there are limits on disclosure, and an offence for unauthorised disclosure, and

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105 *Legislative Standards Act 1992*, section 4(2)(a).

106 The *Criminal Law (Rehabilitation of Offenders) Act 1986* provides that an individual does not have to disclose a conviction for which the rehabilitation period has expired and is not revived, except in limited circumstances.

107 By virtue of the definition of 'criminal history' inserted in Schedule 1 of the FACC Act by the Bill, clause 28.

- there is a requirement for destruction of the information as soon as practicable after the information is no longer needed.

The committee considers there are sufficient protections for the privacy of the individual and sufficient justification for the breach of the individual's right to privacy of personal information, noting:

- the safeguards in the Act and the Bill
- the specific justification around the need to protect the rights and wellbeing of children, and the sensitive and confidential information of them and their families108, and
- the broader public policy concern that persons serving on statutory boards should be 'fit and proper' to do so.

4.1.1.2 Information sharing provisions for internal review and whole-of-systems reviews

The Bill introduces information sharing provisions to facilitate relevant agencies in conducting internal agency reviews following the death or serious physical injury of a child (clause 6 amendments to the CPA Act); and for the purposes of systems reviews conducted by the Child Death Review Board (clause 23 amendments to the FACC Act).

These information sharing provisions involve a potential breach of the fundamental legislative principle that legislation should have sufficient regard to the rights and liberties of individuals, including their right to privacy and confidentiality of personal information.

Consideration has been given to concerns raised by the QLS (see report section 3.1.5.1) and Sisters Inside (see report section 3.2.4.1) in relation to the protections available to individuals and entities under these provisions. These sections of the report outline there is no compulsion to respond to requests for information and no penalty for non-compliance.

Additionally, the explanatory notes stated:

> *The information sharing provisions are necessary to:*
>
> - *ensure agencies have access to information necessary to determine if a review is required by that agency;*
> - *enable relevant agencies to effectively carry out internal agency reviews and share the outcomes;*
> - *support joint learning and collaboration by relevant agencies; and*
> - *ensure the Board can access relevant information necessary to perform its systems review functions.*
>
> *The provisions are considered justified in the interests of assisting ongoing learning and improvements to service delivery across the child protection system and, in turn, supporting the reduction of child deaths that may be avoidable.*[109]

The explanatory notes stated the Bill will include appropriate safeguards and limitations for the sharing of information, and for both internal agency reviews and systems reviews by the Board, notifier information must not be disclosed.[110]

[108] Explanatory notes, p 14.

[109] Explanatory notes, p 13.

[110] Explanatory notes, p 13.

The explanatory notes also stated:

> *… confidential information can only be given by an entity to the Board for the purpose of the Board's functions. Board members will also be subject to existing confidentiality provisions under section 36 of the Family and Child Commission Act.*[111]

The committee is satisfied that the information sharing provisions of the Bill have sufficient regard to the rights and liberties of individuals.

4.1.1.3 Protection from liability for giving information

Whether legislation has sufficient regard for the rights and liberties of the individual depends on whether, for example, it does not confer immunity from proceeding or prosecution without adequate justification.[112] Related to the information sharing provisions discussed above, provisions protecting individuals from liability for giving information, if acting honestly, are introduced in the Bill under clauses 6 (see report sections 3.1.5; 3.1.5.1) and 23 (see report sections 3.2.4; 3.2.4.1).

Clause 6 inserts new section 245V in the CPA, to provide that a person, acting honestly, who gives information under chapter 7A (for example, to a review) is not liable, civilly, criminally or under an administrative process, for giving the information. Further, the person cannot be held to have breached any code of professional etiquette or ethics or to have departed from accepted standards of professional conduct. Clause 23 inserts new section 29T in the FCCA Act, providing protection from liability in identical terms to proposed section 245V.

One of the fundamental principles of law is that everyone is equal before the law, and each person should therefore be fully liable for their acts or omissions. Notwithstanding, conferral of immunity is appropriate in certain situations.[113]

The explanatory notes stated:

> *These provisions are based on existing protections under the Child Protection Act and the Family and Child Commission Act, amended to support the new expanded model.*[114]

The explanatory notes offered this justification:

> *These amendments are intended to ensure that individuals are not reluctant to share or publish information due to concerns about individual liability, even where it would be in the interests of facilitating ongoing learning and improvements in service delivery to children and their families. The protections are limited to apply only to actions done honestly or in good faith.*[115]

It is noted that a person providing information is protected from liability only if they are acting honestly. The committee is satisfied that, on balance, the breaches of fundamental legislative principle are justified in the circumstances.

4.2 Explanatory notes

Part 4 of the LSA relates to explanatory notes. It requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

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111 Explanatory notes, p 13.

112 *Legislative Standards Act 1992*, section 4(3)(h).

113 Office of the Queensland Parliamentary Counsel, *Fundamental Legislative Principles: The OQPC Notebook*, p 64, referencing the Scrutiny of Legislation Committee, *Alert Digest* 1 of 1998, p 5.

114 Explanatory notes, p 15.

115 Explanatory notes, p 15.

Explanatory notes were tabled with the introduction of the Bill. The notes are fairly detailed and contain the information required by Part 4 and a reasonable level of background information and commentary to facilitate understanding of the Bill's aims and origins.

Appendix A – Submitters

Sub #	Submitter
001	Bravehearts Foundation Ltd.
002	Confidential Submission
003	Sisters Inside Inc.
004	PeakCare Inc.
005	Queensland Law Society
006	Australian Association of Social Workers, Queensland Branch

Appendix B – Officials at public departmental briefing

Department of Justice and Attorney-General

- Leanne Robertson, Assistant Director-General, Strategic Policy and Legal Services
- Sakitha Bandaranaike, Director, Strategic Policy
- Caitlin Boveri, Principal Policy Officer, Strategic Policy

Appendix C – Witnesses at public hearing

Queensland Family and Child Commission

- Cheryl Vardon, Principal Commissioner
- Jaime Blackburn, Executive Director, Research and Child Death Prevention
- Zara Berkovits, Director, Child Death Review

Queensland Law Society

- Bill Potts, President
- Damian Bartholomew, Chair of the Children's Law Committee
- Binny De Saram, Legal Policy Manager

Statement of Reservation

Statement of Reservation Child Death Review Legislation Amendment Bill 2019

The LNP supports any measure aimed at protecting the safety of children.

The child safety system has been the subject of many failures under the Palaszczuk Labor government which is why this Bill is needed more than ever.

The LNP members support the objectives of the Bill to implement the recommendation of the Queensland Family and Child Commission (QFCC) report, A systems review of individual agency findings following the death of a child (QFCC report). The expansion of the current requirement to conduct an internal systems review when a child known to Child Safety dies or suffers serious physical injury to other relevant government agencies and the establishment of a new, external and independent Child Death Review Board are two measures the LNP members are in favour of.

However, we question why it has taken so long for the Bill to be introduced considering the report was handed down two and a half years ago. While we appreciate that it takes time to consult with relevant stakeholders, we are of the view that two and a half years is an excessively lengthy period and an earlier introduction of this Bill may have benefited our most vulnerable.

This Bill will hopefully guide much needed improvements within the child safety system that this and previous Labor governments have been slow to address.

Jann Stuckey MP
Member for Currumbin

Simone Wilson MP
Member for Pumicestone