EDUCATION, EMPLOYMENT AND SMALL BUSINESS COMMITTEE

Members present:

Ms LM Linard MP (Chair)
Mr N Dametto MP
Mr MP Healy MP
Mr BM Saunders MP
Mr DG Purdie MP
Mrs SM Wilson MP

Staff present:

Ms L Pretty (Acting Committee Secretary)
Ms A Beem, (Assistant Committee Secretary)

PUBLIC HEARING—INQUIRY INTO THE CHILD DEATH REVIEW LEGISLATION AMENDMENT BILL 2019

TRANSCRIPT OF PROCEEDINGS

MONDAY, 21 OCTOBER 2019

Brisbane

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The committee met at 10.32 am.

CHAIR: Good morning. I now declare open this public hearing for the Education, Employment and Small Business Committee's inquiry into the Child Death Review Legislation Amendment Bill 2019. I would like to acknowledge the traditional owners of the land on which we are meeting this morning and pay my respects to elders past, present and emerging. My name is Leanne Linard. I am the chair of the committee and the member for Nudgee. The other members present today are: Mr Bruce Saunders MP, member for Maryborough; Mrs Simone Wilson, member for Pumicestone; Mr Michael Healy, member for Cairns; Mr Nick Dametto, member for Hinchinbrook; and Mr Dan Purdie, member for Ninderry, appointed as a substitute for the member for Currumbin, who is unable to attend.

The committee's proceedings are proceedings of the Queensland parliament and are subject to the standing rules and orders of the parliament. The proceedings are being recorded by Hansard and broadcast live on the parliament's website. All those present today should note that it is possible you may be filmed or photographed. I ask everyone present to please turn mobile phones off or to silent mode.

The purpose of this public hearing is to hear evidence from stakeholders who made submissions as part of the committee's inquiry into the Child Death Review Legislation Amendment Bill 2019. The committee will also hear from, and ask questions of, the principal commissioner and officials from the Queensland Family and Child Commission.

The bill was introduced into the parliament on 18 September and referred to the committee for examination. The committee will examine the policies the bill gives effect to and the application of fundamental legislative principles, as set out in section 4 of the Legislative Standards Act 1992. The committee must report to parliament by 18 November 2019.

The committee has been briefed by the Department of Justice and Attorney-General on the bill and received the department's response to issues raised in submissions. Witnesses were provided a copy of the department's response to submissions, which is also available on the committee's web page. The program for today's hearing has also been published on the committee's web page, and there are hard copies available from committee staff.

I now welcome Ms Cheryl Vardon and officials from the Queensland Family and Child Commission.

BERKOVITS, Ms Zara, Director, Child Death Review, Queensland Family and Child Commission

BLACKBURN, Ms Jaime Blackburn, Executive Director, Research and Child Death Prevention, Queensland Family and Child Commission

VARDON, Ms Cheryl, Principal Commissioner, Queensland Family and Child Commission

CHAIR: Ms Vardon, thank you for your letter and for agreeing to attend to discuss the commission's previous reports and operational leadership of the Child Death Review Board that is proposed in the bill. As members know, the QFCC report *A systems review of individual agency findings following the death of a child* recommends a revised external and independent model for reviewing deaths of children known to the child protection system. The bill gives effect to aspects of the QFCC's recommendation, including expanding which agencies must review their involvement with a child following a death or serious injury; and establishing a new Child Death Review Board to review systems, identify opportunities for continued improvement and the mechanisms to protect children and prevent deaths that may be avoidable. The officials accompanying Ms Vardon are Ms Jaime Blackburn, Executive Director, Research and Child Death Prevention; and Ms Zara Berkovits, Director, Child Death Review. Good morning. I invite you to provide an opening statement of up to five minutes. After that, we will open for questions. Thank you for joining us.

Ms Vardon: Thank you, Chair and members of the committee, for allowing us to come along this morning and talk about the existing work of the Queensland Family and Child Commission in terms of child death reviews and our child death prevention work. I think it is important for the committee to have that context in order to consider the bill more fully. We already undertake a considerable body of work in child death prevention and in reviews.

First I want to acknowledge the traditional owners of the land on which this hearing is being held. Of course, you have the benefit of the Department of Justice and Attorney-General's very good briefing. I would think you also have access to two reports: one is the Queensland Family and Child Commission annual report on the deaths of children and young people; and the second is the report from the child safety department on the outcomes of the child death case review panels, which is available on their website.

It is an important, as I said, to bring the committee up to date with our work. Our work really focuses on the improvement of systems following the deaths of children. We do that and we have been doing that for the past four years. We maintain the Queensland Child Death Register for all children, including those known to Child Safety, and I will come back and talk about that in a little bit more detail. We reduce the likelihood of child deaths through partnerships and child death prevention work. The QFCC has that considerable body of work. Of course, we support the policy objectives of the bill following the report that we carried out after the tragic death of little Mason Jet Lee in 2016.

What are our powers and what is our child death work that is important to consider? We have an existing mandate and powers to improve systems and prevent child deaths under part 3 of the Family and Child Commission Act. We have always had that. We have undertaken this work since being established on 1 July 2014. Under that act I am required, as the principal commissioner, to reduce the likelihood of child deaths by keeping that register; recording, analysing, researching and reporting on information about child deaths; and making recommendations about laws, policies, practices and services. Under this part I have also had, for the past four years, the powers to request confidential information from relevant agencies and provide reports to the minister. The work of the board that is proposed in the new bill builds on the existing work of the Queensland Family and Child Commission.

Some of you—I hope all of you—would be familiar with the systemic reviews of child death that the QFCC has undertaken of children known to Child Safety. Where there has been multiagency involvement it would seem to be a breakdown of systems bringing about or contributing to the death of a child known to Child Safety. Over these four years the QFCC has made something like 170 recommendations for systems improvementsI emphasise: systems improvements—to the Queensland Premier as our responsible minister and shortly to the Attorney. These recommendations were all accepted and have been included in government reforms.

You would remember the circumstances around the tragic death of Tiahleigh Palmer, a young girl in foster care. We reviewed her death. We do not investigate the deaths of individual children, but there is always an investigation into the death of a particular child who contributes to systems reforms. If you look around the world, there is a name of a child on a report that brings about systems changes. That report was called *When a child is missing*. That led to subsequent reports including *Review of the blue card system*, *Review of the foster care system* and something that we are particularly proud of: a report by the name of *Recommendation 28*—a good name for a report—which regulated home based service environments—services that are carried out for the care of children behind closed doors such as family day care and foster care. Changes to the blue card brought about improvements in safety for kids in those circumstances.

Our way of operating is to make recommendations about systems change but they are specific, they are pragmatic and they are achievable within reasonably short time frames. Some of our recommendations are specific and can be done immediately. Some take a little longer, particularly where there is technology change that we recommend. However, we are nimble: we turn reports around as quickly as possible and make those specific and practical recommendations. I can think of a whole handful that have had a great impact on keeping children safe and contributing towards saving the lives of children.

There are a number of reports and reviews, and I can say that the Attorney-General and Minister for Justice continues to request systems reviews from us following the deaths of children where there are many systems and many agencies involved and there would seem to be some catastrophic breakdowns of those systems that need immediate attention. We are progressing those. Not all the deaths of children in these circumstances end up on the front page of the paper. I really want to emphasise that. We are not driven by what is on the front page of the paper. Otherwise, you would go mad. On the other hand—

Mr HEALY: That is right. You would go mad.

Ms Vardon: We monitor the system as a whole. I have to say that we have strong and collaborative arrangements and relationships with all agencies. We have never in my time received any pushback from agencies saying, 'We can't give you this. We can't tell you this.' Our relationships are strong, sound and collaborative, and we all have a joint purpose.

Just quickly on the Child Death Register, we hold information relating to all child deaths in Queensland since 2004 including that subset of children known to Child Safety. We have built up over that time an extensive database which identifies trends in children's deaths and builds an evidence base for systems improvement. We make that information available to researchers and to other agencies to conduct their work. That broad set of information in relation to all deaths certainly informs in particular the deaths of children known to Child Safety. The government saw fit a couple of years ago to give us some additional money to expand that Child Death Register, a critical part of the work that we do—collecting, analysing and publishing information on the causes of child deaths. We do that and we influence the national agenda.

In terms of some of our prevention activities, we specifically identify where there are critical areas of community education needed to reduce the number of deaths of children. We do research summaries and community education fact sheets, but we also do things that are more in the community's face, if you like. We have done what we call the Seconds Count water safety campaign with Mitch Larkin which was very public. We are about to rev that up again, because one of the leading causes of death around small children is toddler drowning. We are aware of that.

We make submissions to improve safety standards. As an example of one of our partnerships, a while ago now we partnered with Transport and Main Roads so that we could work towards preventing the deaths of children from slow-vehicle run-overs: have a look before you back out, your child might be behind you. Youth suicide is a critical area for us as well—working on research and prevention, understanding the risk factors around youth suicide. Why are so many children right across Australia and elsewhere taking their own lives?

It is important to keep in context that the bill is about systemic learnings and improvements to save the lives of children. We know that the mortality rate of children known to the child protection system is several times higher than the mortality rate of all Queensland children for external causes of death—that is something worth pausing on for a moment—including for drowning, other non-intentional injury, suicide, fatal assault and sudden unexpected infant deaths. Based on that data, and based on the back-up, if you like, that the Queensland Family and Child Commission is able to provide to the board through the proposed legislation, we are in a pretty good place to make sure that those improvements to systems are made in a swift, timely and acceptable fashion.

In closing, the death of every child is a tragedy. Sometimes when I get the first reports of a child who has taken his or her own life I sit and ponder for a while: 'What was in your mind?' The death of every child is a tragedy. The introduction of this bill pays tribute to Mason Jet Lee and all the children who have died, known to Child Safety or not known to Child Safety. Any changes that can make improvements should be brought in swiftly.

CHAIR: Thank you for your opening statement and for the work of the QFCC. Obviously it is very important work. The Child Death Review Board that will be given effect by the bill will broaden your current functions regarding conducting systemic reviews but will replace the child death review panels that are currently in place—and obviously you will continue with the Child Death Register. How will these changes give practical effect to your review recommendations in that regard?

Ms Vardon: Commenting on the bill is something I have to be a bit careful about, because it is before you and before the House. I can certainly talk about the transition period between the current work that we do and the proposed work of the new board. For the past four years, the deaths of children through seeming multisystem and multiagency breakdowns have already come to the Queensland Family and Child Commission. The tier 1 internal review, being a bit esoteric, is carried out by Child Safety. That will broaden under the proposed legislation, but we have had referred to us, previously by the Premier and now the Attorney, the deaths where there would seem to be not simply Child Safety but a range of agencies involved. We have three of those before us at the moment. The ones that are public I have mentioned in passing. From that, a cascade of other reviews can happen, all linked back to improving the lives and preventing the deaths of children.

Once the new board comes into effect, those multiagency reviews will cease being carried out by the Queensland Family and Child Commission but will come within the purview of the board, which is where they should be. The proposed board has a much broader remit than the existing function where it sits in Child Safety. The monitoring of the recommendations that we make will certainly be

part of our oversight activity. Among the QFCC's functions is a very strong oversight of the child protection system responsibility, as well as the evaluation of reforms. At the moment we oversight all of our recommendations and we are looking forward to contributing to the oversight of the recommendations to ensure they move along in a timely fashion under the new arrangements.

CHAIR: Many of the agencies that are mentioned, such as Queensland Police Service and Queensland Health, already have internal review processes, whether it be critical path analysis or whatever that might be, depending on the agency. Do you have any views about how the board will best engage with those different agencies and pull together those internal reviews to better enable the QFCC to do these overall systemic reviews?

Ms Vardon: We know that the bill requests that there is no duplication in the work that is undertaken. In terms of what we call the tier 1 reviews—that is, the internal reviews that each agency has to undertake if that particular child is known to them—the templates and guidelines for those reviews are yet to be written, because we do not want to jump the gun too much. We would want the agencies under review, or requested for information, to really make use of some of the review processes they already have in place so that they are not duplicating. For example, the health department has root-cause analysis reviews, reviews of clinical decisions and so forth. If those reviews and their outcomes are relevant to the internal review requested by the board then they will be made use of, so it will not be duplication and it will not be effort wasted. We think that is a really good thing, because at least some of the recommendations and findings of those additional internal reviews that agencies do anyway will be made more broadly available.

Generally, agencies around the public service—government and non-government—have different levels of experience with taking on a review. Some are used to it. Queensland police certainly is; it is always under scrutiny. Health, Education and the larger agencies are certainly very used to scrutiny of different kinds. A very big education undertaking will be needed to educate all agencies, but particularly those that have not been subject to this kind of review before, about the protections in place for them and the expectations.

Mrs WILSON: You actually answered a question I had on the recommendations the board makes in regard to government departments in relation to the monitoring. Can you explain further how you monitor the recommendations once they have been provided to the department? You say that you are monitoring them, but what is the process involved in that?

Ms Vardon: I can certainly talk about that. This was a direction the QFCC decided to undertake off its own bat, if you like, but as part of its oversight function. It is quite simple. We have regular meetings where we call together the representatives from the agencies concerned and we share the progress of the recommendations, where the blocks are, where there is a need for more of a back story, if you like—an explanation, what was the thinking. That regular meeting, that regular communication, enables us, and me in particular, to conduct that monitoring and, if need be, report back to the directors-general of the agencies or to the ministers about the progress on recommendations we have made through the range of reports that we have undertaken.

Much of that work is successful, because it is a result of the good relationships we have with agencies. We make sure that in our reports of our reviews we do not ever point the finger at people and say, 'You've really made a mess here.' That is counterproductive. We want improvement, and we can only do that when there is good collaboration. Sometimes the discussions are very feisty, as you can imagine, but we work through that. I cannot think of one relationship hiatus that we have had as a result of our reviews, reports and monitoring work. That does not mean that some of it has not been hard.

The other part of what we do in conducting our reviews is say, 'Hey guys, don't wait for us to land a report on you.' That is not helpful. We work out where some of the systems breakdowns have been and were and say, 'Please start work on that straightaway. Don't wait for us. Get going now.' In all cases that has happened. I can point to a couple of examples where we kind of breathe a sigh of relief and think, 'That's going to make a difference.'

Mr HEALY: I could not agree more that any loss of a child under any circumstances is a massive tragedy, so the goals and objectives of this are absolutely essential. There is an expectation in the community that we will continue to review and come up with the appropriate guidelines. One submission raises questions about the organisational location of the new board. Can you share with the committee your findings on the location of the board? Did you consider other agencies—the Ombudsman or the coroner?

Ms Vardon: I recognise the great work of the Department of Justice and Attorney-General in this process and the hard work they have undertaken in the past 18 months or so in designing and building this new model, because there was no point in the QFCC in its report on the death of Mason

to design the new model. That had to be a collaborative arrangement. All agencies that had statutory independence—so could provide that distance—were considered. In the end, it was up to the Attorney and the government to decide the final landing, and we were arms-length from it. Once we have given over our report, we stay at arms-length from the nitty-gritty of it, although we are interested in the implementation of the recommendations. That debate was held. All agencies were consulted, including agencies outside those that are service delivery agencies. In the end, there are a small group of agencies with that statutory independence, and that is where the government, through the Attorney, landed.

Mr PURDIE: I concur in the other members of the committee in passing on my acknowledgment of the great work you do. This is my first day on this committee. I reviewed the legislation and submissions last night, but there might be some silly questions that I ask where I am not fully informed. In relation to the new board and its investigations, I assume that most of its reviews are matters that would have come before the police or the Coroner. Obviously any death of a child is a reportable death under the Coroners Act. I dare say you would not be reviewing accidental deaths or deaths that can be written off with a medical certificate. I also saw that in the legislation there is a six-month time frame on your report being submitted to the Coroner. Was any thought put into how you will work alongside or parallel to a police investigation, be it murder, manslaughter or otherwise, or a coronial inquest or investigation, which normally is put on hold pending a police investigation? It seems that there are some time frames and some ongoing reviews. In your opinion, how will all of that work together seamlessly?

Ms Vardon: Without commenting on the new board and its approaches, because that will be up to the board, the current panel that sits within the Department of Child Safety, Youth and Women is very conscious of those time lines. A clear statement at the outset is that the proposal for the new board, which is the same for the existing panel, is that all deaths of children known to Child Safety will be reviewed where there has been intervention in the past 12 months. Some of those figures are quite interesting in that at this given moment around 84,000 children are known to Child Safety. We are talking about those known to Child Safety in the past 12 months who, sadly, have died. That will not change.

That is a little different from the definition of reportable deaths to the Coroner, some of which may or may not lead to an inquest. Certainly in the work that we have done, we have steered very carefully away from police investigations, remembering that the current work of the QFCC—the current work of the panel, if you like—is not about individual children; it is about what systems changes need to be brought about where systems would seem not to have worked well together and perhaps a child has fallen through the cracks and sadly died.

We are very cognisant of all those time lines. For example, there are still court proceedings underway in relation to little Mason Jet Lee, and I am assuming there will be an inquest later. All of that timing will have to be mapped out very carefully.

Mr PURDIE: In relation to the funding allocation, I read last night there has been some extra funding. I am aware that DOCS already has internal processes in place to review these matters. It might even have a dozen staff that to do it. Earlier you alluded to the fact that obviously Health, Education and the police already have internal systems, but has there been any thought put in to extra funding for the police, Health and Education, who will be doing these new reviews in areas where specifically they might not already be set up to do them, like DOCS is already set up to do them?

Ms Vardon: Each of those agencies would make their own representations through their minister to government, to the cabinet, and I would assume they were doing that. They also have dedicated resources directed towards doing their internal reviews at the moment, so I am sure there will be some debate over resources. With the design of the templates and the way in which we go about seeking information through those tier 1 reviews, the board would certainly be cognisant of the fact that there are existing reviews already resourced in those agencies from which information could be drawn to create that tier 1 review. Yes, when it all happens there will be a machinery-of-government change. We are all familiar with those. Machinery-of-government changes bring about with them the shift of resources. All of that is yet to unfold, but I know that the government has given very careful consideration to the issue of resources. The government understands, and we know too, that we cannot afford to fail on this one.

Mr PURDIE: It is an important issue.

Mr DAMETTO: I also echo the sentiment of the committee. The work that you and the department are doing at the moment and what we are doing within this place to protect children is imperative for Queenslanders and Australians in general. My question is about the criteria for people who will be applying to go onto this board. Can you give us any insight into the kinds of people who would be seen as appropriate to be appointed to this board?

Ms Vardon: The bill I think sets out, as do the requirements for the existing panel, the range of expertise that would be needed to set up for the board. That is something I cannot comment on in detail but, from our own knowledge internally of expertise needed in these particular areas, the board would certainly need to have Aboriginal and Torres Strait Islander representation. That is absolutely key. Reflecting the social and cultural diversity of Queensland is key.

I can talk about the range of skills with the people we work on at the moment. We work closely with child and adolescent psychiatrists, for example, particularly around our suicide work; we work with experts in the area of research on child deaths generally; and we work with experts on domestic violence, because children are sometimes collateral in domestic violence disputes—people look at the adults and sometimes miss the child. There is that whole range of skills and expertise needed. In terms of drawing on people right around Queensland, thinking of our work once again, I think it would be really important to have regional representation, from outside Brisbane.

Mrs WILSON: Since you have been conducting these reviews, have you within the department seen a decrease in child deaths?

Ms Vardon: That is an interesting question. I was looking at that yesterday. It is interesting to work out whether a decrease actually is a trend or if we need to wait a little bit longer. I can say safely that the deaths of children right across Queensland, including those known to Child Safety, has shown some decrease in the past couple of financial years, but I would hesitate to call that a trend or anything that you could hang your hat on because it just needs some extraordinary event, as you can imagine—a large fatality or an epidemic of some kind, thinking of the flu season—to change that. In terms of Child Safety, that number has remained reasonably constant but tending towards some decrease that is hard to pick up as a trend.

What we do know is that quite simple recommendations that we have made sometimes have brought about the potential to prevent the deaths of children. This is public information. The key issue to remember is that, of the 385 children who died right across Queensland in 2017-18—the current report is with the minister at the moment—48 were known to the child protection system. The numbers can decrease or increase. That overrepresentation of those children is very key for the work of the board, we think. Potentially, there is continuing to be room for improvement. For example, I can point to the Our Child work. Our Child is an information-sharing technology initiative. It is about information sharing between agencies to find missing children considerably faster than previously. That means that children who go missing are not then at risk of death or something terrible happening to them.

CHAIR: Thank you very much, Ms Vardon, Ms Blackburn and Ms Berkovits, for your time today and for your expertise and the assistance you have provided our committee.

BARTHOLOMEW, Mr Damian, Chair, Children's Law Committee, Queensland Law Society

De SARAM, Ms Binny, Legal Policy Manager, Queensland Law Society

POTTS, Mr Bill, President, Queensland Law Society

CHAIR: Thank you for your submission. The Queensland Law Society always makes submissions to inquiries and we very much appreciate them. You have raised two issues in that submission. We welcome you to provide an opening statement if you would like to, and then we will open for questions.

Mr Potts: Firstly, I thank you for inviting the Queensland Law Society to appear at this public hearing on the Child Death Review Legislation Amendment Bill 2019. The Law Society is the peak professional body for the state's legal practitioners, over some 13,000 of whom we represent, educate and support. In carrying out its central ethos of advocating for good law and good lawyers, the society proffers views which we believe are truly representative of its member practitioners. The Law Society is an independent, apolitical representative body upon which government and parliament can rely to provide advice which we believe promotes good, evidence based law and policy.

Without trying to sound too prosaic, we are talking about obviously the death of a child. The death of one affects all of us. The aim of the legislation we believe to be truly admirable, and we commend this committee and the parliament for its work with respect to this. I would like to note the society's support for the creation of the Child Death Review Board. We support the purpose and the functions of the board, which will be responsible for carrying out systems reviews following child deaths connected to the child protection system to identify opportunities for continuous improvement to the child protection system and practices and to identify preventive mechanisms to help protect children and prevent deaths that may be avoidable. Someone far smarter and more eloquent than I, Martin Luther King Jr, said—

Injustice anywhere is a threat to justice everywhere. We are caught in an inescapable network of mutuality tied in a single garment of destiny. Whatever affects one directly affects all indirectly.

Just as I started off by saying the death of one child affects us all, we understand and accept that single garment of destiny. We commend and engage with this committee in that spirit, effectively, of preventing injustice. 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 DOCS, looking into each single death—life, of course, is something we hold as valuable, priceless effectively—is a good and excellent thing. I now hand over to Damian Bartholomew, the chair of our Children's Law Committee, to outline our key concerns in relation to the bill.

Mr Bartholomew: There are a couple of issues which we raised in our submission, the first being about the disclosure of privileged documents as set out in section 245B of the bill. Whilst it is acknowledged that there may not be a compulsion to hand over those documents, obviously for the Law Society the preservation and respecting of legal professional privilege is of ultimate importance. What we would be hoping to see in any legislation that discusses the notion of legal professional privilege is a clear statement that reflects that there is nothing in this legislation that attempts to undermine the privilege attaching to a document and that no privileged documents are required to be provided. Essentially, that is the thrust of that point.

The further point that we raise in our submission is about the appointment of the chairperson as set out in section 29V and the notion of getting full parliamentary support for that chairperson just to ensure that perception of independence, which we believe is very important, reflecting the vital role of what the board is doing.

Mr Potts: That is our opening statement.

CHAIR: Thank you very much. Not surprisingly, I will come to your comment in the written submission and that Mr Bartholomew just made with regard to proposed section 245V. Have you seen the department's submission online in response to submissions and their comments? Do you have any comment to make with regard to those?

Mr Bartholomew: Only to say that I recognise that that is the case in that there is not a compulsion and there is not a penalty for noncompliance. There is, however, legislation that requests the provision of that material, and the way that provision is worded in 245V talks about preservation of the privilege attaching to documents after they have been provided. Because there is a similar use of this type of the wording in this legislation 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. It is really about the simplicity and the clarity in the legislation that we think would be desirable.

Mr Potts: To assist members, legal professional privilege does not belong to lawyers; it belongs to their clients. If the client raises it, it can be clearly tested in a court. The documents can be protected effectively by surrendering them to the Magistrates Court, and there are significant processes and indeed a very detailed written protocol of how both the police and the Crime and Corruption Commission will deal with those. In fact, it is a protocol that was worked on in 2016, I think, and published in that year as a result of significant work by the CCC, by the Law Society and by the Queensland Police Service. What we are talking about here is nothing terribly radical. We are just asking for a simple, clear statement to ensure that those processes are protected.

CHAIR: Can you advise, Mr Potts or Mr Bartholomew, whether that line has been included elsewhere? Is there a precedent for that? I am sure you raised it with regard to the Child Protection Act as well.

Mr Bartholomew: It is adopted within the child protection legislation. The contents of that legislation talk about material that is required to be provided and then there is this override that exists within that legislation. There is indeed some ongoing discussion, I think, between parties in relation to what effect that might have upon a privileged document. This legislation does not have that same requirement—that is acknowledged—but by mirroring similar legislation it can indeed cause some confusion without a clear statement that it is not intended to require the provision of a privileged document.

Mr Potts: It just puts it beyond doubt.

CHAIR: Thank you very much. Are there any questions?

Mr HEALY: It is pretty straightforward, Mr Bartholomew, regardless of the accolades from Mr Potts to the committee. No, I think it is pretty straightforward and straight to the point.

CHAIR: Okay. In that case I will ask another question. I am interested in your views with regard to the chair and the importance of the independence of the chair. Were you in the room when that question was asked by my colleague the member for Cairns to the principal commissioner of the commission?

Mr Potts: We came in halfway during Ms Vardon's evidence, so I do not recall that specifically.

CHAIR: That is okay. I was just interested in your views if you had had the opportunity to hear those comments, but I understand you were not here.

Mr Potts: Our general view is that, particularly seeing it is such an important matter for the community as well as for parliament, the independence of the commissioner is of paramount importance. The public need to know that it is beyond—with no disrespect to people present—party politics.

Mr SAUNDERS: None taken!

Mr Potts: It should be a matter of overarching public policy and public concern, so we believe that a person no doubt of eminence with broad experience but with absolute independence is essential to ensure the trust of the public continuing with respect to such a vital concern for them.

CHAIR: Would you say that that impression is somewhat allayed with regard to, again, the response the department gave about the independence of the board and its chairperson being strengthened by the proposed new section 29F?

Mr Bartholomew: I am not sure that that will address the issue in terms of public perception.

CHAIR: It was worth asking, but that is what I assumed.

Mr Bartholomew: I have read that response, but I think the issue is that we are dealing with essentially a review of child safety systems. There will be concerns that government is attempting to preserve its own areas and to hide those areas if indeed there is not some perception from the public that this is an accountable body and this is someone in whom they can have some confidence. Adding this measure in is just going to enhance that public perception, and I think that has been raised by other members of the community and not just by the Law Society.

CHAIR: Would it be fair to say, though—and your use of the word 'perception'— that, looking at the drafting of the bill, it is perception more than reality because the bill does provide significant support for and protection of that independence?

Mr Bartholomew: I think the bill does go some way to address those issues, but in drafting the bill the actualities and the perceptions are equally important.

Mr Potts: To use a somewhat philosophical term, perception is reality. If people believe it to be true, it is true. That belief might be based on ignorance or it might be based on—who knows?—reading the *Courier-Mail*, but it is extraordinarily important that as a parliament and as a government we ensure that the truth of independence is able to be pointed to, not merely the perceptions.

CHAIR: Thank you. There being no further questions, I thank you again for coming before the committee and for the submission you made to us and indeed for the submissions that you always make. They are of great benefit, as is your expertise, so thank you very much. No matters have been taken on notice, so I thank Hansard, the committee secretariat and my fellow committee members for their support today. I declare the public hearing closed.

The committee adjourned at 11.22 am.