1. Following the death of Mason Jet Lee, on 10 April 2017, Government publicly released the Queensland Family and Child Commission (QFCC) report, *A systems review of individual agency findings following the death of a child* (QFCC report) and accepted the report’s single, overarching recommendation to ‘consider a revised external and independent model for reviewing the deaths of children known to the child protection system’.
2. Child Safety and the Director of Child Protection Litigation (DCPL) are currently the only Queensland Government agencies required to conduct a review of their involvement after a death of a child known to the child protection system, with internal reviews considered by multi-disciplinary child death case review panels located within Child Safety.
3. The Child Death Review Legislation Amendment Bill 2019 (the Bill) provides for a system of internal review by relevant government agencies involved with children known to Child Safety who have died or suffered serious physical injury; and establishes a new, independent Child Death Review Board, located within the QFCC, to carry out systems reviews following deaths of children connected to the child protection system.
4. In addition to Child Safety and DCPL, the Bill provides that the chief executive (or appropriate delegate) of Queensland Health, Department of Education, Queensland Police Service and the Department of Youth Justice will be required to conduct an internal agency review if the chief executive (Child Safety) is conducting a review and the agency had involvement with the child in the 12 months prior to their death or serious injury.
5. Internal reviews will be focused on ongoing learning and improvement, accountability and collaboration and joint learning, with the Bill introducing information sharing provisions to support the exchange of confidential information to support review processes.
6. Systems reviews by the Child Death Review Board will identify opportunities for continuous improvement, with the ability to request confidential information from public and private entities; make public recommendations about legislative change and improvements to systems, policies and practices for implementation by government and non-government entities; prepare systemic reports; and will have multi-disciplinary membership with balanced government and non-government representation.
7. Cabinet approved the introduction of the Child Death Review Legislation Amendment Bill 2019 into the Legislative Assembly.
8. *Attachments*
* [Child Death Review Legislation Amendment Bill 2019](Attachments/Bill.PDF)
* [Explanatory Notes](Attachments/ExNotes.PDF)