Tasmania
DEPARTMENT of HEALTH and HUMAN SERVICES

Recommendations of a Review Conducted in Relation to the Death of a Child Involved with the Child Protection System in Tasmania

Preamble:

Following the death of a child involved with the Child Protection system in Tasmania, the Minister for Health and Human Services approved the formation of a Committee to review the circumstances of the child's death. This Committee was established as a sub-committee under the auspices of the Council of Obstetric and Paediatric Mortality and Morbidity Committee, as determined by the *Perinatal Registry Act 1994*.

The purpose of the Review was to look at the consequences of contact, advice and decisions in respect to this child and the child's family, specifically in relation to:

- The Department of Health and Human Services, Tasmania, including:
    - Child and Family Services;
    - Family Child and Youth Health Services;
    - Alcohol and Drug Services; and
    - The Royal Hobart Hospital.
- Other service providers (e.g. General Practitioners, Police, Tasmanian Aboriginal Centre).
- Any other service the Committee considered appropriate.

In this regard, the Committee was asked to examine:

- The discharge of the duty of care, the identification of risk and the appropriateness of the responses to those risks.
- Policies and protocols in relation to:
    - The identification and management of babies born with drug addictions with a particular focus on their care and protection;
    - The interface between Alcohol and Drug Services' methadone program and private prescribers in relation to access to methadone;
    - The management of multiple notifications on similar issues and the weight given to notifications made by professionals; and
    - Communication within and between the services provided by the Department and external service providers in relation to the above matter
- Staff training and development in:
    - The identification of the symptoms of methadone overdose;
    - Collaborative case management; and
    - Assessment of parenting skills in clients with drug issues.

The Review Committee consisted of Mr David Fanning, Commissioner for Children and Dr Elizabeth Hallam, Paediatrician and Director Women's and Children's Services Royal Hobart Hospital - both members from the Paediatric Mortality and Morbidity Committee - together with an external Consultant, Ms Anne Foot, who has considerable experience and expertise in the field of child protection. The Department nominated Ms Alison Jacob, Deputy Secretary, to act as administrative chair of the Committee.

The findings of the Review are confidential as they identify the child and family concerned. However, the report will be discussed with the staff involved in this case by the Review Committee and a copy of the report will also be provided to the Director of Children and Family services so that the recommendations are able to be implemented.

The review's recommendations are attached.

Recommendations

(i) As a matter of urgency, develop legislation to mandate a statutory process for investigating and reviewing child deaths and serious injury related to the child protection system in Tasmania, according to the model expected to be recommended by the Commissioner for Children in forthcoming advice to the Minister.

(ii) Drawing on appropriate models operating in other states, outpost a dedicated child protection worker to the Royal Hobart Hospital, to provide advice and consult on child protection issues identified by hospital personnel and to promote and develop relationships between the services.

Twelve months from commencement of the above, review and evaluate the initiative, with the view to adopting a similar model for major hospitals in the North and North West of the state.

(iii) Create a designated position(s) within the Department's Alcohol and Drug Service (ADS) to participate in case conferences and consult on all child protection cases where drugs and/or alcohol are a significant factor.

(iv) Mandate case conferencing as a pre-requisite to decision making in all complex child protection cases that involve the need for advice of professionals from different disciplines and services. Child protection officers should have primary responsible for initiating and conducting the process, and ensuring the participation of all relevant professional parties.

(v) Develop a Memorandum of Understanding between the Department and the Tasmanian Aboriginal Centre, for working with aboriginal families where there are child protection issues.

(vi) Establish clear parameters around the roles and responsibilities of Child Protection Services and Family Child Youth Health when working with families where there are child protection issues. To assist with providing a continuum of service, ensure staff receive appropriate supervision and training to understand and fulfil their functions.

(vii) Provide formal and ongoing training on the effects of drug and alcohol abuse, to all service providers involved with children potentially at risk, including relevant medical, nursing, allied health and child protection professionals and staff.

(viii) Within each Service Centre, designate a senior position to undertake training and develop expertise in the area of child protection within the early childhood years. Assign to this position the responsibility for signing off all decisions relating to children under 3 years old.

(ix) Recommend amendments to the Children, Young Persons and their Families Act 1997, to provide for notification and involvement at the ante-natal stage.

(x) Investigate the potential for developing a register listing details of families who have been involved with the child protection system in Tasmania .

(xi) Cease the use of 17(b) classifications for cases which have not been confirmed as being on active case load.

(xii) Develop a priority rating system which separates severity of overall risk from response time required for action.

(xiii) Introduce to all relevant CPAARS and Service Centre documentation, a mandatory field for supervisors to date and sign to confirm that they have read and endorsed the decision/ action, together with the reasons for their endorsement.

(xiv) Update the child protection information system to:

- Issue an alert when a child's siblings have been notified;
- Provide an alert if a child has previously been notified;
- Make information and records more readily and consistently accessible statewide.

(xv) The practice of providing parents, particularly parents of young children, with takeaway doses of methadone be reviewed by the Department of Health and Human Services Pharmaceutical Services Branch.

(xvi) Revise recruitment, induction and supervision practices to ensure that all staff recruited to, and working in, CPAARS have sufficient experience, skills and training to appropriately assess cases notified.

(xvii) Assign senior staff to be the first point of call, responsible for initial triaging of calls coming into CPAARS and allocation of the case to a worker.

(xviii) Develop and implement the use of practice guidelines and manuals for all child protection staff working in CPAARS and Service Centres.

(xix) Identify and review any existing guidelines for drug screening of parents involved with the child protection system, and make any recommendations for the implementation of improved processes.