

**Recommendations of a Review conducted by the Child Death Review Committee
in relation to the death of a child whose family had previous involvement with
Children and Family Services**

In July 2007, the Council of Obstetric and Paediatric Mortality and Morbidity was requested to conduct a review of the circumstances of the death of a child whose family had previous involvement with Child Protection Services. The Council convened a review committee for this purpose in accordance with the provisions of the *Perinatal Registry Act 1994 s9*.

The Committee was asked to review the consequences of the contact, advice and decisions relating to the children, primarily in respect to the interactions between Child Protection Services, the family and their service providers. The focus was on identifying any child protection practice issues that may have contributed to the death.

The Review Committee consisted of: the Commissioner for Children, Paul Mason; external Consultant, Ms Anne Foot, who has considerable experience and expertise in the field of child protection; and Ms Alison Jacob, Deputy Secretary Human Services, Department of Health and Human Services. Dr Elizabeth Hallam (the former Consultant Paediatrician and Medical Co-Director Women's and Children's Services at the Royal Hobart Hospital) participated in the initial discussion on the case, but was unable to be present during the interviews with service providers, and the follow up discussions. The involvement of an alternative Paediatrician was explored, but was not able to be arranged in the available time.

As with the earlier reviews conducted by the Review Committee, the Committee members agreed that a report detailing the findings of the review and any other issues and recommendations considered appropriate, would be provided to the Minister for Health and Human Services, via the Council of Obstetric and Paediatric Mortality and Morbidity.

The findings of the Review are confidential as they may identify the child and family concerned. However, the report will be discussed with the staff and key stakeholders involved in these cases and a copy of the report will be provided to the Director of Children and Family Services and the Department of Health and Human Services, so that the recommendations are able to be implemented.

The Review's recommendations are attached.

Recommendations

Child Protection Services:

- (i) Review the general practice of case conferencing and implement training and processes to better enable staff to effectively undertake case planning, following appropriate analysis and assessment of all case information.
- (ii) Review and amend the practice guidelines related to the unborn baby alert process.
- (iii) Instigate a memorandum of understanding between Child Protection Services and Alcohol and Drug Services that contains as a minimum.
 1. Processes for joint case discussion when a client is referred to Alcohol and Drug Services.
 2. Processes for professional dialogue between service providers, when determining how to best manage individual cases.
 3. Processes for joint service provider visits/meetings with families.
 4. A preferred way of undertaking, and reporting on, drug and alcohol assessments for clients referred by Child Protection Services.
- (iv) Ensure that Child Health and Parenting Services (CHAP) nurses are more fully integrated into Children and Family Services, with a legitimate role in contributing to child protection cases. For example, enable joint home visits by Child Protection and Child Health and Parenting Services where a CHAP nurse feels unsafe, is unsure of a parent's capacity to parent, or where a parent with other children on active caseload has care of a new baby.
- (v) Develop guidelines to ensure that Child Protection Workers receive an appropriate level of support and opportunities for reflective practice, following the death or serious injury of a child on their caseload.

General:

- (vi) Work with child health services to consider targeted awareness campaigns to warn parents, families and the general public of the potential dangers of bed sharing between parents and infants.

Review hospital processes for informing new parents of the possible dangers of bed sharing.