

28 November 2007

Lara Giddings
Minister for Health and Human Services

Report on Child Deaths

The Minister for Health and Human Services, Lara Giddings, today released the findings and recommendations of a review into the deaths of children believed to have been known to the child protection system in Tasmania.

Ms Giddings said the review was commissioned following the announcement in November last year of sweeping changes to the child protection system, and the release of the review of the death of a child in 2005.

“The death of a child is always tragic, and the loss impacts on the whole community”, Ms Giddings said.

“It is so important that we try to minimise the risk of a child being harmed in our community. The only way we as a Government can do this is to ensure our systems are strong.

“The review I am releasing today found that the child protection system did not fail these children, but nevertheless there are opportunities to learn and to improve.

“The reforms in the child protection system over the last 12 months have resulted in some significant achievements, and I acknowledge the commitment and dedication of child protection staff and management in this change process”.

The review considered the deaths of 10 children in 2005 and 2006 who were recorded on the register of paediatric deaths believed to have been known to the child protection system.

Ms Giddings said it would not be appropriate to release the full findings of the report because it would identify families and other children involved.

However, of the 10 deaths covered by the report:

- two children were found to not be known to the child protection system before they died and their cases were therefore not reviewed;
- three deaths were from natural causes or as a consequence of a disability that was unrelated to the child protection system;
- two children died of sudden infant death syndrome; and
- three deaths were classified as resulting from suspected abuse or neglect.

“None of the three deaths that could be attributed directly to abuse or neglect were on active child protection case load or on the unallocated list”, Ms Giddings said.

“In one case, there were no notifications to child protection after care transferred from one parent to the other 10 months before the child’s death.

“In the second case, there had been no contact or notifications to child protection for 12 months prior to the child’s death.

“In the third case, the child had never been notified to child protection. His siblings were known to child protection, with the last notification concerning them received 10 months prior to the child’s death.”

The review was conducted by Consultant Paediatrician and Director of Women’s and Children’s Services at the Royal Hobart Hospital, Dr Elizabeth Hallam; the former Acting Commissioner for Children, Dr Susan Jenkins; expert child protection consultant Ann Foot; and DHHS Deputy Secretary Human Services, Alison Jacob.

Ms Giddings said while the review committee concentrated on the three deaths that were recorded as suspected as resulting from abuse or neglect, it also investigated the involvement of the other children with the child protection system, even though their deaths were not suspected as being associated with abuse or neglect.

“This wider investigation was designed to identify any factors that may have been involved in their quality of life and any overall systemic issues related to the child protection system.

“In the case of the two deaths not known to the child protection system, one of the children died from a significant congenital disability and the other died of suspected SIDS.

“There is no suggestion that the child protection system could have intervened to prevent these deaths, if they had been notified.”

Ms Giddings said that, as is the case in other states and territories, details of the results of investigations remain confidential so that individual cases are not able to be identified.

“However, the detailed findings have been discussed with staff involved in the cases and the full report has been provided to the Director of Children and Family Services and the Commissioner for Children.

“Briefings have also been held for the Opposition and Greens representatives for child protection services and will be available for interested members of the Legislative Council.”

Ms Giddings noted that reforms to the child protection system had already addressed many of the issues raised in the review’s recommendations.

“For example, Area Liaison Officers have been established in the South East, South West, North and North West of the State, as part of the response to communication and service interaction issues raised in the report.

“These Officers are developing strong networks with other professionals across the health and welfare system”.

Ms Giddings said that the general findings of the report released today could be grouped into four areas:

1. Communication and cross service interaction and cooperation

There was a general finding that communication between child protection staff and other government and non-government services needed to be improved so that assessment of risk could be based on the best available assessment information from those working with the family.

This was particularly the case when multiple people with different specialist skills, such as drug and alcohol specialists or medical practitioners, were working with the family.

The need for those all involved with a child to participate in regular case conferences was identified.

Measures are now in place to ensure these matters are addressed, including the appointment of Area Liaison Officers; regular meetings of area managers and area child protection managers; and formal pathways for liaison between Child Protection and other services have been established.

2. Training and education

There was a general finding that child protection staff needed ongoing training so that they were increasingly skilled in their complex and difficult work and particularly in making risk assessments.

The need for training of other government and non-government workers to improve understanding of child protection issues and roles and responsibilities was also identified.

Measures taken to address these matters include establishing professional learning days and training programs in performance management, Front Line Leadership development and other areas of professional practice.

3. Assessment, review and quality control

There was a general finding that all decisions relating to child protection needed to be constantly monitored and shared with other staff members.

There is a need to ensure regular supervision of all workers by senior staff; provide opportunities for regular review of decisions; and allow for input by specialists in the range of areas that are often involved in making a risk assessment.

Steps taken to address these findings include regular professional supervision of child protection staff; and the establishment of a Quality Improvement Unit in Children and Family Services.

4. Service provision

The relative lack of service options for adolescents with disabilities was identified along with the difficulty of access to community paediatricians. The need to improve consistency of practice across the state was also identified.

Options to improve access to community paediatricians are being developed; consistency of practice has been addressed through the new organisational structure in Child Protection and a case practice audit tool is being developed to ensure consistency.

A Progress Report showing action taken to date against each of the Recommendations is attached. The Report's Preamble and Recommendations are available at www.dhhs.tas.gov.au