

Recommendations of a
Review Conducted
in Relation to the Deaths
of a Number of Children
Involved with the Child
Protection System in Tasmania

Preamble:

During 2005, there were eight children whose deaths were recorded on the register of Paediatric deaths of the Paediatric Committee of the Obstetric and Paediatric Mortality and Morbidity Committee and who were identified to have possibly had some involvement with the child protection system in Tasmania. As at late 2006, there were a further three children listed on the register, who were thought to have been involved with child protection.

With the endorsement of the Council of Obstetric and Paediatric Mortality and Morbidity Committee, as determined by the *Perinatal Registry Act 1994*, a Review Committee was convened in December 2006, to investigate the circumstances surrounding the deaths of ten of the eleven children. A Child Death Review process had previously been undertaken and finalised for one of the children, with recommendations from that Review publicly released in November 2006.

In particular, 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, their families and their service providers. The focus was on identifying any child protection practice issues that may have contributed to the deaths of these children. The initial examination of the files for the children revealed that two of the ten children had had no involvement with Child Protection Services prior to their deaths, nor had there been any family history with the service. For these cases it was determined that there would be no further investigation by the Review Committee. The remaining eight cases were reviewed as per the terms of reference of the Committee.

The Review Committee consisted of Dr Elizabeth Hallam, Consultant Paediatrician and Medical Co-Director, Women's and Children's Services Royal Hobart Hospital – a member and Chair of the Paediatric Mortality and Morbidity Committee; Dr Susan Jenkins, Acting Commissioner for Children (December 2006 to April 2007); 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.

The findings of the Review are confidential as they may identify the children and families 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, Department of Health and Human Services, so that the recommendations are able to be implemented. A copy of the report will also be provided to the Commissioner for Children.

The Review's recommendations are attached.

Recommendations

- (i) Within the new Area Management structure, review and improve the consistency of Child Protection Services provided across the state and provide mechanisms for the sharing of expertise and good practice.
- (ii) 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 responsibility and be resourced for initiating and conducting the process, and ensuring the participation of all relevant professional parties.
- (iii) Facilitate the use of family group conferencing, prior to statutory intervention being taken, through reviewing and simplifying the guidelines and administrative processes. Provide clarification on:
 - who can call a family group conference; and
 - the differences between case and family group conferences.
- (iv) Mandate the requirement that no priority one child protection assessment is to be completed and/or the file closed, without the subject child(ren) being sighted by the child protection officer responsible for the decision.
- (v) Facilitate ways to obtain formal input from professional experts in the relevant field to assist with decision making in complex cases where neglect, bonding/attachment, drug and alcohol, disability, neurodevelopmental or mental health issues are factors .
- (vi) Facilitate the involvement of Family Child Health Nurses and the use of weight charts and medical and developmental assessments, particularly in cases where the physical growth and development of the child are being assessed or there are neglect issues.

- (vii) Assign senior child protection staff to be the first point of contact at CPAARS, responsible for initial triaging of calls and allocation of the case to a worker.
- (viii) For cases involving an overlap of services, establish formal pathways for liaison between Child Protection Services and: Mental Health Services, Alcohol and Drug Services, and Disability Services at a state, area and local level.
- (ix) In cases where services other than Child Protection Services are monitoring and providing support (under section 17b of the Act), develop a formal protocol and pro-forma to make explicit the expectations on each service. Implement a process where roles and expectations are formally discussed, documented, acknowledged and accepted.
- (x) Develop a process for Child Protection Services to provide written advice to caregivers detailing the conditions which need to be fulfilled in order to prevent further action/ intervention from Child Protection Services.
- (xi) Improve communication and understanding about the roles and responsibilities of Child Protection Services and other service providers, through the development of appropriate, area based networking and information sharing forums and, where appropriate, joint participation in meetings.
- (xii) Ensure Area Managers within Children and Family Services take responsibility for organising area-based professional learning days for government and non-government services about child protection issues. Develop training plans to cover essential learning topics, including roles and responsibilities of child protection and other services, and

consideration of risk factors relating to child safety and family connectedness.

- (xiii) Investigate the potential to update Service Agreements to incorporate a requirement, with adequate resourcing, for government funded, non-government organisations to participate in the professional learning activities referred to in recommendation (xi).
- (xiv) Endorse the Early Support Program and improved access to child and family support services for children and families who do not require the intervention of statutory child protection services, but still require significant assistance.
- (xv) Strengthen the tasks being undertaken by the Intensive Family Support Service as part of the redesign of Child Protection business services being undertaken through outsourced contract during 2007.
- (xvi) Ensure that all child protection staff, including senior staff, receive regular, compulsory professional supervision in accordance with the supervision guidelines.
- (xvii) Develop a protocol that ensures that complex cases (where there is a presence of risk factors, for example, the age of the child, domestic violence, alcohol and drugs, mental health problems in parents, child protection involvement with other siblings etc.) are automatically reviewed by a senior child protection worker.
- (xviii) Provide professional development and resources to senior and supervisory child protection staff to enable them to:
 - Provide formal supervision;
 - Coach and mentor staff to improve their critical analysis, research and assessment skills; and
 - Manage performance.

- (xix) Ensure that professional development and training is available to all child protection staff on a regular basis, to improve their capacity to use professional judgement skills, exercise critical research and analysis techniques, and work with “difficult to engage” families and members of the community.
- (xx) Investigate ways to encourage and support child protection staff to continue formal study in relevant areas (for example, early learning and child development).
- (xxi) Review recruitment options and employment practices to improve strategies for appointing Child Protection Services staff.
- (xxii) Implement quality assurance and a safety check process in Child Protection Services, such as regular audits of cases.
- (xxiii) Mandate the provision of an annual Child Protection report to the Commissioner for Children on agreed data and outcomes.
- (xxiv) Implement a process to ensure that there is a timely and documented feedback process to professional and service provider notifiers from child protection to: acknowledge when notifications have been made, and provide any other relevant information.

- (xxv) Develop a business case for the development and appointment of Community Paediatrician/s across the State. The role of Community Paediatrician positions could include:
- a. Providing medical input into the assessment and review of child protection cases;
 - b. Encouraging, promoting and facilitating the role and participation of Paediatricians and General Practitioners in child protection case conferences;
 - c. Contributing to training and further education for child protection staff regarding social, emotional, behavioural and physical development of children;
 - d. Supporting services and communities in developing preventive and early support initiatives for vulnerable families;
 - e. Advocating for at risk children;
 - f. Membership on Child Death Review panels and equivalent processes in Tasmania.
- (xxvi) Work with Housing Tasmania and Supported Accommodation Assistance Program (SAAP) services to develop a proposal/ business case to significantly improve the accommodation options for adolescents with a disability.
- (xxvii) Develop guidelines for shared guardianship options for children with disabilities.
- (xxviii) Work with paediatric services to investigate the feasibility of establishing a multi-disciplinary state-wide clinic for children with chronic neuromuscular disorders.