Executive Summary

In the absence of a formal process for investigating child deaths, the Department of Health and Human Services (DHHS) has utilised the provisions of the *Perinatal Registry Act 1994* to form a subcommittee of the Council of Obstetric and Paediatric Mortality and Morbidity (*the Council*) to conduct child death reviews.

Having become aware of the stillbirth of a child whose family was known to the child protection system, the Secretary requested the Council to form a subcommittee under those provisions, to review the circumstances surrounding the stillbirth.

The focus of the review was on the interactions of individuals and Departments to determine: -

- The range of processes and policies that were available for officers of a Department to work within; and
- Any deficiencies in systems or system barriers that existed at the time of the child death.

The outcomes of a review focus on two main areas: -

- Findings in relation to the matters listed above; and
- Recommendations for system improvement or further action.

The Review Committee in conducting its review: -

- Undertook a file review of the relevant Child Protection File;
- Interviewed staff in Child Protection Services and the Royal Hobart Hospital;
- Received a copy of the report relating to an ultrasound undertaken by Medical Imagining Services; and
- Received a copy of the electronic patient file of the mother from the Royal Hobart Hospital.

Following the completion of the review the Committee makes the following recommendations: -

- Unborn Baby Alerts;
- Home Visits;
- Administrative Support;
- Complex Care Clinics / Antenatal Clinics;
- Tasmanian Risk Framework;
- Staff Advice on the Death of a Child; and
- Implementation of Recommendations.

Unborn Baby Alerts

1 That policies and processes are developed for Unborn Baby Alerts (UBAs) which includes the following minimum requirements: -

   a) The use of electronic processes for managing UBAs wherever possible;

   b) Electronic recording of UBAs on patients' digital files;

   c) Automatic generation of alerts within specified time frames when any of the following occurs: -

      i. Failure to make an appointment at the antenatal clinic when an UBA exists;

      ii. Cancellation of an appointment when an UBA exists; and

      iii. Failure to attend an appointment when an UBA exists.

   d) The alerts be received by the Antenatal Clinic, Complex Care Clinic and Child Protection Liaison Officer;

   e) An expectation that where a mother is subject to an UBA and has either not made an appointment with the antenatal clinic, failed to attend the clinic or cancelled an appointment with the clinic there is a formal process for follow up;

   f) Assigning responsibility for informing the mother, in a positive manner, when an UBA has been generated; and

   g) Where a mother is the subject of an UBA and there is currently a sibling on case load, the case for that sibling remain open until the assessment of the unborn child is completed.

Note: The Committee is supportive of the flow for UBA processes that was provided to the committee by the Child Protection Liaison Officer, subject to the qualifications outlined in this report.

Home Visits

2 That where a mother is the subject of an UBA and fails to make an appointment, cancels appointments or fails to attend a appointment that: -

   a) contact be initially made by phone; and

   b) a policy and protocol be developed for the allocation of responsibility for conducting a home visit where contact can not be made by phone. The allocation of this responsibility might be shared between the following persons depending on circumstances outlined in the policy: -

      i. Child Health and Parenting Centre Nurse;

      ii. Social Worker from Family Support Service;

      iii. Case Manager of any sibling currently on caseload; or

      iv. Response Team Child Protection.

Administrative Support

3 That following system changes, as suggested in this report, consideration is given to reviewing the administrative support requirements in the complex care unit.

Complex Care Clinics / Antenatal Clinics

4 That consideration be given to the following: -

a) The operation of antenatal clinics in local areas, eg Community Health Centres or soon to be established Child and Family Centres;

b) The appropriateness of the times on which complex care clinics are conducted;

c) Improving the capacity of the Antenatal Social Worker to conduct home visits;

d) Training for medical staff who are running antenatal clinics in complex issues and warning signs and significance of an UBA; and

e) The allocation of a Substance Abuse Worker to the Complex Care Clinic to educate staff and assist in helping addicted mothers to stay free of drugs during pregnancy.

Tasmanian Risk Framework

5 That in any future revision of the Tasmanian Risk Framework consideration is given to: -

a) Giving greater weight to the element of cumulative harm in a structured decision-making process;

b) Including the existence of an UBA as a specific risk factor with appropriate evidence-based weighting; and

c) Greater reliance on conducting collateral enquires to substantiate any self reports in relation to drug use and family violence incidents.

Staff Advice on Death of a Child

6 That a policy and processes are developed for informing all Child Protection Staff, who have had professional contact with a mother's case during the pregnancy, of a baby's miscarriage, stillbirth or perinatal death.

7 That the procedure for informing staff of the death of a child be timely.

8 That the policy includes the provision of avenues for staff to manage emotional responses following a critical incident of this nature.

Implementation of Recommendations

9 That a working group be established under the responsibility of the Director Disability, Children, Youth and Family Services for the purpose of implementing these recommendations.

10 That the working group include representation from the Royal Hobart Hospital and Children's Services.

11 That the working group report to the Deputy Secretary Human Services within six months on the implementation of recommendations.

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