Secretary

Department of Health and Human Services

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COR 2013 004288

Ms Mikaela Meggetto
Coroner's Registrar
Coroner's Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Ms Meggetto

Investigation into the death of Maria Liordos
Court reference: COR 2013 004288

I write in response to your letter of 2 August 2017, which enclosed a copy of Coroner's Audrey Jamieson's Finding with inquest into the death of Maria Liordos, and refer to your request for a written response to the recommendations.

The Department of Health and Human Services (the department) accepts and will implement all three of the recommendations made and provides the following response:

Recommendations One and Three
With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, but the process for accessing the DHHS After Hours Child Protection Emergency Service in fact impedes the contract care workers from seeking an urgent warrant, I recommend this system be reviewed.

With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, I recommend that the DHHS review the efficacy of the range of means of detection/apprehension tools that are available to Child Protection and its Agents such as but not necessarily limited to, the use of the Missing Persons reports to Victoria Police and the use of a "Red Flag" system of the Police LEAP system as was the subject of a Recommendation made following an Inquest into the Death of Krisinda Smart.

To implement recommendations one and three, the department has commissioned a consultancy to conduct an end-to-end review of existing procedures and practices when children are missing. This includes an examination of processes relating to missing person's reports, incident reporting and seeking and executing warrants. As part of the review, consultation has taken place with the Children's Court, Victoria Police, out-of-home care providers and divisional child protection practitioners and managers.

The review will be completed by early November 2017 and will include practical and actionable recommendations about how current practices can be improved, including the process for obtaining warrants, and how new technology and flags on various databases may assist.

Recommendation Two
With the aim of preventing like circumstances where children/adolescents at high risk require urgent detection and apprehension, but the process for accessing the DHHS After Hours Child Protection Emergency Service in fact impedes the contract care workers from seeking an urgent warrant, I recommend that contracted agencies such as Westcare ICMS be provided with a dedicated direct telephone line to access DHHS After Hours Child Protection.

Since Maria's death substantial improvements have been made to the timeliness of After Hours Child Protection Emergency Service responses. In the 2016-17 financial year, the average call response time on the general after hours telephone line was one minute and 16 seconds.

This improvement addressed concerns regarding call wait time when seeking a warrant for a missing child. A new dedicated and direct telephone line has been created for community service organisations, contracted by the department to undertake case management of children and young people in care, to contact the After Hours Child Protection Emergency Service. The new telephone line is anticipated to be implemented by 26 October 2017. This will prevent any disincentives and barriers to requesting a warrant.

Yours sincerely

Kym Peake
Secretary

20 / 10 / 2017