Department of Human Services

Secretary

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Ms Selina Pasut
Coroner's Registrar - Mildura
Coroner's Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Ms Pasut

Inquest into the death of Rory [redacted]
Court reference 2510/2005

I write in response to your letter dated 14 December 2011, and received on 20 December 2011, enclosing the inquest findings and recommendations made by the Coroner under the *Coroners Act 2008*. I also write in response to your request for a written response to the recommendations.

The Department of Human Services ('the department') has carefully considered the recommendations addressed to the department, being recommendations one to four, and provides the following responses.

Recommendation One

That where a case has not been investigated by the Department of Human Services or has been investigated and a significant risk to the wellbeing of children has been identified, in the event the family leave the jurisdiction without notifying the department the file should remain open and every endeavour be made to ascertain the location of the family. There should also be periodic reviews of such cases whilst the whereabouts remain unknown.

Department response:

An alternative to the Coroner's recommendation will be implemented.

The department notes the Coroner's criticism of the failure by child protection to make active attempts to locate the family (during report three in 2004) prior to case closure.

State Government Victoria

The department is of the view that implementing the Coroner's recommendation as is, will not in itself improve attempts to locate children/families and as such will not in isolation of other strategies increase safety for children.

Recognising the intent of the recommendation the department proposes to strengthen the current practice to include a checklist of services to be contacted prior to closing a case involving a missing family to assist in locating a family including utilising the Commonwealth Medicare/Centrelink protocol, which enables contact with federal government departments.

Recommendation Two

That information as to children whose whereabouts are unknown be maintained by the Department of Human Services and accessible to appropriate authorities such as high-ranking members of the police force and Principals of schools.

Department response:

An alternative to the Coroner's recommendation will be implemented.

Currently the information about children whose whereabouts are unknown is maintained by the department and contained in an alert function within the CRIS client file management system which is only accessible by authorised staff.

The department is unable to accept recommendation two, as in authorising other parties such as police and principals to use the CRIS system, it would allow those parties to conduct a search across the entire CRIS system, allowing them access to a level of client confidentiality, which legislation does not permit.

Instead, where police or school principals have concerns for the wellbeing of children or where there are indications of abuse, it would be more appropriate for them to make a referral to Child FIRST or a report to child protection. In both instances a CRIS check would be undertaken by ChildFIRST or child protection staff who are authorised to access CRIS and take appropriate action in respect of a child's safety and wellbeing.

An amendment to CRIS will be made to include a new alert field of 'family missing' to make more explicit concerns for children where an investigation is unable to be conducted or completed due to a family's whereabouts being unknown.

In conjunction with the changes which will be implemented in response to recommendation one, these measures will address the concerns identified by the Coroner in this case.

Recommendation Three

That the Department of Human Services ensure a state wide practice of a worker being made responsible to oversee and liaise on a monthly basis with outside organisations that are engaged to provide assistance to clients of the Department.

Department response:

An alternative to recommendation three has been implemented or is underway.

Since Rory's death in 2005 there have been significant developments in child protection practice and in the delivery of services by community organisations which address the intent of recommendation three:

- The implementation of the *Children, Youth and Families Act 2005* and the introduction of ChildFIRST has enabled the sharing of governance and responsibility for services for vulnerable children and families between child protection and the community service sector. Under ChildFIRST, community based child protection workers ('CBCPW') play a

critical role in working with and between child protection and community based family support services, and alliances of services that work with vulnerable families, to build collaborative relationships, focus on engagement with families, and promote a shared understanding of risk assessment. The CBCPW role meets the intended purpose of the Coroner's recommendation and had it been in place at the time of Rory's death would have played an active role with St Luke's Anglicare the family support service involved with family.

- The FaPMI (Families where a parent has a mental illness) strategy was launched in 2007 to reduce the impact of parental mental illness on all family members and, in particular, dependent children. The strategy is funded by the Division of Mental Health, Drugs and Regions in the Department of Health. The strategy was enhanced in 2008 to include alcohol and other drug (AOD) treatment services. FaPMI coordinators are located across 11 metropolitan and regional area mental health services (AMHS) and provide secondary consultation and professional development to Child FIRST and family services practitioners. Parental mental health and drug and alcohol abuse were issues in this case.

- Practice guidance to child protection practitioners provides detailed information about the process of making a referral to a community service. The practice guidance was developed in April 2007, and is numbered 1042, and titled *Making effective referrals*. It emphasises the need for child protection to ensure that the agency or professional understands the specific tasks or assessment required by a referral, includes the importance of information exchange and notes, in particular, where involvement by the service with the family is terminated, the circumstances in which reporting back to child protection may be required.

- The department has developed a comprehensive proposal under the *Protecting children, changing lives* strategy to substantially remodel the Victorian child protection workforce. The new workforce structure will provide practitioners with more support and practice guidance through senior practitioners and practice leaders who will enhance and impart knowledge and skills in the area of assessing risk where parental drug and alcohol use is a feature.

Recommendation Four

That the Department of Human Services workers receive education centred on drug and alcohol dependency with a view to being able to readily identify these issues and how best to deal with people suffering such effects.

Department response:

The Coroner's recommendation is accepted and will be considered as part of a future training schedule in 2013 once other priorities have been addressed.

Professional development in child protection is delivered through professional education programs, clinical supervision and consultation, and practice guidance.

No specific state-wide alcohol and other drug (AOD) training is currently offered, but is delivered in some regions by local drug and alcohol providers who also provide specialist consultation to child protection practitioners.

The proposed workforce structure and reforms will provide practitioners with more practical support through the provision of senior practitioners and practice leaders which will enhance and impart knowledge and skills in the area of parental drug and alcohol use.

The Specialist Practice Resources (SPRs) developed by the Office of the Principal Practitioner support the *Best interests case practice model* and focus on risk assessment with complex families including where parental alcohol and other drug abuse is evident. This professional development series will continue throughout 2012.

In the meantime, regions will be asked to provide details of the training and consultation arrangements in place with AOD providers, and those regions without current arrangements will requested to develop ongoing systems to ensure practitioners have access to consultation which reflects local trends and place based approaches.

While alternative approaches are proposed in response to recommendations one to three, I am confident the proposed strategies will address the Coroner's findings and concerns.

Yours sincerely

Gill Callister
Secretary