Judge Coate.

Registrar (closed)

Department of Human Services

Secretary

RECEIVED
30 NOV
CORONERS COURT

50 Lonsdale Street
Melbourne
Victoria 3000
GPO Box 4057
Melbourne
Victoria 3001
Telephone: 1300 650 172
Facsimile: (03) 9096 9220
www.dhs.vic.gov.au
DX210081

28 NOV 2011

e2524571

Mr Liam McNaughton
Coroner's Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000

Dear Mr McNaughton

Inquest into the death of Aaron [redacted]
Court reference 1430/08

Further to my letter dated 15 September 2011, in response to the recommendations made by her Honour, Judge Coate regarding the death of Aaron [redacted], I write to respond to recommendation one.

In my letter dated 15 September 2011, I responded to recommendations two and three and advised that the Department of Human Services ('the department') was considering recommendation one and would further respond within two months.

The department provides the following response to recommendation one.

Recommendation one

To enhance the opportunities to identify early intervention for children at risk of harm, the department give serious consideration to imposing a mandatory practice standard for Victoria that requires a unit manager or above to review the proposed department response to any child protection notification once that child's history accumulates three notifications, but has not resulted in a response beyond voluntary intervention. If a response beyond voluntary intervention is not deemed appropriate the unit manager (CPW5) should record an explicit rationale for this decision on the file.

State Government Victoria

Department response

The department is unable to accept this recommendation and proposes an alternative.

The department has closely reviewed Her Honour's findings and understands that Her Honour's intention in making recommendation one is to improve the consideration given to cumulative harm and statutory intervention where appropriate, and to prevent case drift in child protection practice.

The department has in place several standards which provide for comprehensive case review inclusive of these considerations, by a unit manager at key points of child protection involvement.

Currently, a unit manager is required to review every third and subsequent report received in 12 months where the previous reports have not been investigated. The Client Relationship Information System (CRIS) prompts the relevant manager to ensure that this review occurs in the intake phase. In 2010-11, approximately 5000 such reviews were undertaken.

Recommendation one proposes that a unit manager review the proposed department's response to all third reports in the life of a case that have not resulted in a protection application.

Recommendation one, as worded, extends the scope of the reviews currently undertaken in the intake phase and the department has undertaken modelling to identify the number of reviews required if recommendation one was to be accepted.

The modelling was done based on all reports received in 2009-10 so as to allow time to count the outcome of the reports and what proportion progressed further into the child protection program. The modelling showed that 17,149 reviews of 13,870 children would have been required for the 2009-10 period.

Similar data for 2010-11 would yield greater numbers due to a significant 15% increase in the number of reports received to child protection. The total likely number of reviews required based on this increase could be as many as 20,000 for 2010-11 year.

A review as proposed in recommendation one would involve consideration of all past child protection involvement, regardless of the concerns identified in the reports and the period of time between reports, and the recording of an explicit rationale where a response beyond voluntary intervention is deemed as not being required.

The program's capacity to review the individual circumstances of 20,000 children is limited and is likely to lead to this task becoming the primary function of unit managers, thus significantly reducing their capacity to manage other critical activities.

Broadening the scope for unit manager review during the intake and investigation phases, as implied in recommendation one, would not only impose a significant increase in workload demand for the assigned manager, but may not address the concerns identified by the Coroner nor achieve the intent of the recommendation.

In child protection practice, the decision to pursue legal intervention is generally made during the investigation of a report, which includes sighting the child, when a report is substantiated, or at the conclusion of the protective intervention phase.

In addition to the current practice of unit manager review at intake for third reports not investigated in 12 months, there are practice and KPI requirements for unit managers to review cases open greater than 90, 120 and 150 days, and endorse ongoing involvement with statutory intervention.

The department considers the comprehensive case review that these measures involve, to be more effective in focusing intervention in child protection practice, with particular consideration given to cumulative harm, preventing case drift and the need for statutory intervention.

Currently, the CRIS system does not prompt or measure compliance with this standard. Aaron Edwards' client file shows that the 90 and 120 day review requirements during the last period in which child protection were involved with him were not complied with.

The department is proposing as an alternative to recommendation one, to build into CRIS a suitable modification, which would prompt and measure compliance with this standard, and thereby strengthen practice.

The department has recently proposed workforce reforms which, if implemented, will see the introduction of practice leaders, including dedicated practice leaders in the intake environment whose role will include routine sampling of threshold decisions and a focus on strengthening responses to cumulative harm.

The introduction of the *Specialist practice guide on cumulative harm* developed by the Office of the Principal Practitioner in 2010 also strengthens child protection practice and consideration of the impact of cumulative harm.

The department considers that these measures meet the intent of recommendation one in the light of Aaron's tragic death.

Yours sincerely

Gill Callister
Secretary