AN AUDIT & REVIEW OF THE

INFANT RISK ASSESSMENT AND RESPONSE DECISION POLICY AND PROCEDURE

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EXECUTIVE SUMMARY

INTRODUCTION

On 20 November 2020, State Coroner, Judge John Cain provided finding into the death of Baby S with the recommendation the Secretary of the Department of Families, Fairness and Housing (the Department):

'*…conduct a review and audit of the updated Child Protection policies and procedures listed…., to determine whether these changes have effectively improved Child Protection's response to and management of high-risk infants. In addition, I recommend that the Secretary to the Department conduct a compliance audit to ensure that staff are complying with the policies and procedures listed*'.

The policy and procedures referenced within the finding are related to Child Protection's high risk infant policy, procedures and practice.

In June 2018, changes were introduced with the aim of enhancing consistency in Child Protection's management of children under two years of age. These changes were made in recognition the physical fragility, social invisibility and developmental dependence of young infants significantly increases their vulnerability and risk of harm.

COVID AND IMPACT ON CHILD PROTECTION OPERATIONS

Operational guidelines were developed in response to the Coronavirus (COVID-19) pandemic. These changes were effective immediately as of 25 March 2020 and direct face-to-face contact with children and families occurred as necessary. Children and families were engaged through the use of technology unless otherwise indicated and face-to-face visiting continued for those children and families that required that type of contact.

In May 2020, Practice Directions changed to reflect further prioritisation of infants and risk assessment to determine visiting regimes over the remainder of COVID period.

THE AUDIT AND REVIEW METHODOLOGY

A compliance audit and review was conducted throughout November 2021. Activities comprised a file audit of 20 infants' Client Relationship Information System (CRIS) files, focus group discussions with child protection practitioners, specialist practitioners and managers, and review of the policies and procedures referred to in the coronial findings.

ARE CHILD PROTECTION PRACTITIONERS COMPLYING WITH THE PROCEDURE?

Compliance with the procedure varies. Overall, it ranges between 'partially to generally compliant'[1], as follows:

- Practice is generally compliant with requirements to make and review the infant response decision. Classification decisions were made/reviewed at all mandatory points throughout the audit period for all infants. There was no evidence of an Intensive Infant Response (IIR) classification being downgraded by an incorrect delegate.
- CRIS files showed good compliance with the requirement to allocate all IIR infants and prioritise allocation of Infant Response (IR) infants.
- Visiting frequency was fully compliant or generally compliant for just under half the infants in the sample group. Compliance was higher for IIR infants and in metropolitan areas. A small number of visits were conducted virtually. An internal report that measures visit compliance is available on a weekly basis to assist areas.
- Checks of infant sleeping arrangements were referenced for 19 of 20 infants, for most visits.
- Sixteen infants (80 per cent) were subject to one or more consultations with practice leaders (PL) or principal practitioners (PP) during the audit period – this is in addition to PL/PP involvement with IIR infants via IIR meetings and panels.
- Multiple support services addressing multiple infant/parental needs were involved with most infants/parents. However, compliance with case conferencing requirements was only partial, better for IIR infants than IR infants.
- There was evidence of varying levels of IIR meeting involvement for 11 of 13 IIR infants (85 per cent) during the audit period.
- The infant response decision (and therefore the risk assessment and case management) for IIR infants was reviewed more frequently because of the requirement they be subject to PL/PP and IIR meeting/panel consultation and oversight.

[1]For the purpose of this audit, **generally compliant** meant the activity was done when and as described in the procedure most of the time, **partially compliant** meant the activity was partially done as described in the procedure and/or done only some of the time.

HAVE THE CHANGES IMPROVED CHILD PROTECTION'S RESPONSE TO INFANTS?

It was not within the scope of the project to compare past and current high risk infant policies, procedures and practice compliance. That said, a number of the compliance audit findings and observations of focus groups and auditors go towards responding to this question and highlight potential areas for further consideration.

- A good level of support for the policy and procedure was apparent, which is insufficient to deliver a good service but still very important. Focus group participants thought the requirements represented good practice when properly implemented. Participants indicated it was difficult to fully comply with all of the requirements all of the time given high workloads, staff vacancies, staff turnover and insufficient experienced practitioners. The pandemic has made 'everything harder and more complicated'.
- Focus group participants reported classification decisions are subjective and decisions about whether infants are classified IR or IIR vary depending on the decision maker, even across teams in the same area. There appears to be a 'middle group' of infants for whom the distinction between IR and IIR is sensitive and dynamic. This is unsurprising, as family violence, parental substance misuse and parental mental health issues, usually in combination, were risk factors common to most infants living with parents in the sample group. Further clarification of the distinction between IR and IIR may help promote the desired level of consistency.
- Infants classified as IR for whom there is no additional consultation and review by PL/PP were identified as a 'worrying group', as they have fewer 'eyes on them'.
- Valuable input from PL/PP, IIR meetings and panels was evident.
- All focus group participants requested more training for both new and experienced practitioners about infant development and infant practice.

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THE INFANT RISK ASSESSMENT AND RESPONSE DECISION POLICY AND PROCEDURE

The Infant Risk Assessment and Response Decision - Procedure[2](the procedure) outlines the policy and additional practice requirements for all children under the age of two years, from Investigation and Assessment phase to Case Closure phase. Additional information is provided in the Infant Risk Assessment and Response Decision - Advice [3] (the advice).

The procedure and advice were introduced in June 2018 to strengthen service for all infants. The intention is that all infants receive an 'infant response' and those identified most at risk and therefore requiring a higher level of service receive an 'intensive infant response'.

The policy and procedure require child protection practitioners to:

- Classify the necessary level of response as 'infant response' (IR) or 'infant intensive response' (IIR) at substantiation and review the classification at mandatory points throughout the life of the case.
- Follow the service requirements for each classification in relation to:

- Allocation
- Visits and interactions
- Case conferences and care teams
- Consultation with practice leaders and principal practitioners
- Case reviews
- Infant intensive meetings and infant intensive panels.

Three tools support the procedure.

1. An Infant Response Decision Tool (IRDT) provides prompts and questions to guide information gathering, analysis and judgements about risk to infants and the appropriate level of service response.
2. Two templates:
    - for the infant intensive meeting and
    - the infant intensive panel

    both including prompts and questions compatible with the IRDT, support documentation of risk assessment, risk management activities and the case

2 Document ID number 1601, version 5, 20 November 2021.

3 Document ID number 2401, version 4, 20 November 2021.

plan to inform the meeting/panel about the circumstances of the referred infant.

3
METHODOLOGY

Methodology included a file audit of compliance with key aspects of the procedure and focus group discussions with child protection practitioners and managers about their experience of implementing the procedure

File auditing occurred in the first two weeks of November 2021 and focus group discussions in the third week. Auditing was shared by an independent consultant and a practice improvement leader from the Department. Focus group discussions were conducted by the independent consultant.

THE SAMPLE GROUP

Twenty infants' CRIS files were selected from all infant CRIS files open on 1 October 2021. Five infants' CRIS files were randomly selected from each of four groups:

1. Rural area infants classified as IR
2. Rural area infants classified as IIR
3. Metropolitan area infants classified as IR
4. Metropolitan infants classified as IIR.

Selected infants' CRIS files were from 11 departmental areas.

Whilst the intention was to examine an equal number of files of infants requiring an IR response and an IIR response, thirteen fell into the IIR category as three classified as IR as at 1 October 2021 were classified as IIR for the majority of the audit period.

Infants subject to audit were aged between 3.5 months to 1.11 years at the audit end date (1 October 2021).

Eleven infants (55 per cent) had been subject to one or more unborn reports.

Child protection involvement was in Protective Intervention phase or Court Order phase by the audit end date (1 October 2021), as follows:

- Two infants in Protective Intervention
- Eleven infants subject to Interim Accommodation Orders, eight to mother, three to suitable person
- Six infants subject to Family Preservation Orders, one in out of home care (as at 1 October 2021)
- One infant subject to CBSO living in out of home (kinship) care.

Risk factors common to most infants circumstances included family violence, parental substance misuse and parental mental health issues, usually in combination, as well as environmental neglect for some.

THE AUDIT TOOL

An audit tool was developed by the consultant in consultation with the Department. It was based on the procedure.

Procedures are the 'go to' instructions for child protection practitioners, practice specialists and managers, about what they are to do. In this case, the procedure is more succinct than the advice and some variation between what is required in the procedure and the advice is apparent. This is discussed throughout the report where relevant[4].

The tool uses a four-point scale to describe compliance with key aspects of the procedure:

1. Fully compliant when the activity is done when and as described in the procedure.
2. Generally compliant when the activity is done when and as described in the procedure most of the time.
3. Partially compliant when the activity is partially done as described in the procedure and/or done some of the time.
4. No evidence of compliance when no evidence could be found in the CRIS file.

The tool can be found at **Attachment 1.**

AUDITING OF CRIS FILES

The tool was applied to practice activity documented in the CRIS files for a maximum period of 6 months up to 1 October 2021; a shorter period if the current report was opened after 1 April 2021. The shortest period of practice audited was 3.5 months.

Auditors briefly reviewed the majority of case notes, documents and other relevant data in CRIS files to look for evidence of compliance with requirements during the audit period. Given the limited timeframe for completion of the audit, the review of each file was brief. In-depth analysis of the quality of assessment and decision making was not feasible in the time available.

FOCUS GROUP DISCUSSIONS AND INTERVIEWS

Three focus group discussions were conducted with:

- Advanced child protection practitioners (four)
- Practice leaders and principal practitioners (11)
- Team managers and senior supervisory practitioners (five).

Interviews were conducted with area Child Protection Directors (three).

Focus group participants and interviewees represented 11 departmental areas (six metropolitan and five rural).

A list of focus group questions is at **Attachment 2.**

[4] 'Fully compliant' indicates all of the requirements listed were met all of the time. 'Generally compliant' indicates that most of the requirements were met most of the time. 'Partially compliant indicates that some of the requirements were met some of the time'.' No evidence of compliance' indicates that auditors were unable to find any documented reference to the requirements in the CRIS file.

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FINDINGS

Findings are based on file audit results, focus group feedback and review of the policy and procedure documentation.

INFANT RESPONSE DECISIONS

The policy is that all infants must be classified as requiring an IIR or an IR, based on a risk assessment, initially at the point of substantiation and subsequently at mandatory review points.

WHAT DOES THE PROCEDURE REQUIRE?

Infants are to be first classified as IR or IIR at the point of substantiation at the completion of the Investigation and Assessment phase risk assessment.

The classification must then be reviewed, based on risk assessment, when a new court order is made, the case plan is reviewed, a new familial allegation is received, and a closure decision is considered.

The response decision for IR infants is to be reviewed on receipt of new information that increases or decreases risk.

Infants classified as IIR cannot be closed.

Team managers or above are delegated to make classification decisions. Downgrades from IIR to IR are only to be made by practice leaders or above.

Practitioners are to use the IRDT to guide initial investigation and consider using it to assist making the infant response decision.

WHAT DID THE CRIS FILES SHOW?

- Overall, CRIS files show general compliance with this part of the procedure, as follows:
  - Classification decisions were made/reviewed at all mandatory points throughout the audit period for all infants.
  - Classification decisions appear to have been made by the correct delegate[5]. There was no evidence of an IIR classification being downgraded by an incorrect delegate.
- Written rationales for each classification decision were evident in all but one case. Written rationales, particularly when unchanged, were usually succinct.

[5] Some classification decisions were apparently entered by administration staff which occurs in some areas following IIR meetings/panels when administration staff are tasked with entering the IIR meeting/panel minutes in the CRIS file once the meeting chairperson has endorsed. Sometimes the role/delegation level of the person entering the classification decision was not evident in the CRIS file.

- Three infants' classifications were changed during the audit period in response to new information and further assessment.
- Both auditors agreed with most classification decisions. Auditors were uncertain about five decisions (pertaining to four infants). These matters were referred to the Office of Professional Practice for consideration.
- In relation to evidence of use of the IDRT to inform the initial investigation plan and classification of the infants for whom a substantiation decision was made during the audit period (14 infants):

- This was difficult to measure as there was no direct reference to use of the IDRT in any CRIS files (this is not required).
- Ten files included an investigation plan. In an additional four files it was evident varying levels of planning for the investigation post the infants' birth had following unborn reports.
- Auditors considered there was 'indirect evidence' of use of some of the IDRT prompts/concepts to document risk assessment (in so far as information was organised in relation to vulnerability of the infant, pattern and severity of harm, strengths and protective factors and factors that increase/decrease harm likelihood) to varying degrees in at least 10 of these cases.

WHAT DID THE FOCUS GROUPS SAY?

- Participants noted that classification decisions are subjective. Decisions about whether infants are classified as IR or IIR may depend on the decision maker, even across teams in the same area.
- The IDRT is considered *useful but not used enough.* (CPP 4)
- There are varying local area requirements about who is to be consulted about classification and when. Some local arrangements have been implemented in response to adverse events. For example: in one area the default position was all incoming infants were classified as IIR until the practice leader was consulted; and, in another area, an IIR classification can only be downgraded by the IIR internal meeting not by the practice leader or principal practitioner in between monthly IIR meetings.
- Regularly reviewing an infant's classification is good practice because it helps keep risk assessment 'alive'.
- There was concern some infants classified as IR for whom no additional consultation is sought/provided from PL or PP, (as this is optional and area arrangements vary) may be 'flying under the radar':

  You need to have the right eyes on the case (Area Child Protection Director).

- The decision to substantiate (within 28 days) may be too late as the first mandatory point to make the infant response decision.

AUDITORS OBSERVATIONS

- The response decision (and therefore risk assessment and case management) for infants classified as IIR was reviewed more often than the decision for IR because of the requirement for IIR infants to be reviewed by PL/PP and IIR meetings and panels.

- Entry into out of home care usually led to an IR classification, unless there were specific concerns about the placement, for example, when infant was on Interim Accommodation Order[6] (IAO), to a grandparent and the parent was living in the same home.
- There appears to be a 'middle group' for whom the distinction between IR and IIR is sensitive and dynamic. This is unsurprising, as family violence, parental substance misuse and parental mental health issues, usually in combination, were risk factors common to most infants living with parents in the sample group. Further clarification of the distinction may be required to promote the desired level of consistency.
- CRIS does not compel practitioners to enter answers to specific IDRT questions to document risk assessment or provide a rationale for the response decision. This makes it difficult to confidently estimate the extent to which the tool was used.

ALLOCATION OF INFANTS

The policy is that infants requiring an IIR will have an allocated child protection practitioner and IR infants awaiting allocation will be prioritised for allocation.

WHAT DOES THE PROCEDURE REQUIRE?

Infants classified as IIR are to be allocated the same day or the next business day. Infants classified as IR are to be 'prioritised' for allocation.

WHAT DID THE CRIS FILES SHOW?

- CRIS files showed good compliance with this part of the procedure for all infants, as follows:
- 18 of 20 infants were allocated for the entire audit period.
- Two IIR infants were designated as awaiting allocation during the audit period, one for 12 days and one for 8 weeks. In both cases, file notes indicate ongoing activity. The infant awaiting allocation for 8 weeks was visited on 7 occasions and the case actively worked by team manager during this period. For some periods, this infant was also allocated to the team manager.

WHAT DID FOCUS GROUPS SAY?

- High vacancy rates, staff turnover impact on allocation capacity.
- It is strongly preferable to allocate infants, particularly IIR infants, to experienced Child Protection Practitioner (CPP) 4 staff, however there is a shortage of suitable recruits for these roles.

6 An IAO is an order that provides for where a child who is subject to a protection application will reside (or be placed) until the protection application is determined by the court.

AUDITORS OBSERVATIONS

- All infants were prioritized for allocation.

VISITS AND INTERACTION WITH INFANTS & THEIR FAMILIES

The policy is for IIR infants to receive a minimum of weekly visits from a case practitioner and IR infants to receive at least fortnightly visits.

WHAT DOES THE PROCEDURE REQUIRE?

There are multiple requirements regarding visits and interactions, and recording these, in the procedure:

- Infants classified as IIR are to be visited in person weekly at a minimum.
- Infants classified as IR are to be visited in person fortnightly at a minimum.
- Visits are to include face to face contact with the parent/carer and the infant to gather information and assess the progress of the case plan.
- Where there are allegations of physical abuse or neglect, the infant is to be visually examined by the child protection practitioner. A forensic medical examination is to occur if visual examination indicates non accidental injury. A medical examination is to occur for non-crawling babies with bruising.
- A SIDS safe sleeping assessment is to be undertaken at each visit for all infants until sleeping arrangements are assessed as consistently safe.
- Visits/interactions are to be recorded in CRIS using the Client Visit note type.

WHAT DID THE CRIS FILES SHOW?

- Visiting frequency was either fully or generally compliant for nine infants. It was partially compliant for 11 infants.[7]
- Compliance was higher for IIR infants and in metropolitan areas:
  - IIR infants: one case fully compliant; six cases generally compliant (note: most missing only two visits of 26 visits required) and six cases partially compliant.
  - IR infants: two cases fully compliant, five cases partially compliant.
  - Metropolitan areas: six cases fully compliant, four cases partially compliant.
  - Rural areas: one case fully compliant, two cases generally compliant and seven cases partially compliant.
- A small number of visits were conducted virtually.

[7] For the purpose of this audit, 'fully compliant' means 100% compliance with frequency required, e.g., for IIR infant cases open for the entire 6-month audit period, 26 visits were required. For the purposes of this audit, 'generally compliant' in relation to visiting frequency was set at 80% of required visits occurred. Partial compliance means less than 80% of required visits occurred.

- Reference to face-to-face contact with infants, as well as parents/carers was evident in most Client Visit case notes for 19 of 20 cases, though sometimes case notes were very brief (see below).
- In relation to requirements about visual examination and medical examination of infants:

- There was no evidence of infants requiring visual examination or forensic medical examination, due to reports of physical abuse or neglect, during the initial investigation phase.
- In three cases where concerns were raised about marks on an infant, they were promptly visually examined by child protection practitioners and general practitioners (no concerns noted after medical examinations).

- In relation to the requirement to regularly conduct SIDS safe sleeping assessments, auditors found:

- Checks of infant sleeping arrangements were recorded for 19 of 20 infants for most visits conducted. There was only one infant, an IIR, for whom the auditor could find no reference to a SIDS safe sleeping check in case notes.
- In cases where SIDS safe sleeping checks were not evident at every visit, there was no documentation found to state sleeping arrangements had been assessed as consistently safe.

- Compliance with case noting requirements was as follows:

- Case note descriptions of visits fully or generally complied with documentation requirements in 12 of 20 cases, in so far as these case notes referred to: the infant (one or more of: appearance, mood, behaviour, current routines, interactions with parent's/carer and CPP); the parent and others in the home; the home environment including sleeping arrangements; and discussions about protective concerns and case plan progress. However, descriptions were often brief.
- In eight cases, compliance with case note requirements was assessed as 'partial' because descriptions were too brief, sometimes only a heading, a single sentence or a few dot points. Whilst this indicated visiting and observation requirements had been met, it was insufficient to get a picture of the infant, the parent/carer, their interactions or what else was going on in the home as intended by the policy and procedure.

- There is a clear tendency for the focus of case notes (the majority of information) to be about the parent.

WHAT DID THE FOCUS GROUPS SAY?

- There was unanimous and strong endorsement for the importance of regular child protection visits to the infant and parent/carer in the infant's home:

> *"The weekly visit requirement for IIR is necessary because they are the most vulnerable. It must be prioritised and can't be let slip. Even in times of high workload it is the part of the IIR procedure that is non-negotiable."* (CPP 4 group)

- Some teams/areas struggle to regularly meet weekly/fortnightly visiting requirements, despite 'best efforts' and persistent focus on this key performance indicator.
- Sometimes home visits are conducted by duty workers or other team members who are in the vicinity of the infant's home, to sight the infant and their sleeping arrangements, in order to meet the weekly/fortnightly requirement. These visits may be very brief. Some question the value of these visits.
- Requirements to document client visits contemporaneously, if possible before the end of the working day, in the context of heavy workloads, necessitates brief recording.
- Regular checking of infant sleeping arrangements should always occur as sleeping arrangements can change between visits.

AUDITORS OBSERVATIONS

- The weekly and fortnightly visiting requirements are one of the most prominent features of the procedure. Visiting compliance is measured by the program and monitored on a weekly basis. The department's counting rules are very strict, not allowing for gaps any longer than 7 days (for weekly visits for IIR infants) or 14 days (for fortnightly visits for IR infants).
- Focus groups strongly supported the need for weekly visiting of IIR infants in particular, in spite of the additional workload demands this generated. Some held the view that other specialist child and family practitioners/services, such as Enhanced Maternal and Child Health Nurses or the Family Preservation and Reunification Response program could be tasked with supporting compliance with the minimum weekly/fortnightly visiting requirements, but views about the appropriateness of this were mixed.
- All focus groups emphasized the need for more training for practitioners at all levels (entry level through to specialist practitioner level) in relation to infant development and infant practice, including training in relation to practical skills such as SIDS safe sleeping checks

CONSULTATION WITH PRACTICE LEADERS & PRINCIPAL PRACTITIONERS

The policy is that PL and PP are to be involved with assessment, management and case review of all IIR infants and involvement is to be considered for all IR infants.

The intention is that the most 'at risk' infants have a higher level of oversight.

WHAT DOES THE PROCEDURE REQUIRE?

If the infant is classified IIR, a discussion with a PL or PP must occur and be clearly recorded (purpose, direction and actions required). If the infant is classified IR, a discussion with a Pl or PP is to be 'considered'.

WHAT DID THE CRIS FILES SHOW?

- Sixteen of 20 infants were subject to one or more consultations with PL or PP during the audit period (in addition to PL or PP input that occurred at IIR meetings and panels):

- Practice was rated fully compliant for ten of 13 IIR infants, as there was evidence of consultation occurring, sometimes on multiple occasions, and the purpose and outcomes were clearly documented.
- Practice was rated generally compliant for one IIR infant (goals and directions missing from case note) and as partially compliant for two IIR infants (for one there was reference to consultation in the court report but nothing further, for another there was an Aboriginal Family Led Decision Making (AFLDM) but no separate PL consultation outside the IIR meetings).
- For IR infants, PL or PP were consulted in three cases. There was no evidence of consultation for the other four infants. Auditors held no concerns about this as the risk assessments and case plans were clear and appeared appropriate.

- It was clear that PL and PP added **caution, depth and focus** to risk assessment, decision making and risk management activities – for example: recommending specialist family violence assessments; supporting practitioners to insist parents complete urine drug screen tests and reviewing the pattern of missed tests/positive tests; drawing practitioners attention to evidence of 'passive compliance' or where insufficient information had been gathered to make a confident decision.

WHAT DID THE FOCUS GROUPS SAY?

- Focus groups were unanimous about the value of consultations with PL and PP and opportunities for inexperienced practitioners to learn about infant practice by directly observing and being taught by these practice specialists.
- CPP 4 practitioners noted that consultations with practice leaders and principal practitioners also enabled them to manage other cases better.
- Arrangements and systems for PL and PP to monitor and inform infant risk assessment and risk management varies across areas. In part, this may explain why some infants are subject to multiple consultations in addition to PL and PP input at IIR meetings, whilst other infants are subject to only one or two consultations in addition to consideration by the IIR meeting/panel.
- It would be better if all infants were subject to PL/PP consultations.

AUDITORS OBSERVATIONS

- The value added to risk assessment and risk management by this layer of oversight is evident.

CASE CONFERENCES & CARE TEAMS

The policy intent is that infants classified as IIR will have a case conference or care team approach and that infants classified as IR will have a case conference or care team approach considered.

WHAT DOES THE PROCEDURE REQUIRE?

A case conference or care team is to be arranged for every IIR infant and 'considered' for every IR infant. If the child is Aboriginal, Aboriginal Child Specialist Advice Specialist Service (ACSASS) is to be invited to participate. All risk issues and other relevant information shared at meetings is to be documented on the file and the agreed action plan[8].

WHAT DO CRIS FILES SHOW?

- Overall compliance with this requirement was only partial, though better for IIR infants than IR infants, as follows:
  - Multiple support services addressing multiple infant/parental needs were involved with most infants/parents. However, in some cases, even when communication with these services was occurring frequently, there was no evidence of case conference or care team meetings. This was the case for eight of 20 infants during the audit period (though for some, it is worth noting, there was evidence of case conferences/care teams occurring earlier in the current report).
  - For six IIR infants, case conferences/care teams were occurring regularly (fortnightly or monthly).
  - Of the other seven IIR cases, compliance was only partial (one or two case conferences evident) for five infants and no evidence of compliance for two infants (in one of these cases practice was otherwise of a very good standard, in the other case, one case conference was evident but focused only on an older sibling in the home, not the infant).
  - For one IR infant, there were regular care teams throughout the audit period.
  - For six IR infants there was no evidence of case conferences or care teams occurring.
- Documentation was fully or generally compliant with requirements for eight of the 12 infants subject to case conferences or care teams. It was usually not possible to tell from the CRIS file if the minutes had been circulated.
- There were some good examples of practitioners ensuring regular telephone and on-line communication with other professionals/services involved with the infant via group emails.

[8] There is no minimum frequency specified in the procedure. The supporting advice Infant Risk Assessment and Response Decision Advice ID 2401, states 'depending on risk level, case conferences may need to occur on a fortnightly or monthly basis'.

- There was evidence of PL, PP and IIR internal meetings recommending case conferences/care teams be established (and evidence of some external professionals asking for case conferences to be established).

WHAT DID FOCUS GROUPS SAY?

- Partial compliance with case conferencing/care team requirements may be an unintended consequence of the priority given and resources committed to meeting the visiting requirement, compliance with which is measured and monitored.

AUDITORS OBSERVATIONS

- Regular case conferences/care team meetings would have benefited all infants in the sample group.

ABORIGINAL CHILDREN

The policy intent is that child protection assessment and decision-making for an Aboriginal infant is strengthened by consultation with ACSASS and with other Aboriginal services.

WHAT IS REQUIRED? RESPONDING TO ABORIGINAL CHILDREN- ADVICE

If the infant is Aboriginal, ACSASS is to be invited to the infant's case conference/care team, consulted at all significant decisions and invited to the infant intensive response panel. Significant decisions include: intake outcome, substantiation, preparation and review of case plan, removal from parents, court applications/changes to orders, case transfers.

WHAT DID THE CRIS FILES SHOW?

Five of the infants in the sample group were Aboriginal.

- Full compliance was observed with the requirements specific to Aboriginal children in the procedure with one exception. In one case, it was not realised the infant was Aboriginal until four months after the report was made, at which point contact was immediately made with Lakidjeka.

WHAT DID THE FOCUS GROUPS SAY?

- Aboriginal services involved including Lakidjeka and others (mostly AFPR or Stronger Families) are invited to panel meetings when there is an Aboriginal infant being presented or re-presented.

INTENSIVE INFANT RESPONSE MEETINGS & PANELS

The policy intent is that all IIR infants will be referred to and reviewed by an internal meeting comprising specialist practitioners and child protection managers and that

the internal meeting will refer infants to the IIR panel where additional, multi-disciplinary advice and review is necessary.

WHAT IS REQUIRED BY THE PROCEDURE?

Complete a template including a summary of case history, risk assessment, case plan /progress for the internal IIR meeting, or IIR panel if directed by the IIR meeting.

Upload the template including the meeting/panel outcome on CRIS.

WHAT DID CRIS FILES SHOW?

- CRIS files show practice related to infant response meeting and panels requirements is generally compliant, as follows:
  - Auditors found evidence of one or more IIR meeting and panel templates for 11 of 13 IIR infants.
  - There was no evidence in the CRIS files of two infants being considered by an internal IIR meeting or an IIR panel in their CRIS files.
- Three IIR infants were referred to the IIR panel by the IIR meeting.
- The number of times each infant was reviewed by the IIR meeting or panel during the audit period varied. On some files there was evidence of this occurring only once in the audit period. On others there was evidence of it occurring monthly throughout the audit period.
- In relation to the quality of risk assessments evident on the IIR meeting and panel templates:
  - There was evidence of Analysis and Risk Assessment Snapshots on the files of some IIR infants but not all. Some areas seem to rely on these to update monthly IIR meetings.
  - Risk assessments documented on IIR meeting and panel templates on CRIS, and in the Analysis and Risk Assessment Snapshots indicated a generally good understanding of the IDRT information gathering and analysis prompts (some of which are embedded into the templates). The best took new circumstances into account as well as the pattern of concerns and clearly distinguished clearly between strengths and demonstrated protection.
- In relation to the input and outcomes of IIR meetings and panels:
  - Internal meetings were cautious and enhanced risk assessment and case planning for infants. Most IIR meetings re-confirmed the IIR infant response decision. Decisions to downgrade appeared to be made with care, for example, several recommendations from practitioners that the meeting downgrade the classification from IIR to IR were rejected or deferred pending further assessment and testing of situations ahead of further review by the meeting.
  - In some instances, input from panels prompted a change to thinking and ways of working with families. For example: In one situation, the panel decided that there were too many professionals involved with the family and parents may be receiving conflicting messaging. Decision made to consult parents who agreed and proceeded to engage effectively with two professionals and productively work towards meeting case plan goals.

- The adequacy of recording of meeting and panel outcomes varied. Usually, outcomes were recorded only briefly.

WHAT DID FOCUS GROUPS SAY?

- The meetings/panels were seen to provide 'a layer of protection' for practitioners as well as 'fresh eyes' on risk and ideas about ways to move forward.

  It can be very helpful when you've worked with the family for a long time and know them well and need help to clearly see the risk issues or where a family is not adequately adhering to conditions. (CPP4)

- There is considerable variation in the way areas organize the internal IIR meetings. For example:
  - Some areas reported trying out different approaches over the past two years.
  - One area described re-orienting the internal IIR towards monitoring service provision and screening cases appropriate for panel consideration, relying on practice leader and principal practitioner consultations outside the meeting to provide deeper input into risk assessment and case management.
  - Some areas consider every IIR at the monthly meeting. This is easier for smaller areas than larger areas. In larger areas, IIR meetings can take many hours, sometimes requiring more than one session/day per month, and even then allowing only 10-15 minutes per case, which can be insufficient.
  - Some areas require staff to complete a risk analysis snapshot to update the meeting/panel, but others don't insist on a written update if time is short.
- The procedure does not specify how frequently IIR infants are to be considered by the monthly internal IIR meetings or panels, whereas the advice supporting the procedure[9] notes that IIR infants should be discussed monthly.
- One rural area reported difficulty engaging appropriate panel members. Other metropolitan areas reported excellent participation from a range of relevant services.
- Panels are seen as very helpful for complex cases, particularly if there is good representation from mental health and family violence services. Panel members can also help 'open service doors' to infants and families.

AUDITOR OBSERVATIONS

- It was not possible to gauge the full extent of variation in arrangements for infant intensive response meetings across departmental areas as this issue only came to light during focus group discussions which were not representative of all areas.

[9] Cite advice

- The IIR meeting is a valuable layer of oversight by specialist practitioners and senior program managers. Further statewide review of the purpose of these meetings may be useful.

CASE REVIEW

The policy intention is that all infants classifications are to be reviewed regularly.

WHAT IS REQUIRED?

The procedure requires cases be reviewed on a regular basis, including risk issues, action plans and case plan directions.

WHAT DID CRIS FILES SHOW?

- Infant response classification decisions were reviewed at all mandatory points throughout the audit period for all 20 infants, as reported in subsection 4.1.
- IIR infants had their classification reviewed more often than IR infants as a result of more frequent consultations with PL or PP and reviews by IIR internal and panel meetings.
- Not all IR infants were subject to a consultation with PL or PP. Auditors found (and heard) about several instances of PL or PP upgrading IR classifications to IIR classifications following file review or consultation to promote a more intensive service response.

WHAT DID FOCUS GROUPS SAY?

- PL and PP noted: it can be difficult to find the time to regularly review files because of workload demands; and, without a full file review (past and present), practice leaders and principal practitioners are dependent on information provided by practitioners and team managers which may be incomplete.
- It would be preferable if there was capacity for practice leaders and principal practitioners (specialist practitioners) to regularly review **all** infant cases.
- *Some of these infants are out of sight if there is no consultation occurring with the practice leader.*

AUDITOR OBSERVATIONS

- In addition to observations about case review made under previous subsections - auditors found no evidence of case review discussions that can be assumed to be occurring in both scheduled and unscheduled supervision sessions between team managers/supervisory senior practitioners and child protection practitioners being documented in CRIS files.

5
ATTACHMENTS

ATTACHMENT 1
THE AUDIT TEMPLATE

BACKGROUND INFORMATION

Case number	Age range during audit	Duration of period audited	Family/living circumstances	Protective concerns, phase at 1/10/21, case plan direction, other observations about infant/circumstances/management of case.
1-20				
Themes				

CLASSIFICATION OF INFANT AT MANDATORY POINTS

At substantiation, new court order, review of case plan, new familial allegation, closure decision. To be endorsed by TM. Downgrade to IR to be endorsed by PL or above. IDRTT – prompt questions re: vulnerability of infant, pattern and severity of harm, strengths and protective factors, factors increasing/decreasing likelihood of harm.

Case number	Decision made/reviewed at mandatory points during audit period Yes/no	Classification changed during report and audit period?	Rationales clear	Correct delegate endorsed? Yes/no/unclear	Rating FC,GC PC,NEC	Rationale/comments
1-20						
Themes						

ALLOCATION

IIR to be allocated same day/within one working day, IR to be 'prioritised'.

Case number	Allocated same day, next business day? Yes/no	Allocated through period of audit? Yes/no	How long unallocated?	Rating FC/GC/ PC/NEC	Rationale/comments
1-20					
Themes					

INVESTIGATION OF REPORTED CONCERNS/NEW INFORMATION/EXAMINATION/SIDS

Use IRDT to inform investigation, visually examine infant if allegation of physical abuse or neglect, forensic medical if non accidental injury, complete SIDS assessment for all visits and repeat regularly until safe.

Case number	Investigation plan? Yes/no/not applicable	Plan reflects reported concerns/IRDT? FC/GC/PC/NEC	Infant visually examined/forensic medical obtained Yes/no/ NA	SIDS assess and info FC/GC PC/NEC	Overall Rating FC/GC PC/NEC	Rationale/comments
1-20						
Themes						

VISITS AND INTERACTIONS WITH INFANT AND FAMILY

Min weekly IIR, min fortnightly IR, contact with/observation of infant as well as parents, document visits covering new info, observations what was discussed, SIDS check, case plan progress etc.

Case number	How many visits in audit period?	Meets IR/IIR standard? FC/GC PC/NEC	Face to face contact with infant as well as parent FC/GC/PC/NEC	Visits recorded and clear FC/GC/PC/NEC	Rating FC/GC PC/NEC	Rationale/comments
1-20						
Themes						

CONSULTS WITH PRACTICE LEADERS, PRINCIPAL PRACTITIONERS

Must do for IIR, recommended for IR, record of consultation on CRIS is clear about purpose, directions.

Case number	PL/PP consulted/ clearly documented for IIR FC/GC/PC/NEC	PL/PP consulted/consults clearly documented for IR FC/GC/PC/NEC	Other practice specialist consulted?	Overall rating FC/GC PC/NEC	Rationale/comment
1-20					
Themes					

CASE CONFERENCES/CARE TEAMS

Must hold for IIR, to be considered for IR, issues shared and actions to be documented and action plan distributed.

Case number	Evident for IR? Yes/no/Frequency?	Evident for IIR? Yes/no/frequency?	Written summary clear and detailed, distributed? FC/GC/PC/NEC	Overall rating FC/GC PC/NEC	Rationale/comments
		Partially		PC	
Themes					

ABORIGINAL INFANTS

ACSASS to be consulted at specified/all critical decisions and part of IIR panel/ AFLDM requirement.

Case number	ACSASS consulted at all significant decision points in audit period? Yes/no	ACSASS/other Aboriginal services supporting infant/family? AFLDM? Yes/no	Overall rating FC/GC/PC/NEC	Rationale/comments
1-20				
Themes				

IIR INTERNAL MEETING/PANEL MEETING

Prepare template summarising history, risk assessment and case plan, upload to CRIS and include recommendations from meeting, enact recommendations, refer to panel as directed by IIR meeting, prepare panel template, record and enact panel recommendations.

Case number	Completed IIR meeting/panel templates with risk assessment (number?) FC/GC/PC/NEC	Meeting outcomes/recs evident on CRIS FC/GC/PC/NEC	Evidence meeting recs are actioned FC/GC/PC/NEC	Overall rating FC/GC PC/NEC	Rationale and comments
1-20					
Themes					

RISK ASSESSMENT – EVIDENCE OF USE OF THE IRDT PROMPTS AND RISK ANALYSIS SNAPSHOTS

Use IRDT tool/snapshot tool to review risks and plans, at key points, when new significant information arises and regularly.

Case number	IRDT or knowledge of informs risk assessment (info gathered, framing analysis) FC/GC/PC/NEC	New information about risk is analysed and plans adjusted FC/GC/PC/NEC	Evidence of MARAM assessment? Yes/no	Overall rating FC/GC PC/NEC	Rationale/comments
1-20					
Themes					

CASE PLAN AND DAY TO DAY CASE MANAGEMENT

Case number	Plan evident, clear and based on current assessment? FC/GC/PC/NEC	Plan actively implemented in a timely way FC/GC/PC/NEC	Overall rating FC/GC PC/NEC	Rationale and comments
1-20				
Themes				

ATTACHMENT 2
SEMI-STRUCTURED FOCUS GROUP/INTERVIEW QUESTIONS

What do child protection practitioners in different roles say about the procedure?

How clear is the procedure?

Is the infant intensive response decision tool (and analysis snapshot tool) used/useful?

How will the introduction of SAFER support practice with infants?

Does the procedure promote good practice with infants?

How to strengthen?

How feasible is the procedure?

How do the consultation requirements, internal meetings, panel meetings add value to the response provided to infants?

How time consuming are the internal and panel meetings?

Who attends meetings/panels from within DFFH and external professionals?

GLOSSARY

Abbreviations

Aboriginal	Refers to both Aboriginal and Torres Strait Islander peoples.
ACSASS	Aboriginal Child Specialist Advice Support Service.
AFLDM	Aboriginal Family Led Decision Making.
AFPR	Aboriginal Family Preservation and Reunification Response.
CPP	Child Protection Practitioner.
IRDT	Infant Response Decision Tool.
PL	Practice Leader.
PP	Principal Practitioner.

Definitions

ACSASS	It is a requirement under the *Child Youth and Families Act 2005 (*the Act) that in making a decision or taking action in relation to an Aboriginal and Torres Strait Islander child that child protection seek advice from ACSASS. ACSASS provide expert advice about culturally appropriate interventions and also advise on significant decisions in all phases of decision making.
AFLDM	When working with Aboriginal and Torres Strait Islander children, child protection practice requires that practitioners must take into account Aboriginal culture, family relationships and parenting arrangements, to best meet the best interests of Aboriginal children. Aboriginal Family Led Decision Making (AFLDM) gives effect to case planning for Aboriginal and Torres Strait Islander children where protective concerns have been substantiated. AFLDM is a collaborative process, which involves the active participation of family, extended family and community members in decision making.
AFPR	An evidence-based, outcome focussed intensive child and family support model that aims to promote strong families – with children who are safe, healthy, resilient and thriving; and parents and caregivers who

	are supported to create a safe and nurturing home environment.
CPP 4	An advanced child protection practitioner who has significant practical experience and demonstrates this capability consistently in all settings and situations. This role supports, advises and guides other colleagues on the application of this capability in their work.
Infants	Refers to children under the age of two.
Infant Response	All infants subject to protective intervention receive an infant response classification.
Infant Intensive Response	An infant is assessed as requiring an infant intensive response when there are risk factors that have had or are likely to have a significant impact on the infant and where there are insufficient strengths, safety and protection evident, suggesting a more intensive service response from child protection is required.
Practice Leader	Responsible for providing expert case practice advice and leadership; supporting and developing chid protection practitioners in the integration of theory and practice while demonstrating expertise through case management. Practice leaders supervise senior child protection practitioners (Community-based), undertakes case practice quality audits and provide regular practice forums and community education.
Principal Practitioner	Provides case consultation, advice and recommendation to child protection practitioners, case managers and case planners and other key service partners regarding complex cases. Principal Practitioners also undertake case reviews that examine part or all of the history of an individual case to evaluate practice effectiveness and outcomes and identify opportunities for improvement.
Stronger Families	Provides an integrated model of case work and intensive specialist supports to vulnerable children and their families, where the child is at imminent risk of placement in out-of-home care for the first time or has entered out-of-home care for the first time, to enable children to remain at home with their parents, or to support their safe return home to their parent's care.