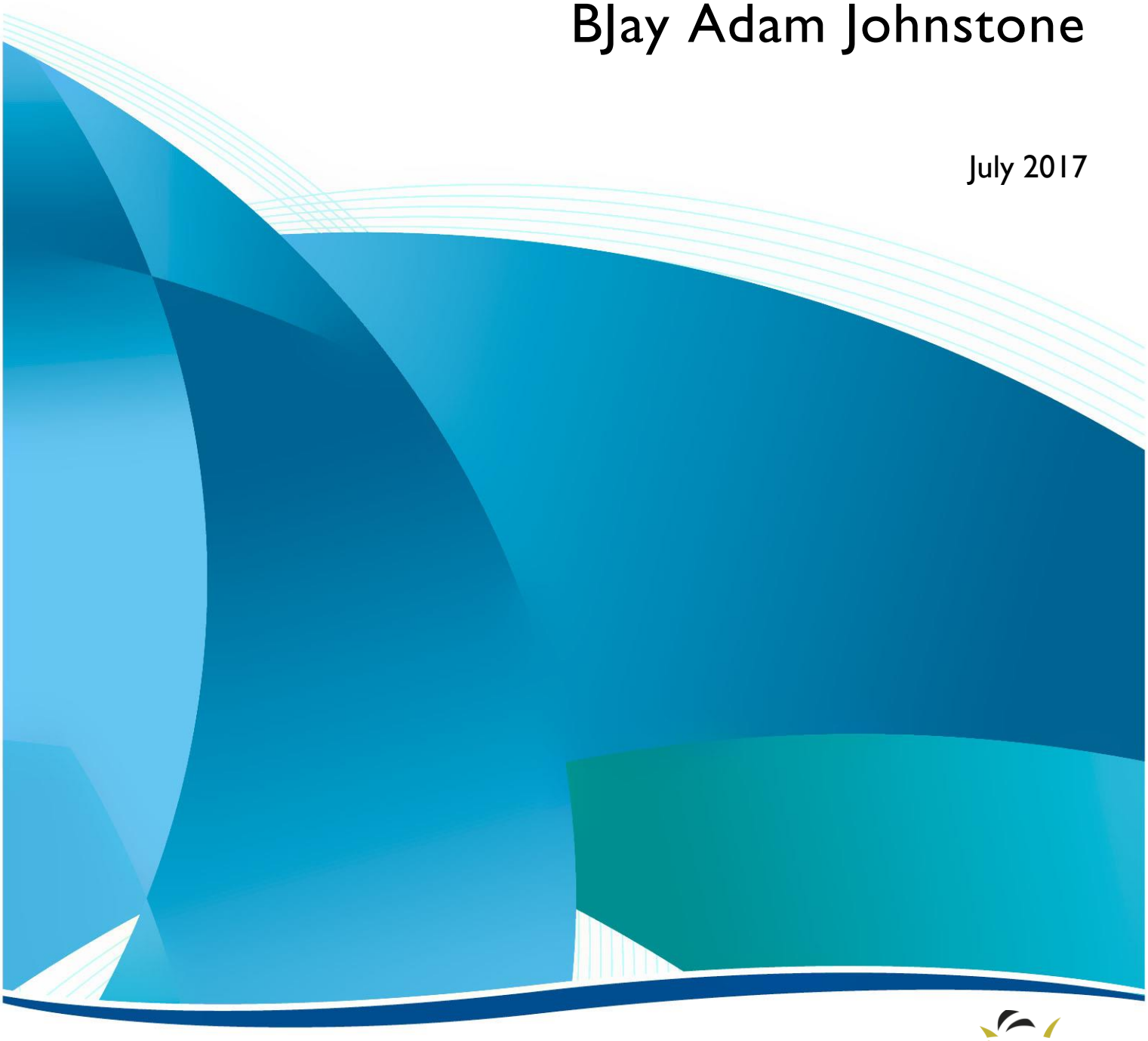
RESPONSE TO THE RECOMMENDATIONS OF CORONER OLIVIA MCTAGGART FOLLOWING THE HOLDING OF AN INQUEST UNDER THE *CORONER'S ACT 1995 (TAS)* INTO THE DEATH OF:

BJay Adam Johnstone

July 2017



Tasmanian Government

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TABLE OF CONTENTS

SUMMARY

The death of BJay Adam Johnstone on 28 November 2012 and the circumstances which led to his death are tragic and we have learned and changed as a result of this tragedy.

The findings, recommendations and comments of Coroner Olivia McTaggart following the holding of an inquest under the *Coroner's Act 1995 (Tas)* provided a comprehensive investigation into the circumstances surrounding BJay's death.

BJay died as a result of severe trauma inflicted by his father Simon Adam Johnstone. The Coroner also found that persons and organisations responsible for BJay's protection failed to keep him safe.

The Coroner's findings identified a number of failures in the system that existed in 2012.

The Tasmanian Government undertook immediate investigations following the death of BJay. This led to a number of detailed recommendations which were considered and acted on. The Government has made significant changes to its systems, processes and practices across the Child Safety Service and Tasmania Police and has made a significant investment through the Strong Families, Safe Kids project.

All of the recommendations have either been completed or are in the process of being actioned. Two recommendations have been considered, with further work required to determine the best way forward.

Frontline Child Safety Officers work in an incredibly difficult and challenging field with every decision balancing the obligation to both protect children and support and strengthen families.

Significant change and improvements have occurred since 2012, and are continuing to occur via the Strong Families, Safe Kids project or through existing agency change processes. There is always more that can be done to ensure continuous improvement in the protection of vulnerable children and supporting families.

Areas of ongoing focus in reform and improving the system include:

- learning and development for professionals working with vulnerable children and families;
- an organised and structured process of continuous quality improvement;
- greater collaboration and continuing engagement on issues relating to family violence, mental health issues, and drug and alcohol abuse; and
- legislative reform where required to help keep children safe to the greatest extent possible.

The Coroner's findings identified a number of failures in the system that existed in 2012. We have learned and changed as a result of this tragedy.

GOVERNMENT REFORMS TO CHILD AND FAMILY SAFETY

Strong Families, Safe Kids

The Strong Families, Safe Kids Implementation Plan outlines actions the Tasmanian Government has taken to build an integrated system that can respond innovatively and effectively to ensure the safety and wellbeing of children and to support families and communities in doing so. This recognises that to ensure child wellbeing and to build strong families requires an all of government, all of service system and whole of community approach. The Department of Health and Human Services (DHHS), the Department of Education and Tasmania Police are signatories to the plan and have a shared commitment to foster a culture of continuous improvement and to ensure children are at the centre of decision making.

The Tasmanian Government has invested more than $20 million over four years into the implementation of the first phase of the redesign. This includes:

- refocussing the current child safety intake service into an integrated Advice and Referral Service – referred to as the Child Advice and Referral Alliance;
- identifying and purchasing intensive and assertive family support services to prevent children from entering the statutory service system;
- providing services and support for children in government schools and Child and Family Centres (CFCs);
- employing two hospital Child Safety Liaison Officers in the North and North West regions;
- providing additional administrative and practice support to frontline child safety staff;
- providing additional psychological support to ensure child safety staff wellbeing and response to concerns around staff resilience and critical incident debriefing; and
- improving information technology to support frontline child safety staff.

Safe Homes, Safe Families

Safe Homes Safe Families, Tasmania's Family Violence Action Plan 2015-2010 provides a coordinated approach to respond effectively to the issues associated with family violence. The Action Plan recognises that the Government cannot prevent family violence on its own, everyone has a role to play. The Tasmanian Government has committed nearly $26 million to new and direct actions over the next four years.

The Government has committed to the following actions:

- **Establishing Safe Families Tasmania** by bringing together government agencies in a statewide collaborative unit to coordinate support services for victims and hold perpetrators to account – referred to as the Safe Families Coordination Unit (SFCU).
- **Changing attitudes and behaviours that lead to family violence** by developing and delivering a Respectful Relationships program in all government schools; taking a lead role in supporting the national campaign to reduce violence against women and their children; joining the national Our

Watch organisation; rolling out White Ribbon's Workplace Accreditation Program across all Tasmanian Government agencies.

- **Supporting families affected by violence** through support to children affected by family violence in government schools and CFCs; supporting children affected by family violence in non-government schools; extending counselling services for children and young people experiencing family violence; providing additional counselling services for adults experiencing family violence; investing in crisis accommodation and providing supported housing options.
- **Strengthening our legal responses** by strengthening the legislative framework to address family violence; extending legal assistance to people experiencing family violence; appointing more specialist police prosecutors; supporting perpetrator programs for low to medium risk offenders; extending forensic medical examination to include victims of family violence; developing a business case for a Criminal Justice Information Management System and improving data collection and reporting.

THE CORONER'S RECOMMENDATIONS

The Coroner made 18 recommendations to improve the systems and services that exist to protect and keep children safe.

DHHS, through Children and Youth Services (CYS) and the Department of Police, Fire and Emergency Management, through Tasmania Police, are the Tasmanian Government agencies primarily responsible for implementing the Tasmanian Government response.

The table below outlines each recommendation and the actions in response.

No.	Coroner's Recommendation	Government Actions in response to the Coroner's Recommendations	Agency
1	(a) That Child Protection Service (CPS) implement a comprehensive training regime for all its workers in the application of the Tasmanian Risk Framework (TRF), CPS Practice Manual and Specialist Guides and (b) that the training be regularly updated to maintain the integrity of the risk assessment process and current learning in the field.	On 1 July 2015, the Children and Youth Services (CYS) Practice Manual was launched to provide a single authoritative source of all CYS policy documents for staff reference and as a result, critical procedures in relation to the TRF and Infant Risk Assessment have been updated. Action is underway to implement a comprehensive training regime through a new learning and development approach which includes: • development of priority learning packages for Child Development. Indicators of Abuse, Assessment of Infant Risk and Risk Assessment to be delivered by the first semester of 2018. • recruitment of 10 Clinical Practice Consultant and Educator (CPCE) positions through the Strong Families, Safe Kids redesign of Child Safety Services who will provide practice support and education to staff on the ground in recognition that 70% of learning is through work-based learning. The CPCEs will have a particular focus within the Intake and Response Teams on critical practice advice relating to Child Safety Assessments using the TRF and Signs of Safety approach, indicators of Abuse and Neglect and identifying and assessing risk and protective factors. Specialist competence based family violence training was actioned in 2015. Mandatory ethic decision making training is to be completed by December 2017. Action is underway to implement regular training updates including: • Learning Pathways Map contained within the Learning and Development Framework identifies Child Development, Indicators of Abuse and Assessment of Infant Risk and Risk Assessment as core training for Child Safety Officers, team leaders and managers; and • consideration of the development of a Learning Management System to track and report on workforce learning. As new practices and processes are updated or implemented, the CPCEs will be engaged to target support and education to Child Safety staff on the ground in order to maintain the integrity of the risk assessment process and current learning.	DHHS
2	That CPS implement a comprehensive independent review of the functionality and usage of the Child Protection Information System (CPIS) including but not limited to: i) the capacity of CPIS to aid CPS in meeting its statutory and organisational responsibilities;	In the 2017-18 State Budget, funding of $300,000 was provided for the Child Safety Client Information System (CPIS) Project which will be used to develop a robust business case and development of requirements for the replacement of the CPIS. The elements of this recommendation are supported, although the recommendation to implement an independent review has been superseded by the decision to develop a replacement	DHHS

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	ii) barriers to CPIS usage - including workplace culture and worker confidence in using the system; iii) the adequacy of staff knowledge and training in CPIS; and iv) the quality of CPIS cases notes, recording of decision-making processes, and use of CPIS for related searches.	information system. A provision of $6 million has been identified for future implementation costs. In the 2016-17 Budget, funding of $550,000 was provided for immediate stabilisation and upgrades to CPIS, including integration with the Kids Intelligence Data System. The following actions are being undertaken in relation to each element of the recommendation: i) a CPIS users group has been established which will incorporate the findings and recommendations of the coronial inquiry as it relates to CPIS functionality. ii) Cultural change, including barriers to CPIS usage, are being addressed through the implementation of the Strong Families, Safe Kids project including additional practice supports. Related activities that are being undertaken to improve workplace culture and confidence within the CYS include the Learning and Development Framework, revised Practice Framework for Child Safety Services (CSS), Recruitment and Retention Strategy, quality improvement framework, implementation of agreed work-place values and behaviours and establishment of whole of service leadership forums. iii) As part of the Strong Families, Safe Kids redesign project, a Systems Trainer will be recruited to support staff in their knowledge and use of CPIS. iv) CYS is close to launching a Quality Improvement Framework to evidence improvement in the quality of case notes, recording decisions and rationale and general use of CPIS to support safe practice.	
3	That CPS implement an audit and quality assurance system to determine i) whether the TRF is being routinely and correctly used; ii) that CPIS searches are being routinely and correctly conducted; and iii) that risk assessments based upon the TRF accord with the statutory responsibilities of CPS and the CPS Practice Manual.	Action is underway to implement an audit and quality assurance system. The CYS Quality Improvement Framework will support an organised and structured process of continuous quality improvement that includes robust case file audits against criteria. Client file audits will be conducted annually and compliment random review files by line managers/team leaders as an ongoing part of supervision. As part of the implementation of the Assessing and Responding to Infants and Young Children Procedure and Practice Advice, the Clinical Practice Consultant and Educators have been tasked with strengthening and improving risk assessment and recording clinical outcomes and decisions within the TRF.	DHHS
4	That CPS implement an audit system in respect of unborn baby notifications for the state to determine whether such notifications are being investigated and actioned properly and in a timely manner and consistent with the Act and CPS Practice Manual.	In December 2016 a review of Intake Procedures was completed. Action is underway to implement an audit system in respect of unborn baby notifications. CYS will undertake a review of the unborn baby notification process via the regional hospital Child Safety Liaison Officers. This will provide evidence of how the notifications are being assessed and responded to across the State to ensure they are managed in line with the Act and CPS Practice Manual.	DHHS
5	That CPS, with the support of DHHS, develop child protection liaison officer positions in the North and North West of the state, the key duties of the roles to include but not limited to: (a) Provision of consultation and assistance to hospital staff in relation to the full range of child protection matters across antenatal, neonatal and paediatric services.	On 17 February 2017, this recommendation was implemented as part of the Strong Families, Safe Kids implementation of the Child Safety Redesign. CYS has created and recruited to the North and North West hospital Child Safety Liaison Officer positions. These positions are located within the Child Safety and Hospital environments in each region and key duties include: a) provision of consultation and assistance to hospital staff in relation to the full range of child protection matters	DHHS

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	(b) Facilitation of positive and effective working relationships between the relevant hospitals, CPS, Gateway, Intensive Family Support Services (IFSS) and government agencies in respect of child protection issues. (c) Management of the unborn baby alert process across the hospitals and CPS, including the coordination of multidisciplinary case conferencing involving social work staff across the maternity and neonatal and paediatric intensive care units.	b) facilitation of positive and effective working relationships between the relevant hospitals, CPS, Gateway, IFSS and government agencies in respect of child protection issues; and c) management of the unborn baby alert process across the hospitals and CPS. This role has been in place in the South of the State since 2007 and has created positive change in the working relationships between the two Agencies through the development of a deeper understanding of each services role and mandate in respect to the assessment and protection of vulnerable children and by creating a pro-active approach to education and collaboration across the two disciplines.	
6	That in respect of infants under six months of age where the subject of a notification involves bruising, CPS arranges an examination of the infant and review of the circumstances by a paediatrician or other suitably qualified medical practitioner as soon as practicable for the purpose of assisting in the determination of whether the bruising is non-accidental in origin.	In November 2016 CYS released new procedures and practice guides relating to how physical abuse is assessed and responded to. The new Practice Guides were developed in consultation with paediatricians and outline 'red flag indicators' which must trigger formal medical examination. These triggers include any bruising to non-mobile infants.	DHHS
7	That CPS provide all notifiers with an electronic receipt for all notifications, including email and telephone notifications.	Action is underway to implement this recommendation through the upcoming CPIS changes and will be incorporated in the system development process for the Redesign project. CYS will consider how the current functions of CPIS in relation to SMS and Email notifications can be used to inform notifiers that their notification has been received.	DHHS
8	That CPS continuously reviews the working and constitution of the Three and Under Panel to ensure that it remains effective in its role.	In 2013, the Three and Under Review Panel (the Panel) was established to ensure that Child Safety cases involving children aged three and under, including Unborn Baby Alerts, are sufficiently assessed prior to closure by an independent multi-disciplinary review, in recognition of the vulnerability of infants. The recommendation that CPS continuously reviews the working and constitution of the Three and Under Panel has already been implemented. In December 2014, a review to provide additional oversight and quality assurance was completed, procedures were reviewed and updated in June 2015 and Unborn Baby notification and assessment procedures were updated on September 2016. Since its development, procedures for the Panel have been refined and improved on an ongoing basis based on: - learnings from BJay Johnstone's death in 2012 including quality improvements identified through the internal review conducted by Suzanne Botak; - an independent review and coronial inquest into the circumstances surrounding another infant death; - the appointment of the Clinical Practice Consultant and Educators within the Child Safety structure; and - feedback from practitioners and other members of the panel. In December 2015, the Government announced that the Council of Obstetric and Paediatric Mortality and Morbidity would be immediately convened to independently review any future child death or serious injury. The work of the Three and Under Panel will be further supported by learning from these reviews.	DHHS
9	That where a notification has been referred by CPS to Gateway, CPS ensures that Gateway is provided with a copy of the completed TRF	In November 2016 the Assessing and Responding to Infants and Young Children Procedure was implemented and the 'Three and Under Panel' role was expanded to ensure that cases presented to the Panel have a TRF which	DHHS

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	relating to the notification, and that Gateway, in turn, provides that document to any IFSS organisations tasked to work with the families.	includes details and consideration of known factors which increase risk to infants. Action is also underway to ensure that Gateway referrals, to and from Child Safety include the mandatory provision of the TRF to Gateway. Under the Strong Families, Safe Kids Project, Government agencies are collaborating to develop joint service plans for vulnerable children, to allow all services working with the family to access the historical context and have a more holistic understanding of the family's needs and what services they are currently involved with. A key action of the Strong Families, Safe Kids implementation plan is the development of a new service, the Children's Advice and Referral Alliance, to be a single point of entry for people seeking information, advice and service referral in regard to concerns for the safety and wellbeing of children. The new service will replace the current dual pathway, the DHHS Child Safety Intake and Response and the Gateway service (a non-government service funded by DHHS).	
10	That as a matter of priority, DHHS implement a formal review of the functions and working of the Community Based Intake Service (CBIS) system, with focus upon; (a) The capacity of a CBIS to effectively manage referrals from CPS in accordance with the Act; (b) The statutory, procedural, organisational and cultural environment in which referrals from CPS take place; and (c) The timeframe for appropriate risk assessments; the adequacy, enhancement and access to the Common Assessment Framework (CAF) tool as a risk assessment tool; the standard of completion of the CAF tool required from CPS; implementation of home visits and personal meetings with the family in nominated higher risk cases; the optimal procedures for comprehensive provision, sharing and disclosure of documents between organisations; intake, case management and case closure procedures; and ongoing quality assurance.	In August 2015, this recommendation was actioned through the Tasmanian Government establishing the Child Protection Redesign Reference Group, chaired by child protection expert Professor Maria Harries, to review the functions and role of Child Safety, Gateway and the broader community in protecting vulnerable children. The Reference Group's Final Report was released on 15 March 2016 and included recommendations to reform the 'Front Door' and intake service. The report was the foundation for the 'Strong Families, Safe Kids' child protection redesign. In alignment with the roll out of the Strong Families, Safe Kid Implementation Plan 2016-2020 the Government has separated the 2017-18 Funding Agreements for Gateway and IFSS. A further review of the CYS process and procedure will occur in light of the findings of this review. This will include a review of how CYS and CBIS interact, the level of information sharing that is currently in place and the degree of joint and collaborative training that occurs. A key actions of the Strong Families, Safe Kids implementation plan is the development of a new service (the Children's Advice and Referral Alliance – (CARA)) as the single point of entry for people seeking information, advice and service referral in regard to significant concerns for the safety and wellbeing of children. CARA will be managed within CYS in the Children and Families portfolio. The operations of the CARA will be supported by strong collaboration across all levels of the CARA; with both government and non-government components sharing responsibility and accountability. CARA will comprise three sections, advice and referral, triage and short-term interventions.	DHHS
11	That CPS, Gateway and Integrated Family Support Services (IFSS) implement regular training for their workers as appropriate to the functions of their organisation in the following: (a) The rarity and significance of bruising on an infant not yet mobile, and associated reporting requirements; (b) The risk factors for family violence, the detection of family violence and the impact of a family violence history upon the ability to be protective towards a child;	As at 16 May 2017, Mission had conducted risk training (Intense Care Management) in response to recommendations from the inquest, as recommended by DHHS. As part of the Service Agreement between DHHS and Gateway Services, there is a requirement for Gateway to employ appropriately qualified, skilled, and where appropriate, credentialed and registered staff. DHHS will commission the Community Partnerships Teams to undertake a review with Gateway and IFSS of the type and frequency of training that is offered to their staff to consider whether it is in line with this recommendation. Opportunities for joint training will be considered and explored as part of this review.	DHHS

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	(c) The possible risk factors posed to a child by the use of cannabis, and the need for a thorough investigation into the extent and effect of that use; and (d) Effective, robust questioning of parents or those with whom a child is living in order to properly assess critical factual matters regarding risk to a child.	CYS Learning Pathways Map identifies Working with Clients with Drug and Alcohol Use as specialist training available to all staff. Training is delivered by the Drug Education Network of Tasmania and is currently available on the CYS Training Calendar. In response to the Tasmanian Commissioner for Children and Young People's Report, Children and Young People's Unique Experiences of Family Violence, a practice guide has been developed to strengthen the understanding of family violence and referral pathways available for Tasmanian service providers and professionals working directly or indirectly for those experiencing family violence. The Strong Families, Safe Kids Project Team is working with Government and the Cross Sectoral Consultative Committee to develop and promote a cross-sectoral approach to sharing education, training and professional development opportunities across government agencies and their non-government service.	
12	That CPS, Gateway and IFFS implement joint training for its workers in risk assessment in respect of children, including but not limited to i) the operation of the Child Protection Manual and TRF as appropriate, ii) the CAF (or any replacement) and iii) the matters referred to in the previous recommendation so as to ensure consistency in knowledge and approach to risk assessment between organisations.	Action to implement joint training in risk assessment is underway. Additional trainers are being recruited to provide resources to enable broader engagement with service partners in Learning and Development in key areas such as Child Development, Indicators of Abuse and Assessment of Infant Risk and Risk Assessment as well as Signs of Safety Basic and Advanced training. CYS's capacity to broaden the learning and development reach beyond its own workforce is limited by: • the availability of trainers • the availability of supports such as project/admin/coordination • the resource to develop learning packages in a timely way. These limitations will be considered by the CYS Executive Leadership Team as part of the implementation of these recommendations.	DHHS
13	That the government considers amendments to the *Children, Young Persons and Their Families Act 1997* to provide for increased powers of the Secretary where the Secretary knows or suspects on reasonable grounds that a child is at risk as a result of drug abuse by a parent, guardian or other person, and the cause of the child being at risk is not being adequately addressed; such powers including orders to ensure that the parent, guardian or other person undergoes appropriate treatment for drug abuse; and to ensure that the parent, guardian or other person submits to periodic testing for drug abuse.	Amendments have been considered, however the DHHS review found the current provisions of the Act provide sufficient powers to act and respond to issues of drug use and abuse. Further changes to the legislation around drug treatment need to effectively target the complex nature of drug use and abuse. Drug abuse is a significant issue in the neglect and abuse of children. Further work is required to develop effective strategies to reduce parental drug abuse and its negative influence on child safety.	DHHS
14	That the CPS Redesign Reference Group and those responsible for developing the Vulnerable Infant Strategy incorporate these recommendations, where appropriate, into the respective strategies with a view to their implementation in a staged and monitored setting.	Action is underway to implement this recommendation. The CPS Redesign Project Team has incorporated the Coroner's recommendations in the design of Strong Families, Safe Kids project, which aims to build a highly collaborative system that can respond effectively to ensure the safety and wellbeing of children and to support families and communities in doing so. The findings of the Coronial Inquest will also be considered in the further development of the Vulnerable Babies and Infants Strategic Framework. The intent of the Strategic Framework is to provide a comprehensive framework to enable a statewide and consistent response for vulnerable infants and babies regardless of the circumstances affecting their families; delivering consistent policies and guidelines for use across child health, community,	DHHS

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		paediatric and obstetric services, and clear notification criteria and referral pathways to other services, like mental health, drug and alcohol, and lactation services, as well as to family support services.	
15	That the government consider strengthening protocols between agencies, utilising the Safe Families Coordination Unit if appropriate, to identify at an early stage high risk perpetrators of family violence who may also perpetrate child abuse.	In March 2015, managers of CSS and the Family Violence Counselling Support Services reviewed the BJay case to identify ways of working together when there are shared clients. This recommendation has been implemented with the Safe Families Coordination Unit (SFCU) commencing operation on 4 July 2016. The key objectives of the SFCU include: o co-locating personnel from multiple government agencies in a single unit, to provide timely responses to family violence; o the collection of the best available evidence from across government, to aid prosecution of offenders and support for people experiencing family violence; o undertaking interagency case assessment for families experiencing family violence; and o identifying and monitoring serious and recidivist family violence perpetrators. The SFCU review all reported family violence. Every reported instance of family violence involving children includes a notification to CSS in DHHS. For all reported matters deemed to be 'high risk' or where the SFCU considers there is an elevated risk (i.e. drug use, relevant history of violence, psychotic episodes [perpetrator], strangulation/choking, assault during pregnancy etc.), these matters are fully examined against whole-of-government information. Those matters involving children will include specific recommendations to Safe at Home agencies where appropriate.	DHHS / THS
16	That Tasmania Police identify whether there is a need across all police officers, or any group of police officers, to provide training and education regarding reports of child abuse or neglect, including: (a) The making of electronic referrals to CPS from the Information Data Management (IDM) system or other system used by police officers; (b) The requirements for reporting to CPS under the Police Manual and/or MOU; (c) The requirements for mandatory reporting under the *Children, Young Persons and Their Families Act 1997*; and (d) The prioritising of the investigation of such reports by an allocated investigating officer.	In March 2016, this recommendation was been implemented with Part 9.2.2 of the Tasmania Police Manual providing instructions for police officers regarding the Mandatory Reporting Requirements with respect to the abuse or neglect of children. These requirements include the submission of electronic referrals to Child and Family Services (now CSS). It was identified that a need existed to strengthen the internal messaging between Tasmania Police and DHHS. Accordingly, in 2016 an amendment was made to the Tasmania Police Manual requiring that, in addition to the submission of a CSS Referral (via IDM), police officers were required to verbally report all cases involving sexual abuse, physical injury or severe neglect to DHHS.	DPAC in consultation with DPFEM, DoJ and DHHS.
17	That, if such need is identified, Tasmania Police implement training and education programs as required in those areas identified, and maintain training and education programs upon a sufficiently regular basis to ensure that police officers are able to respond efficiently and effectively to reports of child abuse or neglect.	This recommendation has been implemented with training in this area already occurring as follows: o Recruit Training o Interviewing Vulnerable Witnesses Course o Sexual Assault Investigation Course o Investigator Professional Development Program o Family Violence Training Work is underway to review the Investigative Practice Training Continuum which will incorporate the Interviewing Vulnerable Witnesses Course and the	DPFEM

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		Investigator Professional Development Program. This recommendation will also be identified for further consideration as part of the review.	
18	That Tasmania Police review the role of the Crime Management Unit (CMU) in vetting information reports regarding child abuse and neglect and the creation of electronic CFS referrals, with a view to enhancing and standardising their role across the state; and, if necessary, create guidelines for CMUs in respect of their role and the processes to be followed.	In March 2016, this recommendation has been implemented as the Tasmania Police Manual was amended to reinforce the responsibility of members from the Crime Management Unit (CMU) and to standardise an organisational response when information affecting the safety of a child is received at the CMU. An organisational communication strategy was implemented in 2016 to reinforce best practice in managing information, particularly information pertaining to child safety. Protocols for the effective and efficient sharing of information between key departments have been reinforced and tested through consultation at senior manager level. A review of the Information Data Management (IDM) system was undertaken in February 2016 to ensure the integrity of child safety information. DPFEM Project UNIFY has received government support and is in the process of identifying and then implementing a new Intelligence management system with a contemporary and more functional capability.	DHHS

RESPONSE

As a service system, it is often that demand outstrips capacity to respond; structures and systems can have unintended negative consequences; and there are always ways to strengthen practice, develop skills, and build better partnerships.

System Improvement

The systemic issues referred to within the Inquest into BJay Johnstone's death identified problems that were inherent in the overall system.

Prior to the findings and recommendations of the Coronial Inquest, a number of actions and initiatives had been undertaken, or are now in progress, to address and improve the specific systemic issues identified.

In 2016 the Tasmanian Government committed to a comprehensive reform of Tasmania's Child Safety Service to create an integrated system that can respond effectively to ensure the safety and wellbeing of children. The implementation plan for the redesign outlined a comprehensive set of actions against five key strategies:

1. Placing the wellbeing of children at the centre of our services;
2. Building a common, integrated risk assessment and planning system;
3. Creating a single front door;
4. Providing better support for children and their families; and
5. Redesigning the Child Protection Service with additional support.

Many of the actions outlined in the implementation plan are directly relevant to addressing the systemic issues identified in the Coroner's Findings and Recommendations.

One of the key actions of the Implementation Plan is a new service to be the single point of entry for people seeking information, advice and service referral in regard to concerns for the safety and wellbeing of children. The new service will replace the current dual pathway operated by DHHS Child Safety Intake and Response and by the Gateway Service which is operated by a non-government service (fully funded by DHHS).

The Children's Advice and Referral Alliance (CARA) is the model that has been developed to achieve this. The model is based on the principle that effective services for children and young people at significant risk requires early action from an integrated service system. That service systems should be capable of responding to the full range of needs for a child at risk and their family ranging from professional advice through to intensive and assertive interventions to the child or young person.

To support the needs of children and families in crisis, the Strong Families, Safe Kids Project is working with stakeholders across Government to develop the capability and capacity for intensive intervention to support highly vulnerable children and their families. This service will significantly improve the ability to respond to the needs of children at risk.

The Strong Families, Safe Kids Project is also building stronger foundations for supporting the wellbeing of children across Government, non-government services and the broader community. A Child and Youth Wellbeing Framework has been released to ensure that there is a common understanding of the needs of children and young people. This framework will form the basis of ongoing work to align and integrate all services to the core needs of children. The framework will also form a foundation of a more robust accountability system for improving outcomes for children and young people in Tasmania.

Targeted review, development and implementation of critical procedures and practice advice which aim to support the risk assessment and response to infants and young children have been achieved since 2012. These new procedures form a large focus of practice development within CSS. In light of the Coroner's recommendations, further development of procedures relating to the provision of risk assessment information to the Gateway will be undertaken.

The Government has created and recruited hospital Child Safety Liaison Officer positions to the North and North West. Both positions were appointed in February 2017. These positions are co-located within CSS and Tasmanian Health Service (THS) environments in each region – creating greater collaboration and communication with hospital personnel in regards to Unborn Baby Alerts and management of high risk infants, post-birth. This role has been in place in the South of the State since 2007 and has created positive change in the working relationships between the two agencies through the development of a deeper understanding of each service's role and mandate in respect to the assessment and protection of vulnerable children and by creating a pro-active approach to education and collaboration across the two disciplines.

The information management system that supports Child Safety practice and process is currently under review and significant funding has been provided to support the redesign of the system to better support workflow, process and practice. Funding of $6.3 million has been allocated in the 2017-18 Budget and forward estimates to improve the system. $300,000 of that funding is provided in the first year to scope that replacement. The Coroner's recommendations have been taken into consideration and are being actioned through the initial improvements to the system.

Tasmania Police has undertaken a review of its Information Data Management (IDM) system and is in the process of identifying and then implementing a new system with a contemporary and more functional capability.

In July 2016 the Safe Families Coordination Unit (SFCU) commenced operation. The key objectives of the SFCU include:

- co-locating personnel from multiple government agencies in a single unit, to provide timely responses to family violence;
- collecting the best available evidence from across government, to aid prosecution of offenders and support for people experiencing family violence;
- undertaking interagency case assessment for families experiencing family violence; and
- identifying and monitoring serious and recidivist family violence perpetrators.

The SFCU review all reported family violence. Every reported instance of family violence involving children includes a notification to CSS. For all reported matters deemed to be 'high risk' or where the SFCU considers there is an elevated risk, such as drug use, relevant history of violence, psychotic perpetrator episodes, strangulation/choking, assault during pregnancy and other matters are fully examined against whole-of-government information. Those matters involving children will include specific recommendations to Safe at Home agencies where appropriate.

CFCs, operated by the Department of Education, are also part of a whole-of-government approach to supporting families. Child Safety Service staff refer and encourage vulnerable families to attend the CFCs to link them in with programs and supports. Safe Homes, Safe Families provided six additional psychologists and social workers based in selected CFCs to help facilitate a coordinated approach to supporting families experience family violence, particularly for families who may have not have a child enrolled at school. Safe Homes, Safe Families has also provided three Aboriginal Family Safety Workers within 'home' CFCs to support Aboriginal families with children from birth to five years to promote family safety, including pregnant women.

Child Youth Services (CYS) has developed a Quality Improvement Framework. This will establish a continuous cycle of qualitative and quantitative audits against the National Out of Home Care Standards and Signs of Safety Quality Assurance System to evidence improvement in the quality of case notes, recording decisions and rationale and general use of CPIS to support safe practice. Results of the continuous cycle of review will inform ongoing training of staff and systems improvement.

Continuing to strengthen frontline specialist services such as Child Safety, Youth Justice, Family Violence and statutory Mental Health services will require specialist and targeted program support functions being in place to guide, monitor and strengthen operational service delivery. Key CYS improvements relating to the Coroner's recommendations would include performance intelligence, analytics and evaluation; quality improvement structures and processes; learning and development activities and policy and program development.

The intent of the Vulnerable Babies and Infants Strategic Framework is to: provide a comprehensive state-wide and consistent response for vulnerable infants and babies regardless of the circumstances affecting their families; deliver consistent policies and guidelines for use across child health, community, pediatric and obstetric services, and clear notification criteria and referral pathways to other services, like mental health, drug and alcohol, and lactation services, as well as to family support services. The findings of the Coronial Inquest will be considered in the further development of this Framework.

The Strong Families Safe Kids project team has considered the recommendations of the Coroner and has incorporated these into the ongoing implementation plan.

The actions in system improvement outlined above address recommendations 1, 2, 3, 5, 7, 9, 10, 14, 15, and 18.

Practice Improvement

Practice improvement will support Child Safety Officers to make the right decisions balancing the obligation to both protect children and support and strengthen families.

Responding to and addressing issues relating to child safety while attempting to support families brings with it many challenges that are enduring, complex and not amenable to a 'quick fix'. Risk assessment, in particular the process of predicting risk, is a complicated and critical task. It requires serious ethical consideration and practice expertise at all stages of service delivery.

Research is clear that at risk infants, particularly those under the age of one year, are the most likely to die from non-accidental injuries, and Government is committed to tailoring our approaches as to how we work with vulnerable infants and their families. This has been a significant priority that has led to many practice changes and improvements since BJay's death in 2012.

The CSS applies an evidence informed practice which optimises all the available practice tools and contributes to improved outcomes for children, young people and families. Since 2014, the CSS has implemented the Signs of Saftey approach, as well as maintaining a focused and targeted approach to strengthening and improving the way in which we assess and respond to infants and young children.

New procedures and specific practice requirements have been developed and implemented within Child Safety with specific reference to the assessment and response to abuse and neglect concerns relating to infants at risk and unborn babies. These new procedures were developed in consultation with pediatricians and other experts in the field and outline indictors that must trigger formal medical examination. These triggers include any bruising to non-mobile infants.

Additionally decision making processes relating to unborn children and children under the age of three years has been strengthened and improved through the revision of the existing Three and Under Panel which is in place to ensure that Child Safety cases involving children aged three and under, including Unborn Baby Alerts, are sufficiently assessed prior to closure by an independent multi-disciplinary review, in recognition of the vulnerability of infants. A review of the unborn baby notification process is also occurring to ensure they are managed in line with agreed practice and procedure.

In December 2015, the Government announced that the Council of Obstetric and Paediatric Mortality and Morbidity would be immediately convened to independently review any future child death or serious injury. This 'early review response' to a child's death has the capacity to identify, at the earliest opportunity, emerging systemic problems for the agencies and service providers involved and produce solutions to safeguard children in the future. The work of the Three and Under Panel will be further supported by learning from these reviews.

Drug abuse is a significant factor in the neglect and abuse of children. Amendments to the *Children Young Persons and their Families Act 1997* have been considered and the Government review found that the current provisions of this Act provide sufficient powers to act and respond to issues of drug use and abuse.

In order to strengthen the internal messaging between Tasmania Police and DHHS, in 2016 an amendment was made to police practice which now requires police officers to verbally report all cases involving sexual abuse, physical injury or severe neglect to Child Safety Services, in addition to submitting a written referral via IDM. Additionally, protocols for the effective and efficient sharing of information between key departments have been reinforced and tested through senior management.

In recognition of the need to better support Child Safety practitioners through direct practice and support, 10 new Clinical Practice Consultant and Educator (CPCE) positions have been funded through the Strong Families, Safe Kids implementation plan. These senior clinical positions play a significant role in supporting and developing practice through case consultation and advice, mentoring and coaching of new and existing child safety staff and forming a link between formal learning activities and the embedding of learning in day to day practice. These roles are working within a state-wide unit which allows for practice to be viewed and understood at both a practice level and in a strategic sense. A priority development area being led by the CPCEs is risk assessment applying the Tasmanian Risk Framework (TRF) and Signs of Safety approach.

In addition, 21 new positions (including the hospital Child Safety Liaison Officer positions) are being engaged to support the CSS to deliver better outcomes for children at risk. These include unit coordinators, workforce development and training resources, support workers and staff health and wellbeing officers.

CYS launched a revised and improved Practice Manual on the 1 July 2015. The Practice Manual provides a comprehensive set of policies, procedures and practice requirements for the delivery of services for

children, youth and families in Tasmania. All staff within CYS must be aware of and comply with the policies and procedures outlined in this manual.

The actions in practice improvement outlined above address recommendations 1, 3, 4, 6, 8, 13, 16, and 18.

Learning and Development

Effective training, learning and development was a primary recommendation of the Coroner.

CYS has developed and launched a comprehensive Learning and Development Framework which sets out how learning and development will be structured and conducted. This framework acknowledges that there is a need to strengthen the transfer of acquired knowledge and skills from formal learning to the workplace. It provides a structured approach to the planning of all learning and development activities, and will lead to high level accountability across the service.

The Child Safety Service Learning Pathway is part of the overarching Learning and Development Framework, and outlines the core and specialist training requirements for Child Safety staff. Core training requirements for Child Safety Officers, Team Leaders and Managers include Child Development, Indicators of Abuse and Assessment of Infant Risk and Risk Assessment and working with clients with drug and alcohol use.

As part of the current Service Agreement between DHHS and Gateway Services, there is a requirement for Gateway to employ appropriately qualified, skilled, and where appropriate, credentialed and registered staff. Gateway operator Mission Australia has conducted risk training in response to recommendations from the inquest.

DHHS will commission the Community Partnerships Teams to undertake a review with Gateway and IFSS on the type and frequency of training that is offered to their staff to consider whether it is in line with the Coroner's findings. Opportunities for joint training will be considered and explored as part of this review.

In response to the Tasmanian Commissioner for Children and Young People's Report, *Children and Young People's Unique Experiences of Family Violence*, a practice guide has been developed to strengthen the understanding of family violence and referral pathways available for Tasmanian service providers and professionals working directly or indirectly for those experiencing family violence.

Additional resources that have been funded through the Strong Families, Safe Kids implementation plan will allow for greater focus on developing learning and development through 'on-the-ground' support as well as providing additional capacity to train and educate staff on the use of relevant IT systems to support practice and process – as it relates to the CPIS system that is currently in place.

In recognition of the need to better support Child Safety practitioners through direct practice and support, the Government has funded ten new senior clinical positions to be embedded within Child Safety teams across the State, this is reflective of the knowledge that 70 per cent of learning occurs through workplace learning.

CYS has implemented a consistent model of professional supervision across the entire service. The model provides a clear and simple format for supervision ensuring that it is supervisee driven, balanced, has a strong focus on reflection, learning and support and encourages accountability on both sides of the supervision relationship.

The Strong Families, Safe Kids Project Team is working with Government and the Cross Sectoral Consultative Committee to develop and promote a cross-sectoral approach to sharing education, training and professional development opportunities across government agencies and their non-government service.

Tasmania Police has provided education and instruction to police officers regarding Mandatory Reporting Requirement with respect to the suspected abuse or neglect of children. Additionally, training has occurred in the following areas:

- Recruit Training;
- Interviewing Vulnerable Witnesses Course;
- Sexual Assault Investigation Course;
- Investigator Professional Development Program; and
- Family Violence Training.

Work is underway to review the Investigative Practice Training Continuum which will incorporate the Interviewing Vulnerable Witnesses Course and the Investigator Professional Development Program which will incorporate findings from this Inquest.

The actions in learning and development outlined above address recommendations 1, 2, 11, 12, 17, and 16.

Workforce and Culture

Workforce development and workplace culture are complex issues that need to be considered alongside all and any change or improvement strategies. Children and Youth Services has placed high priority on this and has been actively leading change processes and cultural shifts in this regard. Specific activities that have supported this are:

- The launch of the Learning and Development Framework;
- Development of a revised Practice Framework for CSS;
- A new Recruitment and Retention Strategy that is aimed at resolving challenges related to the recruitment and retention of Child Safety staff leading to the establishment of a stable, professionally trained and confident workforce within Child Safety;
- Development of a Quality Improvement Framework;
- Development and implementation of agreed workplace values and behaviours;
- Positive and renewed leadership through Children and Youth Services Executive Leadership Team
- Establishment of whole of service leadership forums;
- Investment in leadership training and development programs; and
- Development of an Accountability Framework.

The redesign of the CSS via the Strong Families, Safe Kids plan provides an important opportunity to redevelop how we do our work and to articulate the culture in which we need to work. Importantly, the Strong Families, Safe Kids project is intended to establish a service delivery model which emphasises safety orientated, strength-based work with families over a purely forensic risk assessment approach – in line with the Signs of Safety approach.

As part of the project, Government agencies are collaborating to develop joint service plans for vulnerable children, to allow all services working with the family to access the historical context and have a more holistic understanding of the family's needs and what services they are currently involved with. These plans will reduce duplication and provide a platform for enhanced collaboration across different services.

The actions in workforce and culture outlined above address recommendations 2 and 10.

CLOSING COMMENTS

The Government has a statutory responsibility to safeguard children.

It is vital that we better understand the challenges in being able to get the right response, at the right time, delivered by the right people to ensure better outcomes for vulnerable children and young people.

The death of BJay Johnstone was a tragedy.

In horrific circumstances, people and organisations responsible for BJay's protection let him down, with the most tragic consequences.

Since 2012 the systems and supports that exist to keep vulnerable children safe have changed.

Practices have strengthened. Processes have improved. Supports have increased.

Service delivery and service options will continue to change as part of the Strong Families, Safe Kids reforms.


Tasmanian
Government