

Right to Information Decision – Public Disclosure Log

Right to Information No.: RTI201819-009-CT

Date of Application: 3 September 2018

Date of Decision: 19 October 2018

Information Requested

The information requested:

1. The number of cases the Child Safety Services (SERT) team is investigating relating to the death of a child/baby or sibling of a child who is known to youth services; and
2. The number of cases the DHHS (now DoCT) SERT team is investigating relating to the serious significant injuries of a child/baby or sibling of a child who is known to youth services.

The period for the request 2010 to 31 August 2018.

Decision

Background

Prior to the establishment of the Serious Events Review Team (SERT) in December 2017, the review of child death and serious injury matters were managed on a case-by-case basis. This involved identifying the most appropriate senior practitioner within Children and Youth Services to undertake the review, and, at times, involved the engagement of a party external to Children and Youth Services to lead the review. Issues of independence of the case, required time-frame for completion, and the avoidance of conflicts of interest determined who was best placed to undertake a review. The SERT is designed to provide an early response to matters of death and serious injury through a standardised process; reviewers being independent from operational service delivery.

For clarification the SERT does not *investigate* matters. Investigations of cases of harm to a client are conducted by other areas of Children and Youth Services. The SERT *reviews* matters where a child or young person known to Children and Youth Services has died or is seriously injured. A SERT review includes interrogation of case files, analysis of all other relevant and available information including policy and procedural requirements, and will, wherever possible, include interviews with staff (government and non-government) who were involved in the case. The purpose of the review is to provide evidence-based findings relating to adverse client outcomes to enhance the process of continuous quality improvement (CQI) within Children and Youth Services. The aim of the SERT and all other CQI activity is to reduce the likelihood of the recurrence of adverse client outcomes.

The SERT does not await the findings/investigations of police or the Coroner, but will work alongside police as appropriate. The process used by the SERT to undertake a review is implemented immediately following a death or serious injury.

Draft reports enter into a governance structure that provides for checks and balances relating to the whole of the written report and the review process. The draft report is moderated by senior Children and Youth Services practitioners and senior policy staff who provide feedback including about language, report structure, findings and recommendations. The Moderation Group is chaired by the Manager of the SERT. After clearing by the Moderation Group, the final review report is forwarded to the Deputy Secretary Children. The Report is then tabled at the Senior Events Review Committee (SERC). The SERC is an independent group comprising senior staff from a number of other State Government agencies including Education, Health, Justice and Police. Recommendations from SERT and the SERC are considered by the Deputy Secretary Children for implementation, with advice provided from the SERC to the Secretary, Department of Communities Tasmania. SERT Reports are generally submitted as evidence in a Coronial Inquest and are provided at the earliest possible time.

In response to the two questions asked:

1. SERT is reviewing four (4) deaths of a child/baby or sibling of a child who is known to youth services.
2. SERT is reviewing one (1) serious significant injuries of a child/baby or sibling of a child who is known to youth services.