BABY H

Baby H died on 28 May 2017, aged 4 months. Two days before her death she was placed into the care of the Department of Child Protection and Family Support. The inquest identified multiple missed opportunities for concerns in regard to Baby H's health and wellbeing to be addressed. The cause of death was found to be head and neck injuries and manner of death was unlawful homicide.

CRC members observed the similarities to the inquest into the death of PT and noted of the three recommendations related to the *Children and Community Services Act 2004,* Recommendation one, repeated the recommendation from the PT inquest findings. Members observed that whilst the regulatory impact review proposed in both inquest recommendations was considered to be appropriate, the inquest findings could be reviewed to identify and suggest further areas of potential improvement as they relate to the WA health system.

During discussion of the Baby H inquest findings the CRC considered if the existing child at risk alert processes are sufficient and well managed by Health Service Providers, or if a more strengthened and coordinated approach is required. Members considered the rationale for why mandatory reporting of injuries in non-ambulant children had not previously been expanded, the role of child alerts and work underway to establish a statewide child safety alert system, and concerns that bruising in a non-ambulant child should have been recognised as a sentinel injury.

Discussion focussed on the role of paediatric injury proformas used across WA health system emergency departments. It was observed that, whilst the form originated from the Child and Adolescent Health Service, that the content and governance processes of injury proformas may vary significantly across and within Health Service Providers. It was agreed that the Statewide Protection of Children Coordination Unit (SPOCC) would undertake a review and analysis of existing Health Service Provider paediatric injury proformas and associated systems and suggest recommendations that could improve consistency and governance across the WA health system.

Whilst equivalent paediatric injury proformas are utilised in emergency departments that provide services for children across the WA health system, differences have been observed in the supporting governance processes. Variation included the frequency and membership of 'Safety Net' meetings in which injury proformas are reviewed and the existence of and utilisation of policies, guidelines, and education and training offered.

Members also observed, in both the Baby H and PT inquests that the respective injuries were first identified in child health settings. In noting that there is no equivalent paediatric injury proforma in child health settings, an action was also agreed for WACHS to consider incorporating an injury proforma into the Community Health Information System for use by Child Health Nurses.

February 2022 Update

A report tabling the findings of the review and analysis undertaken by SPOCC was provided to the CRC by the Child and Adolescent Health Service. The report found that there are significant opportunities for improving consistency in the recognition and response of young children presenting with potentially non-accidental injuries in the WA

health system. The review of paediatric injury proforma and safety net meetings across Health Service Providers identified a number of limitations and made 5 recommendations for improved governance and standardised processes. Recommendations 1-3 included the establishment of a single standardised paediatric injury proforma for use in all WA hospitals, standardised governance for safety net meetings and the development of appropriate policies to support this consistent approach to implementation. The continuation of collaboration between CAHS and WACHS in non-ambulant children in community health services was considered in recommendation 4. Recommendation 5 highlighted the need to incorporate education regarding injuries to non-ambulant children into strategies addressing principle 7 of the National Principles for Child Safe Organisations. Each recommendation identified actions and a recommendation lead.

The implementation of the recommendations will continue and progress of this inquest to be included in the next biannual report.