Child Safeguarding Reforms and Recommendations

Policy Framework 2024-2029

Department of **Health**

Tasmanian Government

Acknowledgements

In recognition of the deep history and culture of this island, we acknowledge and pay our respects to all Aboriginal people, the traditional owners of this Country, and recognise their continuing connection to Land, Sea, Waterways and Sky. We pay our respect to Elders past and present, and acknowledge and value their contribution and cultural knowledge.

We recognise all people in Tasmania affected by child sexual abuse. In particular, children and young people, who have a lived experience of child sexual abuse within our care and those who spoke on your behalf - your bravery in speaking out is commended. You are the voices of change, and we hear you. We also acknowledge those who have not shared their stories. If you change your mind and chose to share your story, it is important you know we are listening and there is support available.

The Department would like to thank everyone who has contributed in some way to help bring child safety to the forefront. Our work will not stop after the final recommendation is completed. Keeping our children and young people safe will continue to be a priority for our community.

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Message from the Secretary

Every Tasmanian child and young person has the right to receive the best medical care and to know that they will be safe at all times. The Department of Health is committed to protecting the most vulnerable who are in our care.

It has been three years since we started on this, at times, incredibly difficult journey, looking back at how health has been delivered in Tasmania, in particular to children and young people, and the impact of failings of our health system.

As a result, both the Tasmanian Government and the Department of Health have committed to making the necessary large-scale changes within our health services to improve the safeguarding of children and young people receiving care.

In March 2021, the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission) was established with a final report tabled in Parliament and made publicly available in September 2023.

There are 191 recommendations to implement within specified timeframes. The Department of Health is lead agency for 24 of the recommendations. Today, we are releasing the Child Safeguarding Reforms and Recommendations Framework 2024-29 alongside the Child Safeguarding Reforms and Recommendations Implementation Plan 2024-29. By establishing a Child Safeguarding Taskforce and developing this Framework and the Implementation Plan, we will oversee the implementation of the recommendations and put in place the changes we need to ensure timeframes are met and mistakes are not repeated. Some important actions have already been implemented, such as:

- mandatory child safeguarding training for all DoH employees, volunteers, students and contractors
- Child Safeguarding Advisors located in all four major Tasmanian hospitals
- appointment of a new position of Chief Risk Officer to strengthen the Department's approach to risk and accountability and lead the plan for implementing recommendations from the Commission of Inquiry Report
- establishment of a Child and Young People Advisory Group with representatives from different age groups, backgrounds and cultures
- production of the 'My Say, Our Voices' book created through consultation with children and young people; and
- establishing the new Statewide Complaints Management Oversight Unit.

We will continue to work hard to implement all of the recommendations.

We took immediate action after the initial hearings of the Commission and in July 2022, the Department of Health commissioned the Independent Child Safe Governance Review of the Launceston General Hospital (LGH) and Human Resources (HR) to rebuild the Tasmanian community's confidence in the LGH and our health services. This review resulted in 92 recommendations which were publicly released and accepted in December 2022.

I want to thank the Co-Chairs of the Child safe Governance Review – Adjunct Professor Debora Picone AO and Adjunct Professor Karen Crawshaw PSM, as well as all of the Department of Health staff representatives, other child safety experts and Union representatives for their dedication and commitment to getting the review completed.

Most importantly, I want to thank the victim-survivors who have played a pivotal role by agreeing to participate in this process. Without your strength and bravery in coming forward and telling your stories, the Inquiry and the Review would not be at the point it is today. And I want to acknowledge Dr Maria Harries AM who was instrumental in providing invaluable communication between victim-survivors and the Review panel.

We are committed to embracing the opportunity the Commission's recommendations for reform provide and to strengthen our efforts to keep children safe and protect their wellbeing.

I know that this task is not simple. Health is an incredibly complex environment, and it will require every one of our more than 16,000 staff and volunteers to personally commit to making the safety of children and the vulnerable in our care our number one priority.

I urge all staff and members of the community to join with me to champion the safety and rights of children and young people in our care, so that together we are committed to ensuring the safety of children and young people each and every day across our Health system.

Dale Webster
Acting Secretary
Department of Health

Executive Summary

The Department of Health is committed to implementing the recommendations of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission) and creating real change.

The Department of Health Executive (the Executive) has collectively signed a Statement of Commitment that "All children and young people have the right to feel and be safe. Children and young people want to be believed and to be heard. Keeping children and young people safe is everyone's responsibility."

The Executive is providing oversight and leadership on implementing the 24 recommendations of the Commission where the Department is the lead agency.

The Child Safeguarding Reforms and Recommendations Policy Framework 2024-2029 (the Framework) delivers on Recommendation 15.1 of the Commission and outlines the child safety reviews and reforms that Department has and is undertaking, including:

- details of child safety review and reform programs being implemented by the Department
- key initiatives already implemented by the Department to improve child safeguarding
- overarching Governance arrangements for the implementation of all child safety recommendations

The companion document to this Framework, the Child Safeguarding Reforms and Recommendations Implementation Plan 2024-2029 (link) outlines and prioritises the recommendations and timeframes which have come from the Inquiry including:

- executive responsibility for each recommendation
- timeframes for delivery of each recommendation
- monitoring and reporting arrangements.

The Department of Health will implement all recommendations of the Commission within the timeframes set out by the Commission. The Department will collaborate across Government where relevant to ensure shared outcomes and progress are achieved.

The Framework and Implementation Plan also capture the Department's ongoing commitment to deliver on recommendations from previous reviews, the Independent Child Safe Governance Review and the LGH Community Recovery Initiative Recommendations.

Relationship between Recommendations – Executive Responsibility

The Independent Child Safe Governance Review recommended that:

1. “The executive and clinical leadership team of the LGH join with the Secretary and executive of the Department by collectively and individually committing to improving the safety of children and young people

The Commission of Inquiry Report recommends that:

15.5. “The Department of Health should make health leadership accountable for embedding child safety as a priority… by ensuring that all relevant health leaders have an obligation to act consistently with the National principles for Child Safe Organisations…”

The full text of the above recommendations can be read in the **Child Safeguarding Reforms and Recommendations Implementation Plan 2024-2029 available at health.tas.gov.au.*

Background and Context

Commission of Inquiry

In 2020, the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings (the Commission) was announced to provide an effect response to failures by Tasmanian government systems and institutions to protect children and young people from child sexual abuse.

The Commission's intention was to build upon, but not repeat, the work of the Australian Government Royal Commission into Institutional Responses to Child Sexual Abuse, which was announced in November 2012, commenced hearings in April 2013 and presented a final report in December 2017.

Under the Terms of Reference, the Commission of Inquiry was asked to inquire into what the Tasmanian Government should do to:

- better protect children against child sexual abuse in institutional settings
- achieve best practice in reporting and responding to allegations, incidents and risks of child sexual abuse in institutional settings
- eliminate or reduce problems which currently prevent appropriate responses to child sexual abuse in institutional settings including failures and barriers to report, investigate and respond to allegations and incidents
- address or alleviate the impact on past and future child sexual abuse in institutional settings, in particular ensuring justice for victims through investigation, prosecution and support services.

Public hearings were held in Hobart and Launceston from May to September 2022 with closed hearings held in August 2023.

The Commission examined allegations and incidents of child sexual abuse occurring since 2000 or were reported between 2000 and 2022, covering a 22-year period. A focus was on current responses to allegations and incidents of child sexual abuse in government institutions (eg, hospitals, public schools, youth detention centres) and in non-government institutions where they receive funding from the Tasmanian Government to provide services on its behalf, such as out-of-home care.

The final report was tabled in the Tasmanian Parliament and publicly released on 26 September 2023.

The Tasmanian Government has accepted all 191 recommendations made by the Commission.

Although the Commission of Inquiry has now concluded its work, you can visit the Commission of Inquiry website to view more information and read the Final Report.

Other Child Safety Reviews

In response to the issues that led to the establishment of the Commission of Inquiry, the Department of Health instigated a number of processes to address areas of concern and identify further areas where improvements were required to ensure child safety. These processes were designed to make immediate changes to improve child safety and commence improvements in areas that had arisen through the Commission of Inquiry.

Independent Child Safe Governance Review

Following evidence heard at the Commission of Inquiry hearings, the Department of Health acted immediately to undertake an independent review of child safe governance at the Launceston General Hospital (LGH) and Human Resources (HR) – with a specific focus on the handling of serious misconduct such as institutional child sexual abuse.

The Independent Child Safe Governance Review (the Review) was about making important and necessary changes which focused on resetting the organisational structure of the LGH and HR, with a priority focus on the handling of serious misconduct such as institutional child sexual abuse.

The Review commenced in August 2022 and was undertaken by a Governance Advisory Panel (the Panel) established under Section 13 of the *Tasmanian Health Service Act 2018*, with Adjunct Professors Debora Picone AO and Karen Crawshaw PSM, appointed as independent Co-Chairs of the Panel.

Professor Picone was the CEO of the Australian Commission on Safety and Quality in Health Care at the time of the review, a position she had held since 2012. Professor Picone is a highly respected leader in public administration, with extensive operating and leadership experience in the provision of healthcare services, governance, and hospital administration. In the role with ACSQHC, Professor Picone led the development and implementation of a series of national system-wide safety and quality programs.

Professor Crawshaw has held several senior executive positions within the NSW Public Service, including as NSW Health’s Director Legal and General Counsel for 17 years. Professor Crawshaw also worked as Deputy Secretary Governance, Workforce and Corporate until 2017, with responsibility for a broad range of policy areas including health system governance, regulation, legal services, workplace relations and human resources.

The Panel also included union and staff representatives as well as independent experts with qualifications in governance, child safety, hospital administration and human resources.

The Panel's Terms of Reference were to specifically examine the governance structure of the LGH and HR through a child safety lens, to ensure public confidence in the safety of the service and make recommendations as to changes required to improve:

- organisational structure
- management and leadership including roles, responsibilities and accountabilities
- implementation of mandatory training in leadership and management, through the One Health Cultural Improvement Program, including a focus on accountable leadership and management (already underway)
- implementation of mandatory training in Child Safety, including grooming behaviours and mandatory notifications, through the Child Safe Organisation Project (already underway)
- implementation of the Department of Health Child Safe Organisation Framework and establishment of the Child Safety Panel (already underway)
- establishment of an independent central complaints management unit in the Office of the Secretary, responsible for the review of all reports of inappropriate behaviour or misconduct by an employee, in particular child sexual abuse or grooming behaviours, separate from Human Resources
- policies, procedures, protocols, quality and safety frameworks, systems and data as they relate to the above.

The full membership of the Governance Advisory Panel (the Panel) met on nine occasions, between August and November 2022, with meetings held either online via Microsoft Teams or face-to-face meetings held on location in Launceston.

As well as the Panel meetings, a process for engaging with victim-survivors was established and facilitated by Dr Maria Harries, a Panel member and expert in child safety matters. Dr Harries had significant engagement with a number of the victim-survivors and their families who agreed to participate in the process.

The victim-survivor participants were also given a chance to review the suite of recommendations before they were delivered to Government and provided feedback which was incorporated into the final wording of the recommendations.

In December 2022, the Panel submitted the Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources Report to the Secretary of the Department of Health.

The report contains 92 Recommendations to improve child safeguarding across the Department and our frontline health services – all were accepted by Government. The Department has been implementing these recommendations alongside the 8 Recommendations of the LGH Community Recovery Initiative bringing the total to 100 recommendations. Read more about the review.

At the time of publishing this framework, the majority of the 100 recommendations have been completed. This has allowed the Department to demonstrate significant progress already against the Commission of Inquiry recommendations.

The Department will continue to implement any remaining recommendations of the Review alongside those of the Commission of Inquiry.

LGH Community Recovery Initiative

The Department of Health commenced the Launceston General Community Recovery Initiative to begin rebuilding community trust in the LGH following the hearings for the Commission of Inquiry. At the time of the Commission of Inquiry hearings, anecdotal evidence suggested the northern region community had lost trust in the LGH.

The LGH Community Recovery Initiative had three main objectives:

1. Learn from the community
2. Restore community confidence
3. Build community capability

The Initiative focused on recovery and looking forward and did not investigate liability or finding fault with legal actions and recommendations outside the scope of the recovery initiative.

Respected community members from the northern region, Mrs Elizabeth Daly and Mr Malcolm White led the recovery initiative as independent co-Chairs.

Mrs Daly and Mr White conducted forums to listen to the northern community and understand what the community believed to be important to rebuild their trust in the LGH.

After considering the suggestions raised at the forums, the Co-Chairs produced a final *Launceston General Hospital Community Recovery Initiative Co-Chairs Final Report – 16 November 2022* with 8 recommendations around the themes of Leadership, Communications, and Training and Protocols.

These recommendations were implemented alongside the recommendations of the Independent Child Safe Governance Review, and all recommendations have been completed.

You can read the full report at health.tas.gov.au

Outcomes of Child Safety Reviews

Some of the key actions that have occurred in response to the recommendations of the above reviews include:

- the rollout of mandatory child safety training which has been a significant initiative out of the implementation, with more than 15,500 people having undertaken the training.

  While this is important for our workplace, it also means we have an increased awareness of child safety in our communities as well. This is one of the largest efforts to provide child safety education in living memory.

  The effort will continue, to ensure anyone who hasn't undertaken the training, including new starters and those who have been on leave, complete the training before they work in one of our health services.

- Full-time Child Safeguarding Advisors have been successfully recruited and are now based at each major hospital in Tasmania. The Child Safeguarding Advisors will support and guide the development of the Department of Health's child-safe culture, as well as provide advice on child safeguarding related matters.
- The Safety Reporting and Learning System has been updated to support our staff in raising concerns about children and young people's safety and wellbeing. Child safeguarding concerns reported in SRLS will be sent directly to the Statewide Complaints Management Oversight Unit and will be handled confidentially.
- A new Statewide Complaints Management Framework has been developed and released to ensure a consistent approach to the management of complaints.

  A Statewide Complaints Management Oversight Unit (SCMOU) has been established and sits within the Office of the Secretary. The SCMOU is responsible for supporting the consistent triage and oversight of complaints management in the Department of Health.

- Dedicated rooms have also been made available in all of Tasmania's major public hospitals for patients wanting to make a complaint or raise a concern.
- A secure tab has been added to the Digital Medical Record, allowing authorised clinicians to access a patient's sexual assault and family violence history when they present to one of the State's public hospitals. This will ensure patients will not have to re-tell their stories unnecessarily and clinicians

will have access to information they need to ensure signs of concern are not missed.

- Updates to performance and development discussion templates to help managers support employees in understanding their responsibilities relating to child safety, mandatory reporting, confidentiality and cybersecurity.

  In addition, updates have been made to all current and future Statements of Duties with a new accountability and responsibility relating to child safeguarding.

- The One Health Culture Elevate Management Development Program has been specifically developed for the Department of Health and is designed to upskill managers in the non-clinical aspects of their roles and focuses on development in the areas of planning, delegating, financial and people management, governance, performance management, communication, and human resources.
- The One Health Culture Aspire Leadership Development consists of a series of face-to-face and virtual workshops. Conducted across twenty weeks, the Program covers leadership themes including adaptive leadership, engaging with risk and problem-solving, working collaboratively, communication with integrity and thinking strategically.
- The Department has also undertaken a Human Resources change proposal that aligns with recommendations of the Child Safe Governance Review.

  The Human Resources Transformation Program delivers a new HR service delivery model with a vision to provide a high-quality, responsive and trusted service that will meet the contemporary needs of Tasmania's largest Government Agency.

  The new model incorporates many of the independent review’s recommendations, including those relating to HR Business Partners, as well as ensuring improved record-keeping, enhanced staff capabilities and a greater understanding of reporting requirements.

Child Safeguarding Initiatives

Child Safety and Wellbeing Framework

The Department of Health's Child Safety and Wellbeing Policy Framework outlines the Department's approach to implementing the National Principles for Child Safe Organisations.

Implementation is supported by a Child Safety and Wellbeing Policy which articulates the Department's commitment and obligations to creating and maintaining a child safe organisation and explains key features of the Department's approach to meeting the National Principles.

In February 2019 the Council of Australian Governments endorsed the National Principles outlining at a high level, 10 elements that are fundamental for making an organisation safe for children and young people.

The Framework establishes a formal rights-based approach to child safety and wellbeing, enabling the Department to demonstrate to consumers, the community, government and peers that it is accountable for the safety and wellbeing of children and young people.

Implementation of the Framework is supported by:

- a Statement of Commitment signed by the Department of Health Executive
- the roll out of mandatory child safeguarding training to all Department of Health staff, volunteers, contractors and students.
- establishment of the Child Safety and Wellbeing Panel which is an independent advisory panel that supports review of serious child safeguarding events.
- establishment of a Children and Young People Advisory Group
- improved reporting arrangements for child safety concerns
- educational resources and practice guidance documents on how staff, volunteers and students can safeguard children and young people accessing health services including online and face-to-face training sessions
- Child Safeguarding Advisors at the four major Tasmanian hospitals (Royal Hobart Hospital, Launceston General Hospital, North West Regional Hospital and Mersey Community Hospital).

You can read:

- Child Safety and Wellbeing Framework.
- Summary of the Framework
- Other Resources including Fact Sheets, Guidance Notes
- Visit Child Safety and Wellbeing on the Department of Health website.

Child Safety and Wellbeing Service

The Child Safety and Wellbeing Service (CSWS) was established in late 2022 to lead the Department's implementation of the Child Safety and Wellbeing Framework. Focus areas include:

- supporting the Department's monitoring and response to child safeguarding issues
- supporting work areas to foster a child safe organisation culture by providing DoH workers with education and training in child safeguarding (this includes employees, students, volunteers and contractors)
- providing advice to work areas to strengthen policies and protocols around child safeguarding
- engaging with Tasmania's children and young people.

The CSWS will be responsible for directly implementing a number of the recommendations of the Commission of Inquiry report.

Child Safeguarding Advisors

A key component of the CSWS is full-time Child Safeguarding Advisors (CSAs) based within the Royal Hobart Hospital, the Launceston General Hospital, the North West Regional Hospital and the Mersey Community Hospital.

The CSAs play an important role in liaising with workers regarding the safety and wellbeing of children and young people accessing the Department of Health services and provide advice and deliver training to workers on child safeguarding issues. The CSAs provide consistent messaging and advice about how workers can raise child safeguarding concerns, including how they can fulfill their mandatory reporting obligations.

Through fostering relationships with work areas, the CSAs play a key role in supporting workers to engage with the work of the CSW and other initiatives supporting the *Child Safety and Wellbeing Framework*.

Independent Child Safety and Wellbeing Panel

The Department established an independent Child Safety and Wellbeing Panel in mid-2023. The Panel is made up of five members – a Chair, two independent members and two consumer representatives with lived experience who oversee monitoring of the child safeguarding concerns and is supported by CSWS.

The Panel is integral to the Department of Health's commitment to safeguarding children and is part of the implementation of the Child Safety and Wellbeing Framework.

The role of the Panel is advisory in nature and their scope includes, but is not limited to:

- reviewing and assessing all serious child safeguarding events referred by the Secretary, including completing a root cause analysis of the event;
- conducting defined research, reviews, inspections, or evaluations, and providing independent advice and evidence-based solutions to the Secretary;
- assisting the Department in quality and safety decision-making in relation to child safeguarding;
- advising the Secretary on options for quality improvement in structures, systems, processes, and tools in relation to child safety;
- advising the Secretary on options for systematic management of safety and quality learnings from serious child safeguarding events; and
- advising the Secretary in relation to the appropriate escalation of risks relating to trends identified through the review of investigation findings.

The Panel has already met a number of times and discussed a range of matters such as the implementation of the independent Report for the Child Safe Governance Review of the LGH and HR, the Child Safety and Wellbeing Framework, the DoH structure and role and purpose of the panel.

Children and Young People Advisory Group

In late 2023, the Department established the Children and Young People Advisory Group (CYPAG) as part of the Department of Health's commitment to engaging with young Tasmanians.

CYPAG aims to meet quarterly and provides an opportunity for the Department to seek the views of children and young people on subjects which affect them, and allows for co-design and feedback on how the Department can improve its services to this cohort. 2024 will see a focus on providing ideas into the Emergency Department Redevelopment Project and also looking at the accessibility of the Department's online resources.

CYPAG will also continue to have opportunities to contribute to informing CSWS initiatives, such as Child and Youth Safe Behaviours.

Ideas from CYPAG consultations are captured in and shared through Communiques via the Secretary and other health leaders.

Efforts are made to ensure CYPAG membership is a mixture of age, gender and represents a range of backgrounds, including:

- young Tasmanians with experience using Tasmanian Government health services, such as public hospitals

- Aboriginal and Torres Strait Islander young people
- young people living with disabilities
- young carers
- young Tasmanians with refugee and/or migrant backgrounds
- young Tasmanians from rural/regional/remote areas
- young people with experience of homelessness and out-of-home care
- young people from low-income backgrounds
- LGBTIQA+ young people.

Future CYPAG meetings will include consultation on activities being progressed by the CSWS and will give CYPAG members the opportunity to raise their own interest areas with the Department.

Engaging with children and young people

The Department is committed to listening to and working with children and young people and has run statewide workshops to engage with children and young people and hear about their experiences when accessing health care within our services.

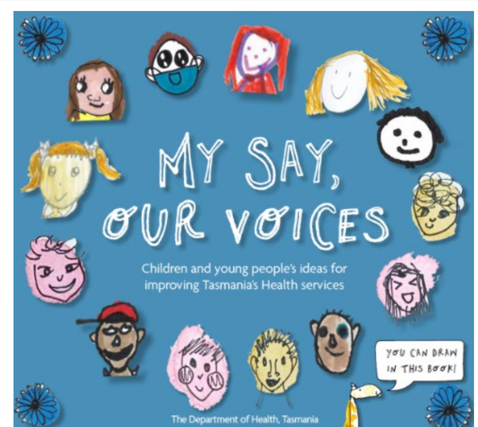
In mid-2023, the newly established Child Safety and Wellbeing Service worked with experts and consulted with children and young people on how the Department can strengthen its services to children and young people, with a particular focus on child safety and wellbeing.

Through consultation activities, including statewide workshops with participants who had experience using the DoH paediatric services, resources have been developed including a book *'My Say, Our Voices'* and a mini book titled *'Me and my health journey'*. Children are encouraged to write and draw about how they feel about the care and support they have received while accessing our health services.

Read more information on engaging with children and young people.

Case Study – *'My Say Our Voices'*

In mid-2023, the newly established Child Safety and Wellbeing Service (CSW Service) worked with engagement experts Dr Simon Spain and Victoria Ryle on a new initiative to consult with children and young people on how the Department could strengthen its health services to children and young people.



Through engagement and collaboration, we have developed a booklet titled 'My Say Our Voices'. This booklet is a result of statewide workshops where children and young people provided feedback on their experiences when receiving care within our health

services. Suggestions, statements and artwork from the workshops have been used as design elements in the booklet.

The booklet aims to help Health leaders, in work areas providing services to children and young people, consider the practical ways they can strengthen their services to children and young people, such as:

- making clinical environments more engaging and welcoming by providing fun activities for patients
- prioritising opportunities to give children and young people a voice in their medical treatment and also give them an opportunity to provide feedback on how we can do better.

Through tear-out pages, readers can also use the booklet to provide further feedback and suggestions about their experiences.

Engagement with children, young people, their families and caregivers is ongoing. We want to hear and learn, particularly from young Tasmanians, on how we can deliver better services when they are in our care.

Mandatory training and reporting

All current and new Department of Health staff (including volunteers, contractors and students) are required to complete mandatory safeguarding children and young people training. e-learning modules are available via the Tasmanian Health Education Online portal (THEO). Non-employees such as students on placement, volunteers and contractors can access the training through the Health Learning Online (HLO) portal. The training package included videos, activities and surveys covering topics such as:

- understanding child abuse in organisations
- creating safer organisations through the code of conduct, recruitment, induction and training
- recognising diversity and inclusion
- safeguarding commitment and culture.

More than 15,500 people completed the initial mandatory training rollout. In addition, staff are required to complete annual online refresher training which is available through THEO and HLO which reinforces the principles of safeguarding children and young people.

In January 2024, the Department moved to a single training model which now serves as mandatory training for both existing staff (as a refresher course) and for new staff starting with the Department. To date more than 4500 staff have completed the training. Supports are available for anyone requiring additional help.

Mandatory reporting obligations

All Department of Health staff, volunteers, contractors and students have a responsibility to understand their mandatory reporting obligations. The Child Safety and Wellbeing Framework outlines responsibilities as mandatory reporters including:

- making a notification to the Strong Families, Safe Kids Advice and Referral line (1800 000 123) if they believe or suspect (on reasonable grounds) that a child or young person has been or is being abused or neglected (*Children, Young Persons and Their Families Act 1997*)
- notifying the Australian Health Practitioner Regulation Agency (AHPRA) if they form a reasonable belief that another registered health practitioner has behaved in a way that constitutes notifiable conduct (*Health Practitioner Regulation National Law (Tasmania) Act 2010*)
- notifying the Registrar of the Registration to Work with Vulnerable People Scheme if a registered person has engaged or may have engaged in reportable behaviour (*Registration to Work With Vulnerable People Act 2013*)
- notifying Tasmania Police if there is a reasonable belief that an employee has engaged in criminal conduct.

Staff are not required to seek formal authorisation before making a mandatory notification which is being made clear in updated and new policies through the Department.

Staff can report concerns via an online form (Reporting Concerns of Inappropriate Behaviour) or via the Safety Reporting and Learning System (SLRS) as well as notifying the relevant external organisations.

The SRLS has been updated and now supports DoH staff in raising concerns about children and young people's safety and wellbeing. Child safeguarding concerns reported in SRLS are managed through the Statewide Complaints Management Oversight Unit.

The Commission of Inquiry highlighted gaps in the knowledge of some health practitioners regarding their mandatory reporting obligations. The Department has collaborated with AHPRA and developed training sessions to help people working in Health to understand AHPRA's public protection role. Training also covers managing notification processes about registered health practitioners and is an opportunity for both notifiers and those who experience notification, to understand the process.

A Memorandum of Understanding (MOU) was signed between the Department and AHPRA to support sharing information relating to sexual misconduct by health practitioners. Under the MOU, both AHPRA and the Department will share information regarding allegations of boundary violations by DOH employees as soon as possible and as allowed by law.

Relationship between Recommendations – Child Safeguarding

The Independent Child Safe Governance Review recommended that:

42. “The size and complexity of the LGH warrants full-time resources for Child Safety Liaison and the establishment of a dedicated Child Safe unit to support the reporting and training in child safety at the LGH under the Child Safe Organisation Framework and to provide expert advice to staff when needed.”

51. “All staff in Tasmanian Health undertake the Child Safety mandatory training by 30 June 2023 and regular refresher training is provided to all staff at appropriate intervals…”

The Commission of Inquiry Report recommends that:

15.6. “The Department of Health to support health services to become child-safe organisations, should ensure… staff responsible for providing care to children have the knowledge and skills to respond to child safety concerns in line with the expectations of a child safe organisation…”

Note: *The full text of the above recommendations can be read in the* ***Child Safeguarding Reforms and Recommendations Implementation Plan 2024-2029*** *available at health.tas.gov.au.*

Statewide Complaints Management

Statewide Complaints Management Framework

In August 2023, the Department of Health released the Statewide Complaints Management Framework (the Framework). The Framework aims to improve the awareness of all staff (including employees, officers, clinicians, fixed-term agency/locum staff, volunteers, students and contractors) regarding the Department's approach to managing concerns and complaints from both external (consumers and matters referred by other organisations) and internal (staff) sources. The Framework is designed to ensure the Department's complaints management approach benefits consumers, staff, managers and the Department.

The Department's complaints management model is founded on a 'no wrong door' approach for making a complaint or registering a concern and is guided by the following principles:

- Trauma-informed
- Promoting and protecting safety
- Respectful and confidential treatment
- Accessible information and processes
- Clear and regular communication
- Taking ownership
- Timeliness
- Transparency
- Fairness and natural justice

The Framework covers:

- the Department's approach to complaints management including leadership and commitment; statewide complaints management model and evaluation and continuous quality improvement
- complaints management guidance such as responding, accessibility, escalation, referrals and withdrawing complaints
- mandatory requirements for the Department.

Statewide Complaints Management Oversight Unit

The Statewide Complaints Management Oversight Unit (SCMOU) sits within the Office of the Secretary and has been established to continue moving the Department of Health towards best practice in dealing with complaints across the agency statewide. The SCMOU supports the implementation of the Statewide Complaints Management Framework in ensuring a consistent approach to managing complaints.

The SCMOU provides oversight and governance for monitoring and managing health complaints and has been established to:

- assess and triage child safeguarding concerns and complaints
- directly manage Tier 1 complaints (as per the Complaints Management Response Matrix summarised in Table 1 of the Framework)
- act as an escalation point for complex or sensitive complaints and an alternative pathway for reporting suspected misconduct of staff
- provide an additional avenue for staff and consumers to confidentially raise concerns or make complaints (independent from local units or business areas)
- provide a quality assurance function by undertaking high level analysis and reporting of statewide complaints data
- manage the Framework and develop tools to support its implementation (a training module will be developed specifically for staff who manage complaints)
- create a complaints management community of practice to support skill development and innovation in trauma-informed complaints management.

The Statewide Complaints Management Oversight Unit team can be contacted by phone on 6166 2374 or 6166 2377 or email: doh.complaints@health.tas.gov.au

Relationship between Recommendations – Complaints Management

The Independent Child Safe Governance Review recommended that:

68. “Tasmanian Health review the Feedback and Complaints Management Framework and Policy, to ensure a consistent, whole of Health complaints management function..”

The Commission of Inquiry Report recommends that:

15.16 – “The Department of Health should have a specific policy on responding to complaints and concerns about staff conduct. The policy should establish a complaints escalation, management and investigation process..”

The full text of the above recommendations can be read in the **Child Safeguarding Reforms and Recommendations Implementation Plan 2024-2029 available at health.tas.gov.au.*

Cultural Improvement – One Health Culture Program

Cultural change is a ten-year plus process.

The Department of Health has introduced its One Health Culture Program Strategy (One Health) to drive cultural improvement, support staff to work together, learn, collaborate and problem-solve, share risk and empower and respect one another. One Health is about building an inclusive working environment reflecting health workforce diversity and supporting employees to work together to improve health and wellbeing of Tasmanians.

One Health has five focus areas:

- leadership accountability
- building capacity
- workplace values and behaviours
- health, safety and wellbeing
- systems and processes.

The program is rolling out leadership and management training to build the capacity of the Department's leaders and managers and ensure they have the skills and tools to effectively perform their roles, which includes safeguarding children and young people and complaints management.

A priority of One Health is developing and implementing programs to enhance staff leadership and management skills.

Aspire Leadership Development Program

The Aspire Leadership Development Program is designed to identify and support senior leaders of the future. The Aspire Program covers leadership themes including adaptive leadership, engaging with risk and problem-solving, working collaboratively, communicating with integrity and thinking strategically.

Elevate Management Program

The Elevate Management Program has been specifically developed for the Department of Health to incorporate recommendations from the Child Safe Governance Review report (recommendations 22, 23, 24 and 25) and the Ambulance Tasmania (AT) Culture Action Plan. The Elevate Program is underpinned by three key elements: **People**, **Safety** and **Systems** and aims to develop management skills in areas of planning, delegating, financial and people management, governance, engaging with risk and problem solving, performance management and communication.

Compassion, Accountability, Respect and Excellence (CARE).

Following consultation with staff, agency-wide values were introduced in August 2023. These values are Compassion, Accountability, Respect and Excellence (CARE).

To help embed CARE values, several initiatives have been launched:

- **CARE Recognition Program –** an opportunity for staff to recognise and celebrate a colleague for demonstrating CARE values
- **CARE in Practice –** an online implementation guide which includes workshops and communication strategies, addressing topics such as defining values, bringing values to life and connecting to the agency's purpose
- **CARE Chats –** a form of 'compassionate candour' where staff are supported to have challenging conversations delivered with compassion

Health, Safety and Wellbeing

Key focus areas of the One Health are health, safety and wellbeing to ensure:

- a workforce who understands and positively engages with worker and patient safety, adjusting or eliminating behaviours and practices as appropriate
- a physical and psychologically safe workplace
- wellbeing supports available to assist people.

This includes delivering on the Commission's recommendation to develop a Critical Incident Response Protocol (CIRP) to provide guidance on what support is available, and how it is arranged and monitored.

Approaching culture holistically

The *Independent Child Safe Governance Review of the Launceston General Hospital and Human Resources* provided an opportunity for the Department to build a positive health culture, with many of the recommendations centred around continuing and enhancing work committed through the One Health program.

Different areas of the Department of Health are implementing local programs to build positive health culture across the organisation, such as Huron Studer Group, Speaking Up For Safety in our Hospitals, Tapping into Talent across Statewide Mental Health Services, and Ambulance Tasmania's Cultural Transformation Strategy.

The One Health Culture Program acts as an umbrella for all of these initiatives, ensuring coherence in the direction we are moving.

Child Safe Behaviours

The Department of Health's One Health Culture Program has collaborated with the Child Safety and Wellbeing Service, to establish a set of Child Safe Behaviours for the Department, and are informed by the CARE values.

The Child Safe Behaviours serve as a set of standards and expectations and guide the delivery of health services in Tasmania.

Statewide online and face-to-face workshops plus an online survey have gained perspectives from a range of locations, professions and backgrounds and include conversations held with employees, volunteers and contractors.

Perspectives gained from the Children and Young People Advisory Group (CYPAG), as well as through wider consultations with Tasmanian children, young people and families, will be used to form a draft set of Department of Health Child Safe Behaviours which will go out for further consultation before being adopted and implemented.

Relationship between Recommendations – Cultural Improvement

The Independent Child Safe Governance Review recommended that:

38. "An overarching Change Plan be developed that strategically integrates the One Health Culture Program and the Child Safe Organisations Project…"

The Commission of Inquiry Report recommends that:

15.3 "The Department of Health ensure its cultural improvement program embeds a safety culture in health services…"

The full text of the above recommendations can be read in the **Child Safeguarding Reforms and Recommendations Implementation Plan 2024-2029 available at health.tas.gov.au.*

National advocacy

In line with the recommendations of the Commission, the Department of Health has commenced advocating at a national level to include the National Principles for Child Safe Organisations as a requirement for accrediting health services.

The Australian Commission for Safety and Quality in Healthcare (ACSQHC) is an independent statutory authority established under the *National Health Reform Act 2011*, funded jointly by the Commonwealth and state and territory governments, to oversee matters in relation to safety and quality in healthcare on a national basis.

The involvement and agreement of the ACSQHC is required to implement a National Standard as a mandatory accreditation requirement.

ACSQHC is required to consult with jurisdictions and other stakeholders including clinicians, lead clinician groups, carers, consumers and the public. Work is usually collaborative and there are established systems and processes for developing, considering and adopting National Standards. The Secretary, Department of Health met with ACSQHC in November 2023 and agreed to collaborate on this matter.

The Commonwealth and all states and territories have previously endorsed the National Principles but are at different stages of implementing specific child safety standards. Tasmania intends to seek agreement from all jurisdictions, through the Health Chief Executives Forum to formally incorporate the National Principles into a National Standard.

Governance of Implementation

The Commission of Inquiry recommended the Tasmanian Government develop a whole-of-government child sexual abuse reform strategy and action plan for preventing, identifying and responding to child sexual abuse (including in institutions) as well as harmful sexual behaviours (*see Recommendation 19.1*).

This strategy and action plan will outline the system response to the Commission of Inquiry and prioritise recommendations for delivery.

The Secretary, Department of Premier and Cabinet, as the chair of the Secretaries Board is responsible for overseeing the child sexual abuse reform strategy and action plan. The Secretaries Board is accountable for endorsing actions and outcomes and resolution of system-wide issues.

The Secretary, Department of Health, is a member of the Secretaries Board and is also a member of the Child and Youth Safety and Wellbeing Subcommittee which is accountable for outcomes and driving strategic reforms.

The Chief Risk Officer is a member of the Child and Youth Safety and Wellbeing Steering Committee, which is responsible for the oversight of working groups, actions, outcomes and strategic reforms.

The Department's existing Health Executive will act as the internal Steering Committee providing oversight of the implementation of Department of Health led recommendations.

Oversight and Accountability

The Department of Health Executive acts as the Steering Committee providing direction and oversight while also monitoring progress of the implementation of Commission's recommendations. This includes any outstanding Independent Child Safe Governance Review recommendations.

Additional meetings are being scheduled monthly to allow the Health Executive dedicated time to work through the recommendations. The COI Health Executive will be considering risks and opportunities, collaboration with other agencies, how the recommendations interact with other recommendations and meeting the Commission's recommended implementation timeframes.

Each COI recommendation has an allocated Health Executive member who is accountable for overseeing and delivering implementation by the required timeframe. In some cases, work has already commenced due to the Child Safe Governance Review recommendations, and is incorporated into the delivery of Commission recommendations.

Responsible Executives will utilise existing resources within their business areas to implement their recommendations and additional resources will be considered as part of the State Budget process.

Child Safety Reform Independent Monitor

In alignment with the recommendations of the Commission the Tasmanian Government is establishing a Child Safety Reform Independent Monitor who will provide oversight of the implementation of all Commission of Inquiry Recommendations.

The Department of Health will comply with all reporting and scrutiny requirements of the Independent Monitor once it has been established.

Supporting and resourcing implementation of the Framework

The Child Safeguarding Taskforce has been established within the Office of the Chief Risk Officer and is responsible for both developing this framework and coordinating implementation of the Commission's recommendations in the Department of Health.

The Taskforce will coordinate monitoring, reporting and communication activities for all Commission related matters for the Department and is the primary area of contact for matters relating to the Inquiry.

Responsible Executives will utilise existing resources within their business areas to implement their recommendations.

Reporting and Communication

The Department of Health will participate in any whole-of-government reporting and communication activities and will provide updates on the Department's progress of implementation via the public website, social media and any other appropriate formats and platforms including the Department's Annual Report.

Recommendations of the Commission of Inquiry

On 1 December 2023, the Tasmanian Government released Keeping Children Safe and Rebuilding Trust. This was in response to the Final Report of the Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings.

The Response summarises the Government's planned implementation of individual recommendations, phased according to the timeframes provided by the Commission and places an emphasis on first phase recommendations.

There is a three-phase reform plan for implementing recommendations:

- Phase 1 by July 2024 (short term)
- Phase 2 by July 2026 (medium term)
- Phase 3 by June 2029 (long term)

To see implementation details for the recommendations of the Commission of Inquiry, and those of the other DoH child safety reviews, please see the ***Child Safeguarding Reforms and Recommendations Implementation Plan 2024-2029*** available at health.tas.gov.au.

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