



# Adverse Events Procedure

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## 1. Purpose

This procedure outlines how staff fulfil their responsibilities to refer matters for consideration by the Adverse Events Panel. The procedure also describes how matters are accepted for review, how reviews are undertaken and the process for the approval of reviews and any associated recommendations.

## 2. Scope

This procedure applies to DCP staff involved in any aspect of Adverse Event Reviews including staff who identify that an adverse event has occurred. The criteria for an adverse event is defined as:

- the death or serious injury of the child or young person occurred during the delivery of services provided or funded by DCP or when child protection and/or adolescent at risk concerns have been notified to the department within the previous 12 months.

## 3. Authority

### 3.1 Legislative context

- [Children and Young People \(Oversight and Advocacy Bodies\) Act 2016](#)
  - Section 38 of the *Children and Young People (Oversight and Advocacy Bodies) Act 2016* allows the Child Death and Serious Injury Review Committee (CDSIRC) to require DCP to provide them information for the purposes of a review of the death or serious injury of a child or young person.

### 3.2 Whole of Government requirements

- Release of Information Protocol between the Child Death and Serious Injury Review Committee (CDSIRC) and DCP
- Release of Information Protocol between the Registrar, Births, Deaths and Marriages and DCP.

### 3.3 DCP requirements

This procedure aligns with best practice governance principles as outlined in the [DCP Quality and Safeguarding Framework](#). The safety of children and young people is the paramount consideration.

The Quality and Safeguarding Framework reflects an integrated system of processes and governance structures that ensure the safety and wellbeing of children and young people and support the delivery of high quality services.

The Adverse Events Program contributes to the operational and corporate governance structures that ensure quality of service design and alignment of policy and practice to continuous improvement and best practice in child protection.

This procedure should be read in conjunction with the [Death of a child or young person in care Procedure](#) in the event that a child or young person in care dies.



### 3.4 Principles

- Safety is paramount.
- Reviews will be child-centred, culturally safe and promote a learning culture.
- Accountability for quality practice and decision making.
- Continuous improvement.

## 4. Procedure requirements

### 4.1 Adverse Event Program is alerted to the death or serious injury of a child

Adverse Events Program Officers (program officers) are alerted to adverse events via notifications by DCP staff, the C3MS worklist, the DCP Significant Incident Reporting Unit (SIRU), the DCP Interagency Child Death Review Panel and Births Deaths and Marriages (BDM).

#### Notifications from DCP staff

When a DCP staff member becomes aware of an adverse event for a child or young person, they should discuss it with their manager. The manager then emails the Adverse Events Program via the [Adverse Events mailbox](#). If a manager needs to discuss the criteria for a referral, they may contact a program officer.

A member of the DCP Executive, the Lead Practitioner and the Aboriginal Lead Practitioner may also refer a matter for review.

Where the criteria for an adverse event is met, a program officer will complete the [Adverse Event Referral Template](#), including liaising with the relevant DCP office.

#### C3MS

Program officers are alerted to child or young person deaths via their C3MS work list. If the death meets the adverse event referral criteria, the program officer will complete a referral.

#### Notifications from DCP Significant Incident Reporting Unit (SIRU)

When the SIRU becomes aware of an adverse event for a child or young person, the Significant Incident Coordinator must email the Adverse Events Program via the [Adverse Events mailbox](#). If a Significant Incident Coordinator needs to discuss the criteria for a referral, they may contact a program officer.

#### Births, Deaths and Marriages

The Attorney-General's Department provides a list of all registered deaths of children and young people under the age of 18 years on a monthly basis to the Adverse Events mailbox. Program officers cross check the names with C3MS to identify children or young people known to DCP. The program officer will make a referral in relation to the deaths that met the criteria for review.

### 4.2 Notification of death or serious injury of an Aboriginal child

On becoming aware of the death or serious injury of an Aboriginal child, the Supervisor, Adverse Events will notify the Director, Aboriginal Practice Directorate (APD) and the Aboriginal Lead Practitioner. A copy of the referral will then be forwarded to the Director, APD and Aboriginal Lead Practitioner.

### 4.3 Identification of significant incidents



All DCP staff are required to notify the SIRU of significant incidents pursuant to the [Significant incident reporting Procedure](#).

The adverse event referral form prompts staff to consider the requirement to notify SIRU.

#### 4.4 Referral of an adverse event to the Adverse Events Panel

The Adverse Events Panel (the Panel) is responsible for considering adverse events for review and overseeing and approving reviews. The Panel is a multi-disciplinary committee made up of senior representatives from across DCP that is governed by the [Adverse Events Panel Terms of Reference](#). The Panel feeds into the Quality, Safeguarding and Operations Subcommittee (QSOS).

Program officers will assess whether the matter meets the criteria for an Adverse Event and where appropriate will prepare a referral for the Adverse Events Panel's consideration. The referral will contain:

- a summary of the adverse event
- a genogram
- information about the child or young person's cultural identity
- family background, including child protection history
- an outline of the current situation.

A draft of the referral is sent to the internal stakeholders including the relevant managers and directors for comment prior to its presentation to the Panel.

The referring program officer will also provide a recommendation and rationale about whether to proceed to a review as well as the proposed scope of the review.

Referrals for deceased children or young people identified as Aboriginal must have a cultural protocol warning coversheet attached. Deceased Aboriginal individuals are referred to by their initials and any mention of Aboriginal Cultural Business is done so sensitively and respectfully and in the pursuit of continuous improvement opportunities.

#### 4.5 Acceptance of an adverse event for review

Where matters meet the criteria for an adverse event, and a review may result in meaningful learnings and associated practice or systems improvements, the Panel will approve the referral for a review.

The acceptance of referrals for review is at the discretion of the Panel. Members of DCP Senior Executive may also direct the Panel to accept a specific case for review and may provide direction about the review process, including requesting DCP staff other than the program officers or external providers complete reviews.

The Panel's decision will be recorded in the referral and the respective DCP office manager and relevant director will be notified about the outcome by the program officers.

On occasion, adverse events may be approved to be grouped together for a thematic review at the discretion of the Panel.

#### 4.6 Completing an adverse event review

The Panel will determine the specific focus of the review.



An adverse event review will:

- establish the facts
- focus on child protection practice and organisational systems and/or processes
- seek to understand what happened, why it happened and how it could be prevented from occurring in the future?
- consider contributing and contextual factors at the time of the incident
- consider interdependencies
- not imply blame
- avoid bias
- consider the delivery of practice against standards of practice/procedure/evidence
- identify system vulnerabilities so that they can be eliminated or mitigated
- identify improvements at a systemic level (in procedures, guidance and/or training) that will seek to reduce the likelihood of similar events in the future.

An adverse event review will involve a lead reviewer and an optional co-reviewer from the Adverse Events Program.

The lead reviewer will undertake a desktop review of the child or young person's records (using the C3MS, Client Information System [CIS] and 85 and 88 case files) to collate relevant information.

Where possible and relevant, the review will involve consultation with staff involved in the case prior to the adverse event (where available) on a voluntary basis and with their line manager's approval. Following this, the lead reviewer will send a record of this consultation to the staff member to check accuracy and ensure the review is a reasonable account of what occurred prior to the adverse event.

The lead reviewer may also invite a subject matter expert (SME), practice leader or Principal Aboriginal Consultant (PAC) to contribute to the review. These consultants will also be sent a record of their advice to ensure accuracy

Following consultations, the lead reviewer will complete the review and develop draft findings and recommendations. The lead reviewer will then finalise the draft report and submit it to the Supervisor, Adverse Events followed by the Practice Leader, Adverse Events and the Director, Specialist Practice for quality assurance.

When appropriate, the Director Specialist Practice will provide the Regional Director with a draft of the review to provide feedback and contribute any further context to the report.

The lead reviewer will discuss any serious staff performance or conduct concerns or active client risk concerns with the Practice Leader, Adverse Events if they arise during the review process. These matters will be escalated to the Director, Specialist Practice as required.

Program officers will record relevant and new information identified during the review on children or young people's C3MS profiles if the information may be useful in a future assessment of their safety. This information may include causes of death and outcomes from criminal proceedings.



#### **4.7 Finalising findings, recommendations and actions**

Before making any recommendations, the lead reviewer will consult with the relevant areas responsible for implementing the recommendations. The review will then finalise the findings and recommendations through the, Supervisor, Adverse Events, Practice Leader, Adverse Events and Director Specialist Practice.

#### **4.8 Endorsement of an adverse event review and any associated recommendations**

The completed adverse event review report, including the findings and any recommendations, will be tabled at the next Panel meeting for endorsement. The Panel may recommend changes to the report, findings or recommendations. The suggested changes will be reflected in the Panel meeting minutes. When finalised, the Panel will endorse the amended report. This can occur out-of-session or during the subsequent Panel meeting.

Approval for an adverse event review and associated recommendations will be provided by the Chief Practitioner, Office of Professional Practice.

The Director, Specialist Practice will accept any amendments made by the Chief Practitioner on behalf of the Panel. Where significant changes are made, the review report will be returned to the Panel for re-endorsement. This can occur out of session.

The review's recommendations will be shared with QSOS for information and noting.

#### **4.9 Management of recommendations and actions**

Recommendations noted by the QSOS are added to the DCP Recommendations Register. Ongoing communication and monitoring of the recommendation implementation will occur in line with the DCP Recommendations Management Business Rules.

#### **4.10 Contribution to practice development**

Where reviews have resulted in significant learnings regarding practice, a vignette of the adverse event and associated learning activities will be produced to support staff reflection and professional development. Vignettes will be published on the DCP intranet.

The Chair of the Panel will highlight practice issues with relevant managers and directors to reinforce practice standards where necessary.

#### **4.11 Reporting on the adverse events program and provision of information to external bodies**

The Adverse Event Supervisor will prepare reports regarding the Adverse Events Program for the Chair of the Panel. Half yearly reports will be tabled at the QSOS.

The Chair of the Panel will ensure the reporting obligations set out in the CDSIRC-DCP Protocol are met. The Protocol requires the Chair to report the prescribed information regarding referrals to the Adverse Events Program on a half-yearly basis. The Protocol also permits the CDSIRC to request specific adverse event reviews in writing. The information and reviews shared with the CDSIRC will be released following the approval of a briefing to the Chief Executive.

Requests for client information made by the South Australian Police and Coroner's Court will be forwarded to the DCP Subpoena and Information Release mailbox for completion. The Subpoena and Information Release Unit will inform the Adverse Events Supervisor via the Adverse Events mailbox of the actioning of requests.



## 4.12 Interface with the Interagency Practice Review Panel for Child Deaths

The Interagency Practice Review Panel for Child Deaths is comprised of senior government leaders and is chaired by DCP's Chief Practitioner, Office of Professional Practice and co-chaired by the Executive Director, Aboriginal Policy and Services when the matter involves an Aboriginal or Torres Strait Islander child or young person.

The purpose of the Interagency Practice Review Panel for Child Deaths is to provide an evidence-informed and culturally responsive process and governance structure to review systems, policies and interagency practices following the death of a child or young person who has been involved in the child protection and family support system in South Australia. All children who meet the criteria will be referred to the Panel for consideration of review.

Following a referral to the Interagency Practice Review Panel for Child Deaths, the child or young person will also be referred to the DCP Internal Adverse Events Panel for consideration of review. Should an internal review be conducted, information and findings from the Interagency Practice Review Panel for Child Deaths report may be considered and taken into account. However, it is noted that the scope, purpose and focus of the two Panels are completely independent of each other.

## 5. Compliance, monitoring and evaluation

This procedure will be reviewed every three years by the Office of Professional Practice.

## 6. Related documents

Related documents, forms and templates
<a href="#">Adverse Events Panel Terms of Reference</a>
<a href="#">Adverse Event Referral Template</a>
<a href="#">Death of a child or young person in care Procedure</a>
<a href="#">Quality and Safeguarding Framework</a>
<a href="#">Significant incident reporting Procedure</a>
<a href="#">Interagency Practice Review Panel for child deaths Procedure</a>

## 7. Glossary

Term	Meaning
Adverse Event	An adverse event is defined as the death or serious injury of a child or young person, during the delivery of services directly provided or funded by DCP; or, where child protection concerns have been notified to the department within the previous twelve months.
Serious injury	A potentially life-threatening injury; or serious and/or likely long-term impairment of physical or mental health or physical, intellectual, emotional, behavioral or social development.
Significant incident	Some incidents require closer scrutiny and oversight. These events would be categorised as significant and for DCP are reportable incidents. All DCP



	staff are required to notify the Significant Incident Reporting Unit (SIRU) of significant incidents immediately, or as soon as practicable given the circumstances. The <a href="#">Significant Incident Reporting Procedure</a> provides guidance regarding the types of incidents and the reporting requirements.
Births, Deaths and Marriages (BDM)	Births, Deaths and Marriages is established under the <i>Births, Deaths and Marriages Registration Act 1996</i> and is responsible for the creation and preservation of accurate, permanent and confidential records of births, deaths, marriages and changes of name that occur in South Australia.
Child Death and Serious Injury Review Committee (CDSIRC)	The CDISRC is established by the <i>Children and Young People (Oversight and Advocacy Bodies) Act 2016</i> . The CDSIRC review cases in which children and young people (across the state, not limited to DCP) die or suffer serious injury with a view to identifying legislative or administrative means of preventing similar cases of death or serious injury in the future.
Quality, Safeguarding and Operations Subcommittee (QSOS)	The subcommittee is a group of DCP Executive and senior professional staff that meet bi-monthly. One of the roles of the subcommittee is to ensure associated recommendations are implemented to ensure continuous improvement of DCP service provision. The subcommittee is accountable to the Senior Executive Group.

## Document control

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2 October 2020	V3.0	Additional section 4.3. Minor edits.
1 October 2021	V4.0	Review of whole document and insertion of additional step involving executive approval of review reports.
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30 July 2024	V5.1	Amend referral criteria from three years to 12 months.
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