Through tragedy comes change

— the legacy of James Whakaruru

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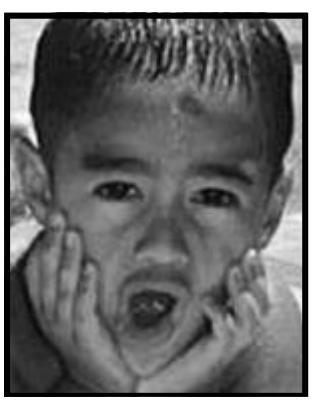
Every year in New Zealand around a dozen children are killed by their parents or caregivers. After the inevitable but brief public hand-wringing and attribution of guilt the family are left to grieve alone, and the tragic affair vanishes from the collective consciousness.

Occasionally however, one of these deaths touches us so deeply that the event precipitates more than public indignation and private grief, but leads to significant changes in public policy and political willingness to take action.



The death of James Whakaruru on the 4th of April 1999 was one such tragedy. The short life and tragic death of James Whakaruru was not markedly different to many of the sad stories we read in our daily newspapers, but the response was.

A detailed and searching inquiry by the Office of the Commissioner for Children followed this death. The Commissioner, Roger McClay, found that multiple systemic failures had occurred in the agencies which are charged by the state with ensuring the protection of children and families from partner violence and child abuse.

Findings

The findings and recommendations of the Commissioner's inquiry were published in June 2000. Steve Maharey, the new Minister of Social Services and Employment, promptly ordered a cross agency response to be prepared, which detailed the steps agencies were taking to close the gaps in policy implementation and service provision identified in the report.

For the health sector there were recommendations for the Ministry of Health, the College of Midwives, the Royal New Zealand Plunket Society and Healthcare Hawkes Bay. While there were some specific issues relating to each of these organisations, there were a number of underlying health sector failings identified. These were:

- poor information sharing within primary care and between primary and secondary care providers
- poor information sharing within hospital departments
- lack of health professional recognition of, and action on, risk factors for abuse
- lack of clarity around the Lead Maternity Carer role
- Lack of recognition of patterns of family violence by health professionals.

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In a parallel but separate process, there had been increasing concern expressed by health and social service professionals about the effectiveness of our statutory child abuse system.

The Department of Child Youth and Family Services (CYF) was coming under increasing criticism for failing to act to protect children, and a huge waiting list of children referred but not allocated to caseworkers was emerging.

At around the same time a paper from the Commissioner for Children's office entitled *The role of primary care providers in identifying and referring child victims of family violence,* written by Gabrielle Maxwell, identified a

lack of confidence or reluctance of general practitioners to refer children in whom abuse was suspected. This reluctance had many reasons but clearly needed to be addressed.

Taken as a whole the picture was clear – the health sector was not doing all it could to protect children from abuse and was not intervening appropriately.

Recommendations

In the Commissioner for Children's report there were a number of recommendations made to the Ministry of Health.

The main ones were:

- Develop and implement a National Child Health Information Strategy (CHIS) which ensures that all health professionals are able to, according to established guidelines, access and record information about health services provided to a child on a common database.
- Implement the 1998 Ministry of Health document *Family violence: guidelines for health sector providers to develop practice protocols*. This should include the development of national guidelines which ensure that health professionals have ongoing training in the recognition and reporting of child abuse and neglect.
- As part of the Primary Care Strategy ensure that issues of provider and professional accountability and resourcing for following up with children who are not accessing routine child health services such as WellChild checks and immunisations are addressed.
- Ensure contracts with WellChild providers include the requirement and resourcing for those providers to engage in inter-agency and community meetings.

Implementation

Supporting and mentoring the implementation of these recommendations has been a major part of my work as Chief Advisor over the last year and a half. We have made considerable progress but there is still much to be done.

The CHIS was developed over an 18-month period and published in March 2000 as a joint Ministry of Health and Health Funding Authority document. The main intentions of the strategy are to ensure that there is better communication about children seen by multiple health professionals, and that children missing out on routine WellChild and immunisation provision are identified and a responsible provider notified.

Social Services and Employment MinisterSteve Maharey, who ordered a cross agency response to the report.

Implementation built on the work of a number of integrated care initiatives, particularly the Kidznet pilot based in Rotorua and Hamilton, which had already begun the consultation process around rules for Privacy and Governance and contracted for the development of software for a linked regional child health database.

Towards a national strategy

The rollout phase of CHIS is now beginning and we are in the final stages of testing the software. Early in 2002 we expect the CHIS will be in place in Counties Manakau, West Auckland, Hamilton and Rotorua. Otago DHB is currently preparing a proposal for the Ministry of Health for a local project and a number of other DHBs have expressed an interest in the concept. However national implementation will take time. The Ministry of Health is working with DHBs to investigate innovative ways of setting up a truly national system, which permits health professionals to ensure all children are able to receive their entitlement to immunisation and Tamariki-Ora/WellChild care, and identify those falling through the gaps so that an appropriate and timely service can be offered to the family.

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Family violence guidelines

Implementation of the family violence guidelines is now in its first year. Much has been achieved. A resource covering child abuse, partner abuse and elder abuse has been developed and training for health professional groups in the areas of family violence and child abuse has begun. The resource for health professionals, entitled *Core elements for health care provider response to victims of family violence: partner abuse, child abuse and elder abuse* has been widely consulted on and supported by professional colleges and medical and nursing organisations.

Early this year general practitioners received a document entitled *Recommended referral process for general practice – suspected child abuse and neglect*, which was jointly developed by CYF, Ministry of Health and the Royal New Zealand College of General Practitioners. This document provided advice about developing practice procedures for the identification and referral of child abuse. It has been followed by a training package for GPs.

A companion document focusing on partner abuse will be released in early 2002. A multidisciplinary workshop on the detection and response

to family violence for health professionals took place as a satellite to the RACP/Paediatric Society annual scientific meeting in November 2001. Further multidisciplinary training, specifically targeted towards health professionals in paediatrics, general practice, emergency departments and obstetrics is planned for next year.

Access to WellChild services

Two main areas of work have focused on the recommendation to improve access to WellChild/Tamariki-Ora services. These are the development of immunisation outreach services and the new Tamariki-Ora/WellChild service framework and specification.

Immunisation outreach will be piloted in a number of high need areas where epidemiological evidence suggests high levels of vaccine preventable disease. This outreach programme will build on existing providers to enable them to spend the time necessary to contact families not accessing immunisation services and either offer domiciliary immunisation or support the family to access existing primary care services. The new Tamariki-Ora/WellChild service framework uses the NZ Deprivation Index to identify areas of higher need, and enables current providers to offer a higher degree of intensity of home visiting to families in difficult circumstances. The framework also acknowledges the requirement for health professionals to spend more time in liaison with communities and undertake inter-agency collaboration.

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Inter-agency collaboration

CYF is in the process of enhancing and upgrading its service provision and is developing with the wider sector a new blueprint for child protection services.

The police, Starship Childrens' Hospital and CYF have been collaborating to develop co-located multidisciplinary services for child abuse investigation in Auckland, and are within sight of their goal. We are also able to widen the scope of investigations into deaths of children and young people through the Child and Youth Mortality Review Committee, which had its first meeting in November 2001.

This committee is charged with monitoring deaths of children and young people, investigating the causes of death and making recommendations about changes to policy and practice, which, if implemented, could prevent further deaths. There is the potential for the sort of lessons learnt from the death of James to be amplified many-fold, and this has the potential to make a significant difference to large numbers of New Zealand children and young people.

From my perspective I am seeing a much greater cohesiveness beginning to emerge in primary care provision for children and young people. There is still a long way to go, but the new Primary Care Strategy is beginning to gather a number of these disparate, although interlinked, initiatives under its wings and continue the work that the death of a four-year-old boy set in train.

In my view, the critical, as yet unresolved issue remains the area of information sharing across primary care and between primary and secondary care providers. If DHBs and the soon to be formed Primary Health Organisations are to function effectively, this gap will need to be addressed urgently.

I believe the sector is ready, and the public see the need for such initiatives. We must seize the opportunity that James Whakaruru has offered us.