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Audit Report: Review of practice, removal of infants, Department for Child Protection

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Audit scope

This report presents the findings of an audit of the practice of removal of infants at birth, alongside three staff focus groups. The audit focused on the experience of the mother in the removal of a baby process. It did not in any way consider or examine the decision to remove the baby, but only given a decision to remove was made, was best practice followed.

The purpose of the audit was two-fold:

1. To understand the current practice relative to international best practice
2. To identify opportunities to strengthen the system of child protection. The audit did not consider individual actions as individual actions, but rather as representative of the system in which those actions were taken.

The basis of the audit was a UK guideline for practice when the state removes a baby. This work is in alignment with the other literature included in this review and also in alignment with the principles of trauma informed care. It is also consistent with the Western Australian child protection guidance in this area, although it goes into further detail. Given best practice includes partnership approaches with health services at a minimum, these interactions were also included in the audit and the subsequent findings.

State of the literature

There has been a recent increase in academic interest in what constitutes best practice in the removal of babies at the birthing hospital. In Australia and internationally, there has been increasing numbers of infants in out of home care, and in South Australia, infants were most likely to be the subject of substantiations (O'Donnell 2023, AIHW).

It is widely accepted in the peer reviewed literature that there is insufficient research to guide decision making in the process of removal of a baby shortly after birth. A comprehensive, systematic review was undertaken in 2019 which identified 27 studies, mostly qualitative and from the perspective of birth mothers and health care staff including midwives (Mason et al, 2019). The work identified many gaps or challenges for practice, and only rarely reported on examples of good practice.

The implications of this heavy reliance on qualitative methods is important to further detail. Qualitative methods involve data collection methods like observation, interviews, focus groups or policy analysis, for example. They are designed to answer why or how questions, or to reflect personal experiences, perceptions, or feelings. This type of research can best help to design an intervention, assess how well a program of work has been implemented, or come up with novel ideas about a problem. In the setting where we want to understand the effectiveness of a practice or intervention, the research methods most able to provide the best evidence are quantitative. Quantitative studies collect data on an intervention and comparison group(s) and use statistical methods to compare the groups. The question of how best to support a mother through child removals to lead to better outcomes for women, the baby, the staff involved and wider society would combine both quantitative and qualitative studies, given the complexity of the intervention in question here (Skivington et al). In the literature no quantitative studies were identified that examined the effectiveness of different practices of baby removals for different circumstances to make an assessment of what was the most effective approach, considering it alongside the qualitative research.

What did the literature tell us about best practice?

The same group who did the Mason et al systematic review noted above, recently undertook a large body of work in the UK to try to bridge the evidence gap their review identified. This work is based on a large, qualitative research project which interviewed either individually or in focus groups 44 parents (38 mothers, 6 fathers) and 9 lawyers, along with 254 professionals (social workers, foster carers, midwives and child advocates) (Mason et al, 2023). This work maintained a high degree of rigour (although the precise details of how the data were analysed was not clear) and appears to represent the views, either lived experience or expert on how baby removals should occur to minimise harm to the baby and also the mother. A similar program of work is occurring in the Australian Centre for Child Protection which concords with the findings from the UK. In summary, the guidelines included practice recommendations on:

- recognising and responding to intersecting disadvantage, and the importance of trauma informed care,
- importance of early notification and engagement given the short time window to intervene in a pregnancy trajectory,
- importance of collaboration, communication and transparency with the woman, her family/network and the other professionals who are working with her (as is safe to do so) and at multiple time points,
- birth arrangement plans should be as collaborative as possible with the parent(s) and communicated by at least 30 weeks gestation and repeatedly from there to ensure it is understood,
- considering and referring for support needs for the mother pre-birth, in hospital and post-birth,
- for the separation, paying attention to parent wishes regarding the detail, where possible, and supporting the mother to create memories of their first hours to support an ongoing connection.

There has also been work in Australia focusing specifically on Aboriginal and Torres Strait Islander babies. This work has not reported on the best practice relating to the removal from the perspective of the mother. It does however point to the critical need for the entire service delivery to be Aboriginal and Torres Strait Islander led, culturally based, and culturally safe. The Birthing in Our Community service is led by Aboriginal and Torres Strait Islander people and governance, involves multi-agency partnerships, continuity of care across the pregnancy, Aboriginal and Torres Strait Islander workforce, holistic wrap around services (social and medical) and run in line with a cultural framework and cultural safety. This program was found to substantially reduce the odds of baby removal (OR 0.37, 95% confidence interval 0.16-0.84) over the 2013-2019 period, noting the study was not randomised but potential confounding factors were adjusted for (O'Dea et al).

The only quantitative data that demonstrated an aspect of effectiveness related to a study which included a requirement to have long-acting reversible contraception (LARC) inserted following the baby removal, coupled with a trauma informed program, which demonstrated a reduction in subsequent pregnancy and also infant removal (Boddy et al). There are substantial ethical issues in requiring a medical intervention (which is not supported), however the principle that all mothers should be offered and supported to access the best reproductive health care stands.

Where there is limited evidence in the peer reviewed literature, a technique called triangulation can be used to include evidence from a different perspective. Relevant here, there is a substantial parallel literature that provides evidence in favour of multi-disciplinary approaches and trauma informed care, especially for people with intersecting disadvantage. This approach has been in practice for many years and adopted across a range of human service disciplines including mental health, and education (Oram et al). A summary of guiding principles of trauma informed care taken from a recent Lancet series focusing on intimate partner violence and mental health is included in Appendix 1. This approach aligns with the guidelines for practice proposed by Mason et al, the basis for the audit tool.

Why focus on the mothers as well?

Much of the focus of recent work in this area relates to how best to support the mother through the process of baby removals. These qualitative studies have demonstrated repeatedly the very high degree of trauma experienced by the mothers in baby removals, describing the experience as profound grief akin to the death of a child. Mothers are also highly stigmatised as a result of the removal, which compounds the grief, which in turn intensifies the already substantial disadvantage they experienced before any contact with child protection services. From an ethical perspective, approaches that provide as much agency to the mother (a tenant of trauma informed care) are critical to wellbeing, given their agency as a parent has been removed by the state.

There is clear evidence that baby removal relating to maternal substance use is associated with an increase in subsequent substance-exposed births. In a retrospective cohort study of 6893 births in 2015 in the USA with prenatal drug and alcohol exposure, 20.4% experienced removal within 30 days of birth. The cohort of mothers who had babies removed were more likely to have a short interval birth (HR 1.61, 95% CI 1.09-2.36) and short interval birth with substance exposure (HR 3.18, 95%CI 1.65-6.08) (Reddy et al). There is also evidence that child removal can lead to further adversity for the mother in a cumulative way, including repeated cycles of future baby removal.

Key authors in the field discussed conceptualising the child protection system as a temporary intervention. When children become adults, many go onto re-engage with the birth family. If the birth family has not had the opportunity to heal or grow over time, then this is a re-traumatising process for the child/adult (Broadhurst & Mason).

Finally, a practice that includes consideration for the mother is consistent with a principle of the *Children and Young People (Safety) Act 2017,* Chapter 2, Part 1, Section 4(4):

It is the intention of the Parliament of South Australia that the performance of functions in the administration and operation of this Act be done in collaboration with, and with the cooperation of, children and young people and their families rather than simply being done to or for them.

Why focus separately on Aboriginal babies and mothers?

There was a separate focus on Aboriginal babies and mothers in acknowledgement of the serious intergenerational trauma experienced by Aboriginal peoples by actions of the State. It is considered by many Aboriginal leaders that the process of child removal is continuing the Stolen Generations. As such, processes relating to Aboriginal children have been reviewed separately.

It is also acknowledged that through the strength and resilience of Aboriginal communities that Aboriginal culture continues to thrive.

Audit summary findings

An audit of the case notes of infants who were removed at birth or shortly after at a birthing hospital was undertaken, with all cases selected from the years 2022 and 2023 (189 infants). Given the selection criteria, the audit does not present findings relevant to all Unborn Child Concern (UCC) notification, but rather only the smaller number of notifications which ended in a newborn infant removal.

- The vast majority of UCC were allocated to a case worker within days of the notification.
- The minority of UCC cases were referred for Family Group Conferences prior to birth.
- Practice Leaders and where relevant Principal Aboriginal Consultants were consulted in some of the cases, but not all. Principle Aboriginal Consultants were not the decision makers relating to removal or the process of removal.
- Many of the UCC cases were informed of child protection concerns prior to birth, although not necessarily that removal had been decided. There was a number of cases where there was no communication about serious concerns prior to birth.
- A number of the UCC cases leading to removal were not informed of the decision to remove (as opposed to serious child protection concerns) prior to the removal itself. For some of these cases there was a documented rationale for why the information was not shared prior to removal, but many did not have a documented reason to not inform about the pending removal.
- Supports were generally offered both pre and post birth, but it was not clear that anyone received a high level of intervention from the mother's (or father's) health and wellbeing perspective following birth.
- In the majority of cases the hospital was informed of the intended removal prior to the actual removal, however the timings vary.

Overall pattern of child removal, 2019-2023

To provide context for the audit findings, a high-level descriptive analysis of removal and re-unification data for children up to four years old was undertaken. Removal data for the years 2019-2023 are presented in Table 1. The analysis demonstrates there has been an absolute reduction in number of removals of children by year in the four year old and younger age group from 2019 to 2023.

Table 1: Age at infant/child removal, 2019-2023, Department for Child Protection

Calendar year	**Age**			
	0-7 days	**8-31 days**	**32 days - 4 years**	**Total**
2019	84	39	284	**407**
2020	106	47	299	**452**
2021	92	35	264	**391**
2022	85	25	249	**359**
2023	71	21	199	**291**
Total	**438**	**167**	**1295**	**1900**

Future considerations

The focus of this work has been on system level findings in relation to a single specific audit conducted over a rapid time scale, alongside three staff focus groups. Key findings are outlined below:

1. ***Digital system optimisation to support safety and quality care:*** It was noted that in order to conduct an audit it was not possible to rapidly extract information. The process involved going through longform notes to identify key data elements. This limits the ability to conduct ongoing systematic safety and quality assessments of practice. This could be improved through a bespoke collection of data (akin to a clinical quality registry) in line with DCP strategy and policy (Zuchowski et al).

2. ***Triage automation support:*** Noted that additionally, the system does not have features that supports quality care such as flagging urgent cases according to a pre-specified algorithm that may reduce the risk that a case will be missed in allocation, from the first allocation team. The process currently is manual, requiring staff to read through notifications, and from there assess urgency and allocate to DCP Offices accordingly on the eCARL system.

3. ***Seeking further information on cases:*** Consideration could be made into streamlining information seeking on cases by automatic provision of data to DCP. For example, if all the data from partner organisations that currently provide information on request could be provided to DCP and held securely, then a reporting platform could enable DCP to rapidly find information on any DCP case from the held data. In this model the majority of the held data would never be used, as it can only be accessed in relation to a DCP case and for no other reason.

4. ***Service that provides care for the mother pre and post birth independently to the child protection concerns:*** A fundamental issue relates to the focus of DCP on the risks relating to infants and children, in line with the requirements of legislation. While this is necessary and appropriate, this leads to somewhat of a gap in the focus on the mother. Structurally the health care providers who may have worked with the mother up until the birth and for some weeks after birth no longer have a role in her care given the healthcare is related to the pregnancy.

This audit and other published research found that the cohort of women who have had a baby removed at birth have often had previous child or baby removals by DCP. These women are known to DCP and so there is a major opportunity to provide supportive care for women for the benefit of the women but also to potentially prevent subsequent baby removal and possibly increase the chance that subsequent pregnancies include antenatal care (the latter statement based on first principles, not trial evidence). This care may be more appropriately offered/managed by a different agency of Government than DCP. It would be an intensive, flexible, case management, trauma informed response that considers health (mental health, physical health, reproductive health), social, and cultural needs as a minimum. For Aboriginal women the provider should be Aboriginal, ideally from an Aboriginal Community Controlled Service. Importantly, this service would not be based on the woman's role as a mother, but as a person who is in need of additional support. There is also a need for consideration of supports for the father, and further to enable ongoing contact with their baby(ies).

5. **Greater consistency in practice for UCC**: There is opportunity for more consistency in practice in UCC through adding guidance to the Manual of Practice. This could outline best practice approaches for:
    a. Family Group Conferences, or family conferences led by DCP for every UCC as a mechanism to include the voice of the mother, father and family in the decisions.
    b. Explicit criteria on how to critically assess flight or safety risk, and document the risk.
    c. Need for consultation of Practice Lead and Principal Aboriginal Consultants for every UCC and the decision to remove the infant.
    d. The need for Principal Aboriginal Consultants to be involved in every UCC of an Aboriginal baby at the time of UCC allocation.

High-risk infant workers who conduct most of the UCC work could have enhanced professional development opportunities given their pivotal role. Reinstating the High-risk infant workers collegiate network would also support best practice approaches and consistency.

It is further noted that the number of High-risk infant workers in some offices cannot meet the demand for services. This means that UCC cannot be managed within the funding/staff allocation and so are not actively investigated by DCP in the pre-birth period. In these circumstances, DCP is re-engaged in the case at the time of birth, which limits the ability to undertake best practice in the pre-birth period.

6. ***Aboriginal practitioners taking the lead for Aboriginal babies and mothers:*** The advice given by the Principal Aboriginal Consultant (and the Practice Lead) can be overridden by the Supervisor in relation to the need for removal and the manner in which removal occurs. A process could be considered that allows for the Principal Aboriginal Consultant to escalate the decision where it conflicts with their advice, to seek additional input. Further discussion with Aboriginal staff is needed to understand what a better model for Aboriginal led decision making could look like within the delegation structure of DCP.

7. ***Interagency collaboration:*** There appears to be significant challenges in the DCP interaction with partner agencies which impacts the work. There could be consideration of a joint policy directive and protocol on the process of removal at birth with SA Health. There should be consideration of ways to improve a partnership approach which would include formal agreements and associated governance, increased transparency in decision making, clear roles and responsibilities and considering other partnership models of working. For example, a model used in one office was sharing a High-risk infant worker across the hospital and the local DCP office. The existing model could be evaluated for effectiveness and considered more broadly if it is working to break down professional barriers and generate greater understanding of the issues at hand from all perspectives.

8. ***Research program to directly support work***: Taking a formal research translation approach, key questions of practice that are relevant to staff and key stakeholders could be systematically appraised, with evidence being folded rapidly back into practice with ongoing evaluation.

Limitations

Case note audits reflect what occurred and then was recorded, rather than a full account of what occurred with each case. Given this limitation, further information was sourced from focus groups of staff, however it is acknowledged the time frame was rapid and the scope narrow which will limit the quality of the findings.

As an audit where the outcome was baby removal, the findings are not generalisable for all UCC.

The audit did not extend to partner agencies. The references made in the report to partner related actions are made in the absence of seeking different perspectives on the matter, which would be necessary to seek prior to any consideration of the findings.

Finally, a number of the findings relate to aspects of a comprehensive safety and quality system. As this was not the explicit reason for the audit, all aspects of the existing system could not be included in findings. This would span, for example, from DCP strategy, policy/legislation, guidelines, organisational structure and workforce, workforce culture and quality and safety committees/governance to review critical incidents. Only components that were apparent through the audit were highlighted.

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Appendix 1: The Lancet Commission, Guiding principles of trauma-informed care and implementation, page 505

	Description	How service users might experience it
Safety	Throughout the organisation, staff and the people they serve feel physically and psychologically safe.	"The most important thing is that I feel safe when getting help."
Trustworthiness and transparency	Organisational operations and decisions are conducted with transparency and with the goal of building and maintaining trust among staff, service users, and family members of those receiving services.	"The trust I had before was so badly betrayed, it is hard for me trust things will be different this time."
Peer support and mutual self-help	These are integral to the organisational and service delivery approach, and are understood to be a key vehicle for building trust, establishing safety, and empowerment.	"Being around other women who have been through what I have been through makes me feel understood."
Collaboration and mutuality	There is true partnering and levelling of power differences between staff and service users and among organisational staff, from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision making. The organisation recognises that everyone has a role in a trauma-informed approach. One does not have to be a therapist to be therapeutic.	"I feel like we are working together, and nobody is taking over yet, which is different."
Empowerment, voice, and choice	Throughout the organisation and among service users, individuals' strengths are recognised, built on, and validated, and new skills are developed as necessary. The organisation aims to strengthen staff, service users', and family members' experience of choice and to recognise that every person's experience is unique and requires an individualised approach. This approach includes a belief in resilience and in the ability of individuals, organisations, and communities to heal and promote recovery from trauma. It builds on what service users, staff, and communities have to offer, rather than responding to perceived deficits.	"I am learning how to speak my mind for the first time in a long time."
Cultural, historical, and gender issues	The organisation actively moves past cultural stereotypes and biases (eg, based on sex, gender identity, gender inequality, sexual orientation, race, ethnicity, age, geography), offers services that are cognisant of gender power differentials and promote service users' autonomy, dignity, and self-determination, leverages the healing value of traditional cultural connections, and recognises and addresses historical trauma.	"I am taken seriously as a whole person here, not just treated as a victim."

Table 2: **Guiding principles of trauma-informed care and implementation**[25,4,27]

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