Child Inquiry Analysis Report

Who's Holding the Baby?

Improving the Intersectoral Relationship Between Maternity and Child Protection Services

An Analysis of Child Protection Infant Deaths 1995–1999

9 August 2000
Presented to the Director, Community Care Division Department of Human Services and the Victorian Child Death Review Committee

1. Introduction 3
   1.1 Who's Holding the Baby? 3
   1.2 Case Study 3
   1.3. Definitions 4
2. Background and Purpose of Report 5
3. Terms of Reference 6
4. Methodology 6
5. Contextual Issues 7
   5.1. Child Protection for Infants under 12 Months and the Identification of Risk 7
   5.2 Sudden Infant Death Syndrome (SIDS) 8
   5.3 The Obstetric Population 9
   5.4 Overview of Child Protection Infant Deaths 1995–1999 9
6. Themes 13
6.1 Introduction 13
   6.2 Principles 13
   6.3 Conceptualising the Client 13
   6.4 Early Identification 14
   6.5 Early and Multidisciplinary Intervention 17
   6.6 Care Planning Involving Discharge Planning 18
   6.7 Information Flow –Formalised Processes 19
   6.8 Confidentiality 20
   6.9 Post-Hospital links 21
   6.10 Collaboration 21
   6.11 General Practitioners/Medical Doctors 21
   6.12 Summary 22
7. Recommendations 22
8. Case Summary 25
9. Responses to the Draft Report 26
Appendices 29
Appendix 1 The Process for the Review of Child Protection Client Deaths in Victoria 29
   Appendix 2 People Interviewed by the Panel 30
   Appendix 3 Raw Data of Cases Reviewed by the Panel 31
   Appendix 4 Program Areas and Initiatives 32
Bibliography 35

1. Introduction

1.1 Who's Holding the Baby?

The title 'Who's Holding the Baby?' has been adopted by the panel to express a fundamental premise of this report: the care of infants in our society is a responsibility we all share. As individual parents, as maternity services, as health professionals, as child protection workers and as members of this society, we are all responsible for the care of an infant—we are all responsible for 'holding' the baby. The concept of 'holding' is adopted from D.Winnicott, a world-renowned paediatrician and child psychoanalyst. 'Holding' is not just meant in terms of providing physical care, but also includes the capacity of a parent, significant other, caregiver and society to provide a loving and nurturing environment, free from abuse and neglect in which the infant can grow and develop. The optimal outcome of 'good enough' holding is the integration of an individual in a useful way into society and the fulfilment of that individual's 'self'.

1.2 Case Study

The following hypothetical case scenario is drawn from cases of infant deaths known to Child Protection Services, that were examined by the panel. (These cases had undergone an inquiry process, as detailed in Appendix 1). The case graphically illustrates the issues that will be raised in this report and describes the target group of infants and their families that this report addresses.

Case Study:

> Crystal was born prematurely and opiate-dependent. Crystal's mother, Jodie, 16 years, had attended the antenatal clinic twice in late pregnancy before presenting in advanced labour. Jodie had been a client of Child Protection Services and resided in residential placements during her early adolescence but was now living at home with her mother. The relationship was described as volatile and characterised by frequent periods of Jodie 'moving out' to live with Brant, Crystal's father, 17 years, who is described as abusive to Jodie.
>
> Nurses on the ward described Jodie as 'appearing disinterested in Crystal' but Jodie told the hospital social worker that she was 'keen to get involved with the infant' and would accept services in the community when discharged from hospital. The Social Work Department made the appropriate referrals to community agencies then closed the case.
>
> Jodie discharged herself and Crystal from hospital on the third day, although Crystal was still displaying irritability possibly due to drug withdrawal. Jodie declined visits from the domiciliary nurse. The usual hospital referral was made to the Maternal and Child Health Nurse (MCHN) who visited Crystal at her grandmother's home and assessed the baby as making adequate progress. Jodie was not present and grandmother indicated that Jodie was usually with Brant, probably using drugs, and that she was 'sick of being left with the baby'.
>
> On the next MCHN outreach visit, the grandmother reported that three days ago she and Jodie had had an argument and that Jodie had taken the baby and left the house. She assumed they were with Brant but did not have an address. Grandmother also confirmed that no other community services were involved with Jodie and that Jodie 'didn't have a clue about caring for an infant'. The MCHN contacted the Child Protection Services and a notification was accepted based on the likelihood that Crystal was at risk of significant harm.

However, without an address, child protection workers were unable to make immediate contact with Jodie and Crystal.

Three days later, the police were called to a flat they described as filthy, with syringes and empty liquor bottles in evidence. Crystal had died while sharing a mattress on the floor with Jodie and Brant.

1.3. Definitions

Before proceeding further it is important to specify the intended meanings of key terms used throughout the report.

- **Maternity Services** refers to the range of services and professionals providing antenatal, perinatal and postnatal care. The key agencies and professionals that need to be involved in providing this care throughout the various stages are:
  - Maternity hospitals, including all associated services and related professionals.
  - Medical professionals such as General Practitioners, Obstetricians and Gynaecologists (when in a Share Care arrangement).
  - Community midwives.
  - The Maternal and Child Health Service, which at a policy level includes the Parenting Support and Child Development Unit of Department of Human Services.

- **Additional key agencies** that may be required to provide care and support as an adjunct to Maternity Services are:
  - Family and Community Support Agencies
  - Child Protection Services (CPS).

- **Family** refers to the mother, father and/or significant others. However, in most cases the primary caregiver shall be the mother.

- **Infant** refers to both the newborn and unborn child.

- **Client** refers to both the family and the infant.

- **High risk** refers to protective high risk, that being at risk of abuse or neglect.

- **High Risk Infant Project (HRI Project)** is a Department initiative to provide enhanced practice and services to high risk infants and their families known to CPS.

- **Specialist Infant Protective Workers (SIPW),** an initiative of the HRI Project, they provide consultancy to child protection staff concerning high risk infants.

2. Background and Purpose of Report

The purpose of this report is to consider systemic issues and common themes and patterns arising from a group of deaths. (The process used for the review of child protection deaths is attached in Appendix 1, with an explanation of the Victorian Child Death Review Committee).

The Victorian Child Death Review Committee (VCDRC), in its consideration of deaths of infant clients (known to CPS) has noted concerns relating to the role of the broader health sector and linkages to CPS. Accordingly, the VCDRC requested that 'an analysis be undertaken on the intersectoral relationship between maternity services and protective services as they relate to young mothers, using as a starting point the cases highlighted by this Committee'.

The committee noted they had seen:

> 'five SIDS deaths where the link between the hospital/medical sector and the protective system had been cause for concern. Issues related to unplanned discharges, poor post natal supports and the failure of support agencies to fulfil their obligations'.

They commented that such issues are potentially of concern for any infant, but when combined with a very young mother without appropriate supports who may be a drug user, then the risk of harm to the infant becomes extreme.

On 9 August 1999, the Director, Youth and Family Services, endorsed the committee's recommendation to conduct an analysis 'on the intersectoral relationship between maternity services and protective services as they relate to young mothers, using as a starting point the cases highlighted by the committee.'

3. Terms of Reference

The terms of reference for this Child Death Inquiry are firstly, those applied to the analysis tier for Victorian Child Death Inquiries:

> To examine whether case management decisions and actions of the Department of Human Services and other agencies were adequate and appropriate in providing a service to the client/s. This should be considered in the context of the *Children and Young Persons Act 1989*, and established practice knowledge and professional wisdom.

Secondly, the analysis was required to address the following issues raised by the VCDRC:

- The intersectoral relationship between maternity services and CPS as they relate to young mothers, including the identification and exploration of this relationship.
- Specific issues related to:
  - unplanned discharges
  - poor postnatal supports
  - support agencies not proactively engaging with families, post birth
  - the need for services to systemically recognise the high risk nature of the circumstances for some infants and families.

4. Methodology

The analysis was undertaken by a panel comprising:

Panel Chairperson: Colleen Murphy,
Manager, Chemical Dependency Unit, Royal Women's Hospital

Panel Members: Sarah Goding
Manager, Quality Branch, Acute Health, Department of Human Services

Johanna Breen
Senior Program Adviser, Practice Leadership Unit
Child Protection and Juvenile Justice Branch, Department of Human Services

Executive Officer: Lynne McCrae
Child Death Inquiries Unit, Department of Human Services

The panel consulted with 12 service providers/professionals from the maternity and child protection field, with a range from metropolitan, rural and semi-rural Victoria and Departmental and non-Departmental staff. The details of the methodology used by the panel in undertaking this investigation are attached in Appendix 2. The panel also undertook a minor literature review and the literature used in the development of this report is detailed in the bibliography.

This investigative process undertaken enabled the panel to:

- Identify and explore key issues as detailed in the terms of reference.
- Establish the extent to which the issues identified in the interface between protective services and maternity services are being addressed.
- Make recommendations that will enhance future practice.

5. Contextual Issues

5.1. Child Protection for Infants under 12 Months and the Identification of Risk

All infants are vulnerable due to their total dependence on a caregiver to meet all their needs. However, some infants, when impacted upon by a combination of risk factors, are at higher or extreme risk.

The table below sets out a range of risk factors, developed by CPS, that can be seen as a guide to inform risk assessment for infants in a range of services. It is important to acknowledge that no one risk factor will predict abuse and that harm is more likely to occur when there are a number of risk factors present with few if any protective or supportive factors in evidence. The following list is an inclusive list, and there are probably a smaller number of more powerful predictive variables that can be used to identify risk for infants.

Table 1: Potential Risk Factors That Have Been Retrospectively Identified in Families Where Abuse/Neglect Has Been Identified

Child	**Female Caregiver**
• premature • currently underweight • born drug dependent • feeding/sleeping difficulties • prolonged/frequent crying • significant meaning to mother • seen as problematic/over demanding	• under 20 now/at first baby • pregnancy/birth complications • poor antenatal care • substance abuse • current/past history of family violence • psychiatric illness • single parent/de facto • other child removed/died • intellectual disability
Family	**Male Caregiver**
• isolated • fragmented • chaotic • transient/homeless • intolerant of children • history of Child Protection involvement	• history of childhood abuse • history of abusing children • poor understanding of infant needs • history of criminal behaviour • poor impulse control • past/current perpetrator of family violence • substance abuse
System	**Structural**
• risk assessment incomplete • agency conflict • case conference not held • critical decisions not confirmed	• poverty • poor health • social isolation • geographical isolation • low educational status

A case file review of infants under two years of age, known to CPS, was conducted in 1999 as part of the overall evaluation for the High Risk Infants Service Quality Initiatives Project (HRI Project). One aspect of the review of 158 cases (approximately 5 per cent of infant cases within CPS) concerned the collation of risk factors for these cases and the determination of their significance in the conduct of the case. In order of frequency, the top variables, that is, those listed as present in over 40 per cent of the cases, were:

- Chaotic family– 56%
- Family violence–(mother 55%) and (father 48%)
- Substance abuse–(mother 50%)
- Isolated family–47%
- Poor impulse control (father)–45%
- Child protection history–45%
- Under 20 at first child (mother)–43%

As illustrated in the opening scenario, families caring for infants in high risk situations are also more likely to be isolated from family and community supportive services. Their reluctance to seek, or accept, assistance may lead to statutory services becoming involved as the service of last resort. The population of infants that is likely to require early, intensive intervention, defined in medical terms as a 'care coordination service' discussed later in the report, is small but both labour and financially intensive and, if appropriate intervention is not provided, the consequences can be tragic.

Data obtained through the HRI Project indicates that in the year from March 1999 to February 2000, CPS received 4,427 notifications concerning infants 0–2 years. Infants 0–2 years, comprise 10% (or 1,342) of the substantiated CPS cases. More pertinent to this report, however, for the year July 1998 to June 1999, there were:

- 1,397 notifications for infants aged 0–6 months of age
- 33,361 notifications for children over six months of age
- Total notifications: 34,758.

5.2 Sudden Infant Death Syndrome (SIDS)

The panel decided to widen the scope of their analysis to include all infant deaths reviewed by the VCDRC from 1995–1999. This decision was based on the determination that in all instances, including the SIDS cases, high risk factors for child abuse and neglect were present. The presence of these high risk factors required an early intervention response.

SIDS is listed as the cause of death when an infant dies suddenly, usually during sleep, and all other possible causes for the death are excluded through forensic investigations usually including an autopsy. SIDS is a medical term not a specific cause of death. SIDS remains the major diagnosis of death for infants under one year in Australia. In nine of the 14 cases reviewed for this analysis, the infants' death was attributed to SIDS.

In 1991, the Sudden Infant Death Research Foundation (SIDRF) introduced the Reducing the Risk of SIDS campaign which highlighted child care practices to address SIDS risk factors.

Following this campaign, the incidence of SIDS in the general population has reduced dramatically. However, although it is not possible to accurately establish a rate of SIDS deaths within the CPS population, it is concerning that it appears that the occurrence of SIDS deaths has not decreased over time. Between 1989 and 1997 over 40 per cent of infant deaths were attributed to SIDS. This percentage remains stable and an average of between two and three infants die of SIDS each year in families known to CPS.

Although infant death diagnosed as SIDS is not a new problem, recently the focus of prevention has moved 'from attempts to uncover intrinsic defects in the child to consideration of the environmental influences on the infant during life and in the time preceding death' (Hobbs and Wynn, 1996, p.156). Following on from this shift in focus, the dramatic reduction in infant deaths attributed to SIDS has highlighted the number of sleeping accidents involving infants which result in their death. Many of these deaths might have historically been attributed to SIDS. However, the final attribution of death to either SIDS or a sleeping accident is still dependent on further research and pathology reports of the death.

Numerous studies (for a thorough review see Hobbs and Wynn, 1996) correlate risk factors for SIDS. These non-modifiable risk factors for SIDS are also frequently present in families who come under notice of CPS and other child welfare agencies. These risk factors include young, single mothers with an educational level below year 12, substance abuse or dependence, and limited attendance at antenatal checkups. Infants at risk of SIDS more often have low birth weight and are born prematurely and exhibit inter-uterine growth retardation. Their home environment is more often smoky, crowded and unsettled. These risk factors for SIDS also correlate with drug dependency.

The fact that the young women represented in the cases being analysed exhibited most, or all, of these risk factors for abuse and neglect and SIDS needs to be acknowledged and made explicit in any recommended risk screening/assessment process and appropriate education and support provided.

A focus on risk factors for abuse and neglect will also address SIDS risk factors and may also lead to a decrease in the incidence of SIDS for this high risk group. Any early intervention program with high risk families would require an educational component on known SIDS risk factors (such as sleeping position, overheating and smoky environment).

5.3 The Obstetric Population

In Victoria, around 61,000 babies are born each year. Approximately two-thirds are public patients, or just over 45,000. Eighteen different models of antenatal care have been identified in Victoria. Sixty per cent of women were enrolled in antenatal care which may have no formal visits with midwives. Thirty-three per cent of women were in models of care where midwives may be involved and 6 per cent were in models of care where midwives provided most or all antenatal care. This study found that 207 women or nearly 1 per cent received no antenatal care at 20 weeks and this reduced to 59 women at term. (1999 study conducted by the Perinatal Data Collection Unit).

5.4 Overview of Child Protection Infant Deaths 1995–1999

From November 1995 to November 1999, the VCDRC has reviewed 28 deaths of infants under the age of two; 23 of these deaths were of infants aged 12 months or less, and five were aged

between one and two years. In reviewing these 28 cases, the panel decided a number of the cases were not appropriate for this analysis. The panel established the following criteria for inclusion in this project:

1. Child was under 12 months at time of death
2. Child had not died of natural causes (not including SIDS)
3. Mother was at least under 25 (although there was one case where the age of the mother was unknown, and this was not excluded).

The panel decided to include cases where the mother was over 20 years of age, up to 25 years of age, as it was evident in these cases that there were indicators, in the antenatal period, that the infant was at risk of abuse or neglect. The panel excluded cases in which a notification was made to CPS post-incident, as there was little known about the family background. However, there were indications that at least some of these cases showed characteristics of the target group. A total of 14 cases fitted into the target group.

Of these 14 cases, the panel extrapolated the following demographic information:

- Ten of the infants were aged three months or under and the remaining four were over six months, but under twelve months.
- Nine of the infants had died from SIDS; three were accidental deaths; one had died from an 'acquired illness-disease' and one from 'non-accidental trauma'.
- Thirteen of the mothers were under 25 years of age. Of these, seven were under 20 years of age. The age of one mother was not known.
- Six of the infants were female and eight were male.

The raw data from these cases is attached in Appendix 3.

The panel studied these cases by reading the Child Death Inquiry Reports and/or the relevant regional documents pertaining to each case. The following list provides a summary of the key findings from the panel's review of these 14 cases:

Demographic Findings

- Some mothers were extremely young, being under 16 years of age.
- In a number of cases there were signs of maternal ambivalence towards the infants.
- Parental substance abuse and dependence were common.
- There were many indicators that the majority of parents were living chaotic lifestyles, with frequent moves and frequent changes in partners. The relationships with their partners and other family members were often volatile. Many were socially isolated. There was a consistent theme that accommodation arrangements were unsuitable for an infant. Infants were often left in the care of others without any consideration as to the appropriateness of those carers.
- Babies were often at increased medical risk due to: prematurity, medical conditions, low birth weight, drug dependency, failure to thrive and later signs of dehydration.

Additional Findings:

- In most of the cases there were indicators of potential protective risk to the baby that could have been identified antenatally. Nevertheless, there was no evidence of any intervention in the antenatal period.
- A lack of recognition of the infants' high risk status, by all professionals including CPS. This was compounded by a tendency of professionals to minimise the infant's level of risk.
- An over-reliance by CPS on professionals who are not trained in child protection to understand protective risk, this included the medical profession and maternal and child health nurses.
- Anticipated support networks for the mother were often not established, and there was limited evidence that assertive outreach was attempted. Likewise, there was no follow-up to check proposed links were established.
- There were problems in the communication exchange both between and within services, with numerous reasons for these blocks to effective communication about protective concerns being cited in the cases reviewed.
- A lack of adequate planning for the infant in the light of known risks. There was little evidence of discharge planning from hospitals for these protective high risk infants.
- In cases where an infant was identified as high risk there were some problems for CPS in gaining the support of the courts.

Beyond Blame (1993) which studied a number of child death inquiries in England shows that the characteristics of our sample of infants who had died were similar to those found in their study of child deaths.

Although there were still many areas requiring improvement to ensure better servicing to infants who are potentially at high risk of abuse or neglect, the panel noted from their consultations and materials provided that there had been improvements in the services to high risk infants over the four-year period that this analysis covers (see list Appendix 4, some are also discussed under 'Themes'). Some of the latter cases demonstrated examples of best practice, in terms of the services provided by CPS and other services.

6. Themes

6.1 Introduction

Through review of the cases and in general discussion with professionals who met with the panel, it has become clear that there are many recurring issues in the care for infant clients deemed a protective high risk. These issues may be condensed into themes that have run through all aspects of care for this group. It must be recognised that although the themes that emerged from the panel's review process are applicable to good practice for all clients, they are of crucial importance in managing care for high risk infant clients. The models of care for this high risk group need to be flexible in nature but must address the major themes that have been identified. Not all clients will require the levels of intervention identified for high risk infant clients. It is precisely because they are high risk that a more resource intensive approach is needed.

6.2 Principles

The panel found from their discussions and readings that the following principles were important in providing a service to potentially high risk infants.

- All service providers share responsibility for the support and protection of infants at potential risk. This shared responsibility should be enacted through formal processes for assessment, planning, service delivery, monitoring and review across organisational boundaries.
- Potential risk to the infant should be identified as early as possible.
- Families at risk should be actively engaged in planning for the management of the birth and the postnatal and early parenting periods.
- Specialised knowledge and expertise must be drawn upon to engage and work positively with at risk clients.
- Multidisciplinary care for clients at risk should focus on positive psychological and social support for the family unit while attending to the protection of the infant.
- Given the complexity of providing support and protection to the client group, particular attention must be given to multidisciplinary and multi-agency review within a quality improvement framework.

6.3 Conceptualising the Client

A perennial issue for health professionals working with this client group is **'who is the client?'**. Balancing the needs of the mother and infant is a complex system-wide issue. An unborn child is not a legal entity until it is born. However, this does not preclude working with the mother/unborn infant unit and significant others in a meaningful way prior to delivery. A difficulty that faces many health professionals is the dilemma of conceptualising future harms to an unborn child and giving these concerns weight in the planning process. Recognising duty of care for the unborn infant is an imperative. In most of the cases reviewed by the panel, there were indicators of protective risk to the baby either before the birth or at the hospital shortly after the birth, such as maternal young age, substance abuse, domestic violence, poor parenting knowledge, insecure attachment in infant parent dyad or a previous child abuse record.

A further difficulty identified in this area is a paradigm problem for health and other professionals working with the family unit. Prior to birth, the client is the mother with the anticipation of a future client. After birth there are two clients, mother and infant (along with significant others). Health

professionals, used to focusing on adults, **demonstrate difficulty at times in giving equal weight to the child as a client**. After birth, a hospital is a safe and nurturing environment and midwives and nurses experience difficulty in identifying risk factors or in giving appropriate weight to potential harms in the home environment (Hospital Senior Social Worker (SSW) and High Risk Infant Program Manager (HRI–PM)/semi-rural). In current generalist birthing hospitals it can be difficult to detect subtle risk factors as the mother and infant are only in for a brief period (three days) and the focus is on supporting the mother to care for the infant (Charge Nurse, metropolitan hospital). Conceptualising the infant as equally important as the mother as a client is essential in being able to identify risks to the infant.

Even those who work with the infant can sometimes underestimate the impacts of family risk factors on the wellbeing of the child (HRI–PMs and Case 6). It is sometimes easier to bend with parents than focus on the needs of the child and their experience of abuse (HRI-PM/rural). Whilst it is recognised that the family structure is the best place for a child to grow up in, interventions need to focus on ensuring the family is a safe place for the child.

CPS have developed a model of care that allows for earlier interventions through the identification of high risk infants (HRI Project). This best practice model provides the capacity to work collaboratively with the mother and significant others in the antenatal period, however, there are variations across Regions in its implementation. Training and education in risk factors for infants, to health professionals and collaborative projects between CPS and health services will facilitate the development of a shared understanding of who the client is. The encouragement of collaboration between CPS and health services through collaborative projects would enhance shared responsibility and breakdown competing paradigms.

6.4 Early Identification

It is recognised that early identification of an infant potentially at a protective high risk is essential in providing adequate care and appropriate intervention. In reviewing the cases, the absence of identification of risk factors, monitoring or intervention in the antenatal period was glaringly obvious. This is despite the fact that most of the pregnant women would have had some, if not regular, antenatal care by health professionals.

Identification and assessment are two different things.

Early identification is the responsibility of all service providers throughout the maternity system. General practitioners, antenatal caregivers, midwives, social workers, obstetricians, paediatricians, community services involved with these women, ward staff in maternity hospitals, ward staff in special care nurseries, domiciliary staff and maternal and child health nurses all hold responsibility for identification of high risk clients. This needs to be conducted by all health care providers through the natural course of pregnancy, however, the focus in early pregnancy, rather than crisis management after birth, leads to better outcomes for this client group. Breakey et al. 1991, in *Health Growth for Hawaii's Health Start,* indicate that systematic identification of at risk families is the key to the prevention of child abuse and neglect. This involves systematic hospital-based screening to identify high risk families.

Maternity care providers in the antenatal period, given their exposure to clients, are in an excellent position to screen for identification and to monitor risk factors. The identification of risk is better achieved in the early antenatal period as research indicated that risk factors that will affect an infant are present in the antenatal period (Manager and Program Adviser, Family and Community Support Branch, (F&CS), Department of Human Services).

Midwives providing care in the antenatal period are in an excellent position to identify high risk situations for unborn infants (HRI–PM)/rural) however, are often unsure about how to respond. Some hospitals have introduced screening tools to identify risk factors and ensure appropriate referral occurs early in the antenatal period This referral is often to the social work department in a hospital, however, if the client does not follow through with the referral then the identified issues are not addressed. There is a need to monitor the client through the antenatal period and share appropriate information.

Even if the client does not follow through with the referral then the antenatal midwives are in an excellent position to continue to monitor the psychosocial situation prior to birth and discuss options with the mother. Pregnancy is generally a window of opportunity, a powerful time to facilitate and enhance change. It is often a time where clients rethink their lives and values and are open to interventions. As health professionals, it is a time of great opportunity.

Shared responsibility for high risk infants is a paramount issue. It is not enough to identify potentially high risk families; appropriate referral, intervention or monitoring must occur. All service providers along the continuum of care must accept the responsibility for identification of risk and appropriate intervention. Numerous studies (*High Risk Infants known to Child Protection Services: Literature Review, Annotation and Analysis, 1999*) confirm the effectiveness of screening tools in identifying at risk families. However, it must be cautioned that they are not definitive and they will not in themselves pick up all families at risk. A single application of a screening tool will not identify all families that require assistance as risk level in a family is not stable. Conversely, it cannot be assumed that if a family does present with potential risk factors then the infant is at risk. Rather, it strongly indicates that this family will need further assessment to more clearly determine the actual risk. Screening for risk also requires a high level of skill and needs to be conducted by professionals appropriately trained in child protection risk identification.

Currently a number of antenatal psychosocial screening tools are being developed and piloted in hospitals throughout Victoria. It is important to note that screening in Victorian hospitals is relatively new and will require ongoing evaluation and continual refinement. The screening tools have variations, but are consistent in their attempt to make an early identification of an infant's risk due to psychosocial factors in the family. The development of the screening tools has not been solely to identify the protective risk to an infant, rather to assist families to be provided with the appropriate support services. However, one of the stated aims in most of the screening tools is to identify protective risk. In most cases it is hoped that early identification and intervention will prevent a referral to a secondary or tertiary services, such as CPS. (Further comments on the screening tools can be found in Appendix 4.)

A minority of clients do not present until labour or have little antenatal care. However, by not attending regular antenatal care these clients are already indicating possible risk. **Lack of antenatal**

care or fragmented antenatal care should be considered in postnatal assessment of risk and therefore in determining discharge planning.

Identification of risk should lead to appropriate referral for assessment. This requires a move from simple monitoring to a more complex coordination role. Early assessment and intervention have been shown to be extremely effective in reducing risk factors (HRI–PM and hospital SSW/semi-rural). In order to inform appropriate care, assessment must be continuous and fluid.

Assessment is inextricably linked to care planning and discharge planning. Good care and discharge planning is based on appropriate assessment and begins at first point of contact. Lack of appropriate assessment by protective workers was identified, in the cases reviewed, as being a primary factor linked to adverse outcomes (Cases 3, 4, 6). In some cases, protective workers lacked the knowledge and experience to ask appropriate questions, seek relevant information and to evaluate and analyse the information. There appears to be a structural issue of appropriate resourcing, training and education and supervision impinging on the capacity of protective workers developing adequate skills in assessment (HRI–PM/rural, Paediatrician, metropolitan hospital, Cases 6, 3). Time for reflection and analysis of cases to improve service delivery is also lacking (Manager and Program Adviser, F&CS).

It is important to recognise assessment is a complex procedure and **must take in all risk factors identified by CPS**. Some settings may adversely impact on health professional's capacity to assess adequately and, therefore, opportunities for protective interventions are lost. For example, nurturing hospital settings minimising risk factors such as attachment issues, adolescent mothers, and violence in relationships (HRI–PM and hospital SSW/semi-rural, Charge Nurse at metropolitan hospital, Paediatrician at metropolitan hospital, Case 6). This is despite many risk factors being present in the reviewed cases at time of birth.

There appears to be a general lack of understanding by health professionals about how to assess for protective risk factors and then what to do when they have been identified, such as how to make a notification (HRI–PM and Hospital SSW/semi-rural, Charge Nurse at metropolitan hospital). This has been found despite CPS reliance, sometimes over-reliance, on health professional's opinions with regard to protective risks (Cases 6, 7, 4).

Health professionals—especially maternity providers—need adequate training in identifying and responding to protective risk factors. This training will improve their 'ownership' of responsibility for identification.

Ultimately, however, once a notification is made, it is CPS' responsibility for the assessment of risk, therefore resources need to be adequate to ensure the support of workers making such assessments (Cases 7, 6, 4). The issue of resourcing CPS remains pertinent. Lack of resources leads to poor quality assessments and service. Many staff are young or inexperienced and need more training (HRI–PMs, SSW– metropolitan hospital) and there is a problem recruiting specialist and experienced staff to regional country areas (HRI–PM and Hospital SSW/semi-rural).

6.5 Early and Multidisciplinary Intervention

For high risk infants the best form of intervention is an early one. *High Risk Infants Known to Child Protection Services: Literature Review, Annotation and Analysis, 1999* indicates that this is an identified issue and that to reduce the risk level in these families, early intervention is required.

High risk families, given their complexity of needs, benefit most from interventions that are multidisciplinary in approach. Although a multidisciplinary team approach to care is often resource intensive, the small group of high risk clients requiring this type of intervention are the exception rather than the rule and respond better to this form of care. (Best practice model: special care/intensive care at a metropolitan Maternity Hospital has specific role: coordinate discharge plan, with a small multidisciplinary team of midwives, paediatrician, social worker and team midwifery.) Mainstream models of care are generally not suitable for this client group as they are usually a difficult group to engage, being less responsive and often transitory.

Components of a multidisciplinary team were evident in the cases reviewed, however, they lacked one vital aspect—a **coordinating role**. In the cases reviewed, many problems arose through the lack of a case coordinator or case manager. Information flow was impeded, responsibilities of services were not clarified and referrals that were made were not followed up (Cases 6, 3, 4, 7, 11). A coordinating role would have held the responsibility for ensuring this occurred.

A case management role is often not available given limited community resources, however identifying a person/service who holds the responsibility for case coordination would ensure continuity of care for clients. This may be a fluid role that differing services may adopt over the course of care, for example, the midwife in the antenatal period, maternal and child health nurse in the postnatal period. However, all services involved would be aware of the coordinator. This coordinator has the capacity to bring different services together in community collaboration or partnerships to form a multidisciplinary approach to care. **It is essential that the coordinator in any case, but especially high risk cases, is identified and formalised**.

While community collaboration and community partnerships may form the membership of the multidisciplinary team providing care for high risk infants, an essential component is that of outreach. Maternal and child health nurses have four piloted outreach services currently undergoing evaluation in Victoria. These outreach services target single mothers, adolescent mothers and high needs mothers, for example, mothers who had a child protection history. The evaluation indicates the programs are extremely successful and an example of best practice (Program Adviser, F&CS). Many of the cases reviewed indicated that the parents were transient or living chaotic lifestyles, had frequent changes in partners and volatile relationships with partners and other family members. These clients often did not actively engage services identified as supporting new mothers and, as a result, established no ongoing links or in many cases support networks. **Assertive outreach** for this high risk minority is a best practice form of engagement and is more likely to engage and retain the client in support services.

Services involved in caring for high risk infants and their families also need to be flexible with regards to access for clients. Since maternal and child health nursing has moved from a 'drop in' approach to an appointment-based system, there has been a loss in information gathered along with the loss of

informal contact (Manager, F&CS). Clients with lifestyle issues are less likely to access care through appointment-based systems than a more flexible system.

6.6 Care Planning Involving Discharge Planning

Unplanned discharges were identified in many cases reviewed as being a primary contributing factor to adverse outcomes for infants (Cases 3, 4).

At maternity hospitals there are generally no formal processes for discharge planning for high risk infants (HRI–PM/rural, Manager and Program Adviser, F&CS, Paediatrician–metropolitan hospital) or alternatively there may be parallel plans. For example, a medical plan on the medical file and a social work plan on the social work file (Paediatrician–metropolitan hospital). In most hospitals there are formalised care maps, however these deal primarily with medical issues and discharge planning revolves around these (Charge Nurse–metropolitan hospital, Paediatrician–metropolitan hospital).

Given that most maternity wards are task-oriented under funding limitations, women are only admitted for an average of three days, there are rotating medical and nursing staff, and admissions and discharges may occur over the weekend (Charge Nurse–metropolitan hospital). Therefore, the maternity ward is not the ideal place to develop a discharge plan for high risk infants. Care planning involving discharge planning ideally begins when risks are identified in the antenatal period.

In a medical setting, adequate **discharge planning must involve a psychosocial component as well as a medical component** and this links strongly with the need for early risk identification and assessment. Should these risk factors not be identified early, maternity ward staff are highly skilled and may pick up risk factors. A **formal process is required** where staff understand and accept responsibility for notification to CPS of high risk infants.

Discharge planning at hospital level needs to be conceptualised as more than 'leaving the maternity hospital'. Good discharge planning may be a plan for the first three months of the infant's life (given that all the infants that died under six months of age were actually three months or younger). However, the maternity hospital experience is a brief moment in the life of a family, therefore, intervention needs to take place in collaboration with and within the community. Mothers and infants are only in hospital for a very short time and often can only alert other services to the vulnerabilities and risks—intervention has to occur from the community (hospital SSWs and HRI-PM/metropolitan). Formalised processes are needed to ensure community referrals and linkages are made and followed up and information is passed on—a feedback loop. The aim is to have a smooth constructive progression from identification onwards.

Poor discharge planning was also evident in protective interventions in a number of cases reviewed (Cases 11, 4). Adequate supervision and training is required to ensure appropriate discharge planning occurs (HRI-PM/rural).

6.7 Information Flow –Formalised Processes

Information flow and, consequently, continuity of care for high risk infants and their families is compromised by a lack of formal processes and protocols between health care providers and between CPS and health care providers. This issue also has impacts on post-hospital support services being able to respond adequately to needs of clients.

In reviewing the cases, numerous problems were identified in the exchange of information ranging from professionals not communicating due to concerns about confidentiality, worries about 'losing the mother', or to CPS not giving concerns raised the due consideration they required. A general lack of formalised protocols around information sharing hindered adequate care for the high risk infants involved.

There is no consistent, statewide, formalised process of information flow of psychosocial risk factors from maternity wards to domiciliary nurses and maternal and child health nurses (Charge Nurse–metropolitan hospital, Paediatrician–metropolitan hospital, Manager and Program Adviser, F&CS, hospital SSW and HRI–PM/metropolitan). This information flow relies heavily on verbal contact, individual staff feeling a sense of urgency or responsibility, and the relationships developed between maternity wards and maternal and child health and domiciliary nurses. A formal process would ensure appropriate information about risks is communicated.

The Victorian Maternal and Child Health service is an example of best practice that is enshrined in legislation. Victorian maternal and child health nurses offer a first home visit to all mothers through notification of birth. In some States the onus is on the mother to contact the nurse. However, the birth notification to the maternal and child health nurse contains minimal information; sex of baby, date and time of birth, premature or full term, and addresses given to the hospital at time of first contact. No psycho-social information is contained in the birth notification that may alert the nurse to protective concerns.

The *Health Act 1958* requires that the maternal and child health nurse contact the house (not the mother and infant) where the mother resides. This is reasonable given that it may not be possible to contact the mother if the details on the birth notification are inaccurate or incorrect at the time of delivery. In this case every effort is made to locate the family, but the obligation under the Act is fulfilled (Manager and Program Adviser, F&CS). Given the transient nature of high risk clients, address details can change during the antenatal period. A formalised process for ensuring correct details are updated by hospitals would enhance this current best practice and maternal and child health nurses could also be involved in discharge planning prior to discharge. The maternal and child health nurse gets very little information and there needs to be a strengthening of continuity of care via discharge planning. No matter who notes the issues for the family, there should be a formal process for discharge planning and information exchange that everyone knows about (Program Adviser, F&CS).

Often poor communication within hospitals contributes to family risk factors being missed: for example, separate social work and medical files may prevent access to important information in the discharge process, separate mother and infant files with often little psychosocial information on the infant file, neonatal databases not linked to maternal data bases (Paediatrician–metropolitan hospital,

Charge Nurse–metropolitan hospital). Weekends are high risk situations as many medical and nursing staff rosters are different on weekends. Communication relies heavily on adequate file notation and appropriate planning. If a health professional is anxious and uncertain about making a notification on a client, a lack of formal processes will lead to a lack of action (HRI–PM/rural). Unplanned discharges on weekends carry a higher than usual risk for these clients.

Care maps have been developed within hospitals to facilitate continuity of care for clients and to formalise the process of care. However, care maps involve primarily medical information, notation by exception and tick the box questions. These maps are an example of good process for a healthy person, however, they are not adequate for high risk or high needs clients (Paediatrician–metropolitan hospital, Charge Nurse–metropolitan hospital).

Information flow is also an issue within CPS (Case 7) and guidelines need to be developed concerning the sharing of information between multiple workers involved with a single family. Formalised processes are required to ensure a feedback loop occurs and clients do not fall through gaps in the care system (Cases 11, 4). Often community services and post-hospital supports that were expected to engage the client failed, CPS had no knowledge of this and disengaged with the clients. A formalised information feedback loop would ensure appropriate information flow and ensure clients do not fall through gaps in the service system.

6.8 Confidentiality

The protection of confidentiality is central to any professional relationship and is recognised in privacy principles, however, it represents a potential barrier to sharing information about potentially high risk infants. Confidentiality can prevent the appropriate sharing of vital information essential to the care of high risk infants between professionals and agencies
(HRI–PM and hospital SSW/semi-rural, Case 4).

Standards and codes of professionals can inhibit continuity of care for high risk infants. Maternal and child health nurses are highly skilled trained in general nursing, midwifery and postgraduate studies in Child and Family Studies, with the ability to identify psychosocial risk factors. Many are also trained in parenting skills. However, restrictions on the exchange of information between maternal and child health services without parental consent, can inhibit follow-up of at risk families (Manager and Program Adviser, F&CS, Case 4). This is especially pertinent when it involves transient clients moving interstate or in to country areas. It is of concern that recommendations had been made in previous CDI reports in relation to maternal and child health nurse difficulties and although they have been agreed to in principle, as yet they have not been implemented. A central registry for maternal and child health high risk infants would ensure appropriate exchange of information occurs.

Competing professional paradigms inhibit understanding of confidentiality and release of information (hospital SSWs and HRI-PM, metropolitan hospital). Collaborative projects between maternity health care providers and CPS would facilitate trust and shared understandings of models of care for high risk infants. Duty of care requires that information about an infant that is potentially at risk is disclosed. As a failure to inform appropriately of concerns about an infant, can place the infant at an even greater risk (Legal Adviser, Department of Human Services). Note that under section 64 (3) of the Children and Young person's Act 1989, a notification to Child Protection that is made in 'good

faith', 'does not constitute a contravention of section 141 of the *Health Services Act 1988* or section 120A of the *Mental Health Act 1986'*.

Duty of care encapsulates good information flow in potentially high risk situations, however confidentiality can sometimes be raised as an obstacle which leads to poor risk management, for example, medico-legal fears, professional indemnity concerns (HRI–PM and hospital SSW/semi-rural). These issues can often be cultural and related to paradigms rather than legal in health care professions (Legal Adviser, Department of Human Services). To facilitate appropriate sharing of information, hospitals could ensure that the Ethics Committee is involved in developing hospital-wide protocols for the release of information as it relates to high risk infants. Appropriate training around confidentiality is important in all health professions. The sharing of information should be linked to outcomes and confidentiality should be understood in the context of the circumstances in which the information should be provided.

6.9 Post-Hospital links

Post-hospital links have been identified as inadequate (Cases 6, 4). There also exist problems with support services not being resourced to be proactive in their response with a lack of outreach (HRI-PM/rural). There is very little in-home family support available and long waiting lists for limited services. Very few case management services exist to facilitate continuity of care and intensive care for high risk clients and those that do are terribly overburdened (hospital SSWs and HRI–PM, metropolitan hospital).

6.10 Collaboration

In a majority of the cases reviewed, better collaboration both within and between CPS and the health services involved would have improved care for this client population. Collaboration is linked to information sharing and also to paradigms of care and the identification of the client being serviced. Lack of collaboration leads to a lack of a shared plan for clients and a 'silo' approach to care which inhibits continuity (HRI–PM/rural,
HRI–PM and hospital SSW/semi-rural, hospital SSWs and HRI–PM, metropolitan hospital).

Collaborative projects involving formalised links, shared understandings of client care and risk factors, agreed upon processes and protocols and channels of communication along with the development of trust between CPS and health services will facilitate the continuity of care for high risk infants.

6.11 General Practitioners/Medical Doctors

Doctors are often the missing link in risk identification for this client population. This is of concern as doctors are most likely to see the clients on a regular basis.

Despite indications in the cases reviewed that child protection workers rely on the medical profession for an adequate assessment of protective risks, the medical profession is often not trained to make such assessments. There is a weakness in the training of medical staff around psychosocial indicators and risk factors and they are often not equipped to identify and assess protective risks (Paediatrician- metropolitan hospital). Doctors require more information and training about the impacts and indicators of abuse (HRI-PM/rural, Paediatrician–metropolitan hospital). In

organisations such as hospitals and health care centres, authorisation needs to come from the top levels to give the training credibility.

6.12 Summary

Caring for the infant potentially at a protective high risk is complex and requires a multidisciplinary approach with formal, agreed upon processes. There needs to be an understood shared responsibility for identification and follow-up and appropriate linkages to community services. This requires case coordination and common understandings between different parts of the service system. This high risk group can be challenging for workers and also for codes of ethics. However, they are the exception rather than the rule and this approach, despite being resource intensive, is more likely to produce better outcomes than the current fragmented system.

7. Recommendations

The definitions for these recommendations have been noted under section 1.3 of this report. However, the definition of maternity services is provided here:

- **Maternity Services** refers to the range of services and professionals providing antenatal, perinatal and postnatal care. The key agencies and professionals that need to be involved in providing this care throughout the various stages are:
  - Maternity hospitals, including all associated services and related professionals
  - Medical professionals such as General Practitioners, Obstetricians and Gynaecologists (when in a Share Care arrangement)
  - Community midwives
  - The Maternal and Child Health Service, which at a policy level includes the Parenting Support and Child Development Unit of Department of Human Services.

The recommendations are:

1. That maternity services, in consultation with CPS, be responsible for the development of a system of early identification of families at risk. The system would include:
   - a general screening tool to determine potentially at risk families
   - a formal process of monitoring families identified as being potentially at risk, including outreach follow-up.

2. That maternity services and CPS collaborate to ensure that health professionals in the antenatal area receive professional education and training to enable them:
   - to effectively use screening tools
   - to identify risk factors for future likelihood of abuse and neglect
   - to conceptualise both the mother and infant as the client
   - to develop effective engagement practices to assist in working effectively with families at risk.

3. That maternity services in consultation with CPS, be responsible for the development and implementation of a specialised, comprehensive medical and psycho-social assessment framework to be undertaken with families identified through screening as being potentially at

risk.

4. That maternity services be responsible for the development of a care plan, including a discharge plan, to be undertaken with families identified through the medical and psychosocial assessment as likely to have abuse and neglect issues. This plan is to identify who is responsible for the care plan and ensure that appropriate referrals are followed. Best practice models of care may be characterised by:
   - a multi-disciplinary approach
   - a formal process ensuring continuity of care
   - comprehensive care planning and case coordination.

5. That CPS and maternity service providers establish a formalised system of information exchange at both a regional practice and branch policy level.

6. That Maternal and Child Health Services establish a central registry for high risk infants that can be accessed by services across the State.

7. That maternity services develop policies and protocols for sharing information concerning high risk infants within the hospital and with appropriate external parties.

8. That the birth hospital be invited to participate in all Department of Human Services Child Death Inquiries and VCDRC reviews concerning infants under three months of age.

9. That regional HRI Project Managers continue to establish and develop collaborative links and protocols with all hospitals providing local and statewide maternity services. Child Protection and Juvenile Justice Branch to take a coordinating function to ensure consistency across the State.

10. Professional bodies for maternity services, and other relevant health professionals, in collaboration with CPS, ensure that pre-service and in-service training addresses child abuse, and incorporates a focus on antenatal protective risk factors.

11. That CPS and maternity service providers establish work exchange programs.

12. That the College of Obstetricians and Gynaecologists and College of General Practitioners, develop guidelines for the sharing of information, within maternity services, about potentially high risk families.

13. That the Department of Human Services funds a small number of demonstration pilot projects to assist maternity service providers and CPS to implement the recommendations made in this report. The findings of the demonstration projects are to be used to disseminate information on effective intersectoral service delivery.

    The program areas of Department of Human Services that are identified as appropriate to contribute to this demonstration project are:
   - Acute Health Division

- Quality and Care Continuity Branch
- Community Care Division
  - Child Protection and Juvenile Justice Branch
  - Family and Community Support Branch

14. The demonstration models should involve an evaluation of screening tools regarding their effectiveness, the resources needed for adequate referrals and a follow-up evaluation regarding wether the screening and referral has produced the desired outcome, that is, reduction in risk for clients.

    - Acute Health Services, in consultation with CPS, should take an overall coordinating role for recommendations pertaining to maternity services.

8. Case Summary

While acknowledging infants will die despite all our best efforts, the panel suggests that the adoption of the recommendations might result in an improved outcome in the case scenario presented at the start of the report. What follows is an adaptation of the case of Crystal incorporating some of the recommendations made in this report which may lead, hopefully, to a more positive outcome.

> Crystal was born prematurely and opiate-dependent. Crystal's mother, Jodie, 16 years, had been a client of Child Protection Services and resided in residential placements during her early adolescence but was now living at home with her mother. The relationship was described as volatile and characterised by frequent periods of Jodie 'moving out' to live with Brant, Crystal's father, 17 years, who is described as abusive to Jodie.
>
> Jodie had attended the antenatal clinic twice in late pregnancy and had been identified through the antenatal clinic's screening program as having high risk behaviours and chaotic living situation likely to be detrimental to her health and the health and welfare of her child. When antenatal appointments were missed, the clinic's outreach follow-up system located Jodie at her mother's home and provided travel vouchers to ensure Jodie, accompanied by her mother, were able to attend the clinic regularly. Jodie attended the clinic over the next three weeks before she presented for the birth.
>
> Nurses on the ward described Jodie as 'appearing disinterested in Crystal' but Jodie told the hospital social worker that she was 'keen to get involved with the infant' and would accept services in the community when discharged from hospital. The social work department was already involved with Jodie after the initial screening and arranged a community meeting to plan for Jodie and Crystal's discharge from hospital. Participants included medical services, family support agency, outreach drug and alcohol worker, local maternal and child health and domiciliary services. As Jodie was expressing compliance with this planning, Child Protection Services were not involved. The plan included the identification of the hospital social worker as the coordinator for the first month after discharge, who would then cease her involvement, and then the family support agency would assume this role.
>
> Jodie discharged herself and Crystal from hospital on the third day, although Crystal was still displaying irritability possibly due to drug withdrawal. Jodie declined visits from the domiciliary nurse. The maternal and child health nurse visited Crystal at her grandmother's home and assessed baby as making adequate progress. Jodie was not present and grandmother indicated that Jodie was usually with Brant, probably using drugs, and that she was 'sick of being left with the baby'. Both the domiciliary nurse and the maternal and child health nurse contacted the hospital social worker with their concerns. A notification to CPS was made and another meeting was convened which included CPS. A decision was made for the drug services worker to accompany the CPS worker on a home visit.
>
> The visit was undertaken and Jodie agreed to services being engaged, including a youth mediation worker to work with her and her mother. Grandmother said that she was 'sick of being left with the baby' and it became apparent that grandmother was caring for Crystal and that Jodie was unprepared and fearful of providing the baby's care. CPS made a referral to the regional in-home Parenting Assessment and Skill Development Service (part of the High Risk Infants Project) to determine Jodie's capacity and motivation to care for Crystal and to determine in which areas she required additional skills training. CPS maintained case

management during this period with a view toward the family support agency providing coordination of services in the longer term.

The future for Jodie and Crystal remains unclear. Jodie may or may not be able to make use of services offered at this time and her drug use may take precedence to the extent that Crystal's welfare is put in jeopardy and CPS would remain involved to ensure Crystal's needs are met within a safe environment. However, this best practice scenario illustrates a strong community response to its most vulnerable members and provides an example of how a family can be assisted and strengthened to help themselves and thereby being able to keep their baby safe.

9. Responses to the Draft Report

A draft copy of this report was forwarded to key services and professionals in the field, including various Branches of the Department of Human Services, all Regions of Department, all metropolitan maternity hospitals, larger rural maternity hospitals, medical colleges and associations. A total of 17 hospitals were provided with copies of the report. Written responses were received from most of the Department of Human Services program areas, as requested. Six of the nine Regional offices provided a written response and one offered some verbal comment. Seven hospitals provided written responses and two provided verbal comment. One written response was received from a medical college.

The responses to the draft report were overwhelmingly positive, stating the report highlighted a number of the issues that have been identified within the system. There was a general consensus that this is an area that needs further attention. Some of the responses indicated an interest to be involved in future developments. Aside from this there was a great deal of diversity in the responses, indicating that reaching agreement about the best way to proceed in improving the identification and intervention with infants at a high risk of abuse or neglect will provide great challenges in the future.

The most commonly cited concern was about the development of a screening tool, with some responses expressing hesitation about the validity or feasibility of these tools. The panel, while understanding this reticence, can only reiterate that progress needs to be made, and there are examples now in practice where screening tools are being used effectively. The panel does, however, recognise that a formal evaluation process must be developed alongside any form of screening tool.

Concerns were noted by two hospitals about the responsiveness of CPS with the following comment demonstrating some of the tensions:

> 'It is our experience that child protection services are under-resourced, and have a high turnover of staff in some areas with a resultant gap in skill base. There are instances where referrals are not accepted, not acted on promptly, or involvement in high risk situations is brief with an expectation that community outreach will provide ongoing services. Unfortunately the community lacks the resources or the mandate to provide this.' (metropolitan hospital)

Responses consistently supported the recommendations to provide training for maternity providers in the identification and appropriate response to protective risk. However, there was a question raised about where to direct the training (public versus private health system) and it was suggested that the mechanisms to provide this training requires further development. One response suggested that the training needs to be '...basic and non-bureaucratic to ensure adherence by the widest possible set of

health care providers' (rural maternity hospital). It is suggested by the Acute Health Division of Department of Human Services that recommendations regarding education and training will need to involve various Branches of Department of Human Services and '...liaison and negotiation with the range of organisations associated with training and ongoing professional development for general practitioners, midwives and obstetricians.'

In general, intersectoral and interdivisional collaboration is viewed as essential and general support was given '...to the recommendations to improve information sharing and formal protocols to ensure earlier, responsive, collaborative and appropriate case management for infants at risk' (Acute Health Division, Department of Human Services).

Some comments were made expressing concern about the resources required to implement the recommendations made in the report. Acute Health Division, Department of Human Services states: 'One project funded by this division involves the addition of an average of 20 minutes per woman to current antenatal care provision and referrals to social work have increased from 6% to 30%.' The panel recognises that a commitment to the recommendations will require some additional funding to the maternity sector.

Requests from reviewers of the report were made to consider recommendations that were outside the parameters of this inquiry report, such as requests that child protection fund hospital beds when there is a delay in the response to a notification; or that inter-uterine foetal deaths be reviewed. Although the panel can see the worthiness of these suggestions, they believe they are outside their terms of reference, and suggest that they may be best considered through other avenues than this report.

As the Acute Health Division will have primary responsibility for the implementation of the report's first three recommendations, it is important to include their response to these recommendations. The Division has raised concerns about the viability of the recommendations based on their concern that: 'The resource implications involved are substantial'. 'Within current resource constraints the implementation of these recommendations would mean that other components of antenatal care [might] be reduced or compromised'. The Division has suggested that the first three recommendations be reframed to the following two recommendations:

"1. That Acute Health Division, in collaboration with the Consultative Council on Obstetric and Paediatric Mortality and Morbidity and Child Protection Services, organise a round table discussion or forum to consider the implementation of a psychosocial assessment framework to assist the identification and support of families at risk. This discussion should be organised as soon as possible, and have a multidisciplinary approach to the questions and issues involved.

2. That the current use of screening tools and psychosocial assessment procedures which have been developed in the last two years be reviewed with a view to establishing:

   2.1 The effectiveness of the various options for antenatal risk assessment and screening.
   2.2 The effectiveness of referral options and subsequent interventions for woman and infants identified at risk.

2.3 The resource implications of screening 45,000 women each year and the resource implications of referrals arising.
2.4 An agreed way forward to improve outcomes for women and their babies.'

It is proposed by the Acute Health Division that the Maternity Services Advisory Committee, which has a large and multidisciplinary membership, take up and consider these recommendations.

Any form of best practice model would include the current issues with screening tools, evaluation outcomes of screening tools currently in use and evaluations of current referral models.

Appendices

Appendix 1 The Process for the Review of Child Protection Client Deaths in Victoria

A process for reviewing deaths of children and young persons known to CPS was first established by the Department of Human Services in 1985 with a formal system announced in 1989. This process was significantly enhanced with the establishment of a Ministerial Advisory Body, the Victorian Child Death Review Committee (VCDRC) in 1995.

The broad role of the VCDRC is to review all deaths of child protection clients, to advise the Minister of the implications of findings, evaluate service system responses, describe trend patterns and themes, identify the prevalence of particular risk factors and make recommendations about the requirement for further investigation, as well a linking outcomes to the broader health and welfare context.

Prior to 1998, the Department of Human Services undertook a regional review of all child protection deaths through the Department's critical incident reporting procedures. In cases where there were additional issues requiring further investigation, a Child Death Inquiry (CDI) panel was established. An Inquiry was endorsed by the then Director, Youth and Family Services. CDI panels were conducted by a panel of professionals who had expertise in the issues to be explored and were comprised of Departmental and non-Departmental staff.

In 1998, the CDI procedures were enhanced and a common review tool was applied to all child protection deaths, with an optional analytical process that may be applied to either a specific death if issues warrant, or a group of deaths if further in depth investigation is required.

The current CDI process is a three-tiered model:

1. A CDI Case Practice Review (CPR) is conducted for all child protection deaths. The aim of the CPR is establish the facts of the protective service case and to ascertain whether established Departmental procedures, standards, guidelines and protocols were followed in the management of a case. The CPR is conducted by a senior Departmental staff member, from another Region than where the death occurred, and is approved by the Director, Community Care Division, Department of Human Services.
2. A Child Death Inquiry–Analysis may be recommended in the CPR, or from the VCDRC. The CDI Analysis is approved by the Director, Community Care Division, Department of Human Services. The aim of a CDI Analysis is to further explore critical issues relating to a single death or to consider systemic issues and common themes and patterns arising from a group of deaths. An analysis is conducted by a panel of professionals who have expertise in the issues to be explored and is comprised of Departmental and non-Departmental staff.
3. The VCDRC overviews all child protection client deaths in Victoria and provides advice to the Minister for Community Services regarding common themes and patterns and on issues that require attention by the Department.

A range of CDI reports were used for this analysis including regional reviews, inquiry panel reports prior to 1998 and case practice reviews after 1998.

Appendix 2 People Interviewed by the Panel

The panel initially considered the information provided through reports from the Child Death Inquiry process. Additional information was sought from other sources, including relevant literature and current initiatives.

Consultation occurred with relevant Departmental program areas and the service sector including:

- High Risk Infant Project Managers
    - One from a rural region, one from a semi-rural region and one from a metropolitan region.

- Hospital Senior Social Workers
    - One from a semi-rural hospital and two from metropolitan hospitals.

- Paediatrician from a metropolitan hospital.

- Charge Nurse from a high risk maternity ward at a metropolitan hospital.

- Family and Community Support (F&CS) Branch, Department of Human Services
    - Manager, Parent Support and Child Development Unit
    - Program Adviser.

- Acute Health Division, Department of Human Services
    - Senior Project Officer, Effectiveness Unit, Quality Branch.

- Legal Services Branch, Department of Human Services
    - Senior Legal Officer.

Appendix 3 Raw Data of Cases Reviewed by the Panel

Case No.	Sex of Child	Age of Child	Age of Mother	Cause of Death	Year of Death
Under 3 Months					
1	Male	3 mths	under 20	SIDS	1999
2	Female	3 wks	under 25	Accidental	1998
3	Female	1 mth	under 20	SIDS	1998
4	Male	3 mths	under 20	SIDS	1997
5	Male	2 mths	under 20	SIDS	1996
6	Male	3 mths	under 20	SIDS	1996
7	Female	1.5 mths	under 20	SIDS	1996
8	Female	2 mths	under 25	SIDS	1996
9	Female	1 mth	not known	Acquired disease - illness	1995
10	Male	1 mth	under 25	SIDS	1995
Under 12 Months					
11	Male	7 mths	under 20	SIDS	1999
12	Male	11 mths	under 25	Accidental	1997
13	Female	11 mths	under 25	Non-accidental trauma	1996
14	Male	10 mths	under 25	Accidental	1995

Appendix 4 Program Areas and Initiatives

<table>
<tr>
<td>High Risk Infant Service Quality Initiatives Project</td>
<td>The Department of Human Services, Child Protection and Juvenile Justice Branches' High Risk Infants Service Quality Initiatives Project (HRI Project) commenced in mid-1997 and has developed and implemented a range of significant initiatives to improve the quality of Protection and Care services to infants at risk of significant harm from maltreatment, and their families, including:

Specialist Infant Protective Worker (SIPW) Positions
Twenty-five statewide, specialist positions have been introduced to support and assist regional child protection workers concerning risk assessment and risk management and to enhance service delivery to infants and promote networks with the wider service system. Some of their roles include:

Consultation with child protection workers concerning work with high risk infants.
Development of linkages with other services that provide care to high risk infants, such as hospitals, M&CHS, and community agencies.
Provision of education to professionals and services involved in the care of HRIs, leading to increased professional and community awareness about the risks to infants.
Support for workers engaged in legal processes.

Flexible HRI Regional Budget
This budget supports the SIPW initiative and provides funds to purchase services or material goods for families.
Parenting Assessment and Skill Development Services (PASDS)
These services are regionally based and provide both a parenting capacity assessment service and a parenting skill development, education and support service in a residential, day stay or in-home setting for this target group.
Other programs undertaken through the HRI Project include:

A comprehensive training program for child protection workers concerning SIDS and unsafe sleeping environments as they relate to the child protection population.
Development of a practice policy concerning the importance of working with families prior to the birth of their infant that is likely to be at risk of harm following birth.

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APPENDIX 4 continued

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<tr><td>Hospital-Based Screening for infants at protective risk due to psychosocial risk factors in their families</td><td>A number of metropolitan, rural and semi-rural hospitals have introduced or are in the process of introducing, antenatal screening for infants to identify psychosocial risk factors in families.
The examples the panel found had variations, but were all consistent in their attempt to make an early identification of an infant's risk due to psychosocial factors in their family.
The development of the screening tools has not been solely to identify a protective risk to an infant, rather to assist families to be provided with the appropriate support services. However, one of the stated aims in most of the screening tools is to identify protective risk. In most cases it is hoped that early identification and intervention will prevent a referral to a secondary or tertiary services, such as CPS.

Examples are:
A semi rural hospital has been using a high social risk tool in their antenatal clinic since 1994. This hospital has had to modify the screening tool due to resource limitations. It is now targeted only to the very high risk families due to the resource limitations.
A network of rural hospitals have developed an evidenced based tool which will be evaluated during a trial at approximately eight sites. It is anticipated that the final version may be 'multi-tiered' with midwives conducting the first layer of assessment and social workers conducting the next layer, after a need is identified. The social worker would determine appropriate management strategies and referrals.
In a large metropolitan hospital a 28 week antenatal screening tool is currently being developed. A component of this tool is the referral to appropriate services, as indicated in the screening tool.</td></tr>
<tr><td>Pilot Project between a semi rural hospital and the regional Child Protection Service</td><td>During 1997 and 1998, a semi rural maternity hospital, in conjunction with CPS developed a pilot project which consisted of the administering an antenatal screening tool to provide preventative work and to develop community links.

This pilot project has now finished, but reportedly the links between the services networks continue. The findings of this pilot project have been published and the authors conclude that:<blockquote>"Discharge planning and early identification of risk factors is an integrated part of the practice and procedure in the ante natal clinic. Liaison regarding information and education sessions continues to be an accepted part of professional practice". (Pg 7 in article by Moore, Hawke and Dungey, Yr).</blockquote></td></tr>
</table>

APPENDIX 4 continued

Acute Health Division, DHS	This Division of DHS, through the Maternity Services Program, has committed recurrent funding, for four years since 1998–99, to improve public maternity services across Victoria. (Also called maternity enhancement funding.) Additional funding has already been provided to maternity hospitals for the provision of postnatal domiciliary services, as a response to trends in early discharge. Domiciliary services offer a universal post-hospital visit from a registered midwife. More can be offered if the woman has special needs. Currently, domiciliary services are coordinated by hospitals and there is no consistent model of practice for domiciliary services across the State. There has been numerous projects from this Division that have a bearing on the findings of this report: • Review of antenatal care, where it was found that share care is not satisfactory for high risk mothers (social and medical?). It was also found that GPs generally do not know a lot about women's social needs. • There are initiatives to: - investigate postnatal issues more broadly - improve the links between domiciliary and M&CH services - improve discharge planning.
Maternal and Child Health Service, Family and Community Support Branch, Community Care Division, DHS	The MCH Service provides universal primary care for all Victorian families with children aged 0–6 years. The service is jointly funded by State and local government and managed in most instances by local government. The key features of the service are health surveillance, health promotion and education, parenting support , identification of concerns and referral and a focus on maternal health and wellbeing. Victorian legislation requires the local government where the mother resides, to be notified of a birth to enable a MCH nurse to visit the family where possible. As part of the universal service, additional visits are provided for first time mothers and families with particular needs. The service has been limited in its capacity to provide intensive support to families with high needs in the past, but has been well placed to implement strategies for early identification and intervention for this client group. Some targeted services for vulnerable families have been implemented over the past four years in some municipalities and a new Enhanced Home Visiting Service is currently being developed for vulnerable families across the State. The current targeted services for vulnerable families include four Pilot Outreach Services and 31 'new initiatives'. These services utilise differing models, staffing and target groups. An evaluation of four Pilot Outreach Projects has been completed and the evaluation of the 'new initiatives' will be completed in April 2001. The final report of the evaluation of the Pilot Outreach Projects has led to 13 recommendations. The following findings of the evaluation are relevant to the findings of this report: • An assertive outreach approach is to be encouraged. • Outreach services should be effectively promoted to a wide range of potential referral sources. • Screening potential high risk groups through mainstream services is to be encouraged. • There is a definite role for antenatal identification and intervention for targeted families. • Home visiting is a key component of the outreach service. • Appropriate qualifications were identified as being important. • Links with other professionals undertaking similar roles and regular professional supervision are important. • Protocols should be developed which assist the outreach services to work cooperatively with other agencies.

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