

# Collaborative Case Management of High Risk Infants in Hospitals Policy Guideline

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# Collaborative Case Management of High Risk Infants in Hospitals Policy Guideline

## 1. Policy Statement

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SA Health is committed to supporting the rights of all children (including the unborn child) and offers particular support to infants where it has been identified they are at high risk of harm, having regard to their safety and protection.

This Policy Guideline describes the roles and responsibilities of staff in each agency and is to be read in conjunction with the Collaborative Case Management of High Risk Infants in Hospitals Policy Directive.

This Policy Guideline aims to facilitate optimal outcomes for women with high and complex needs and their infants, through:

- engagement and early intervention when psycho-social complexity and risk(s) are identified in the ante-natal period.
- working in partnership to achieve the best outcomes for infants (including the unborn child) and families where there are child protection concerns.
- joint case planning and collaboration between the staff of SA Health and the Department for Child Protection (DCP).
- procedural guidelines which describe the roles and responsibilities of staff in each agency.
- a common process from hospital post-delivery to next point of care (i.e. Child and Family Health Service (CaFHS) and other support services).

## 2. Roles and Responsibilities

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SA Health hospitals and Department for Child Protection (DCP) staff will share responsibility and act together to form an integrated, cohesive and coordinated service system so that infants and their families receive the best combination of services to meet their care and safety needs.

Health Professionals working in Drug and Alcohol Services, SA Ambulance Service or Mental Health Services, have a responsibility to consider the safety and wellbeing of clients' children, including the unborn, under this Policy Guideline.

Detailed information about which role, organisation, or group plays a role in the implementation of this Policy Guideline is provided in Attachment 1.

### 2.1 Chief Executive SA Health

- Will take reasonably practical steps to develop and issue system-wide policies applying to Local Health Networks, the SA Ambulance Service, and the Department for Health and Well-being ensuring the safety and welfare of children in SA Health care.

### 2.2 Local Health Network Governing Boards

- Will take reasonably practical steps to ensure that effective clinical and corporate governance (where relevant) frameworks are in place to ensure the LHNs are compliant with this Policy Guideline and its accompanying Policy Directive.

**2.3 Chief Executive Officers will:**

- ensure staff are aware of their obligations to report suspected physical or psychological development if an unborn child is at risk (whether due to an act or omission of the mother or otherwise).
- ensure systems are in place to assist staff in identifying when a child is or may be at risk of harm.
- ensure staff, including volunteers receive appropriate education relating to identifying and responding to risks of harm.

**2.4 Executive Directors, Directors and other senior managers will:**

- develop, implement and monitor local protocols that ensure staff respond to suspicions that a child is, or may be at risk in a timely manner.
- ensure incidents where a person suspects on reasonable grounds that a child is, or may be at risk are notified in accordance with mandatory reporting requirements.
- support staff and organisational systems to work collaboratively with other agencies to address risk factors.

**2.5 All SA Health staff (including volunteers) involved in the care of a woman and her baby will:**

- adhere to the principles and aims of this Policy Guideline and ensure they operate in accordance with its reporting requirements.
- ensure incidents where a person suspects on reasonable grounds that a child is, or may be at risk are notified in accordance with mandatory reporting requirements.
- ensure an unborn child identified at risk, due to high and complex psycho-social concerns is notified to the Child Abuse Report Line (CARL).
- work collaboratively and within organisational expectations to address risk factors.

### 3. Policy Requirements

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**3.1 Scope**

- Pregnant women whose unborn children are identified as being at high risk, due to high complex psycho-social concerns.
- Management of cases where it is considered that the physical or psychological development of an unborn child is at risk or an infant is or may be at risk of harm.
- High Risk Infants (HRI) at birth as determined by the DCP.
- Removal of newborn High Risk Infants from parental care in a birthing hospital by the DCP.
- A common process is established from hospital post-delivery to next point of care e.g. DCP; Child and Family Health Service (CaFHS) and other support services.
- Management of cases where an infant or unborn child is considered to be at risk.

### 3.2 General Principles

SA Health supports the rights of all children (including the unborn child) and offers particular support to infants where it has been identified they are at high risk.

SA Health is committed to protecting children from physical and psychological harm. With the implementation of this Policy Guideline SA Health will ensure:

- all cases where an unborn child or infant at birth is identified as being at risk are reported to the DCP, Child Abuse Report Line (CARL).
- the infant's vulnerabilities necessitate extra attention when assessing their protective and care needs.
- all decisions will be based upon high quality, holistic risk assessment that takes into consideration the child, their family and the social context.
- systems are in place to assist staff in the review and assessment of risk and with interventional support.
- staff are aware of their legal obligations to report a high risk pregnancy/birth of infant.
- staff are knowledgeable in the areas of child protection.
- families will experience Person and Family Centered Care principles and practices.
- services will collaborate to achieve the best outcomes for infants (including the unborn) and families.
- staff will understand cultural influences on family and parenting practices and respond in a culturally sensitive way including use of the Aboriginal and Torres Strait Islander Child Placement Principle for Aboriginal children.

### 3.3 A lead professional in each agency (the key worker/ case coordinator) is identified to case manage the multi-agency/multi-disciplinary coordination and information exchange/flow within and between the agencies.

- Flinders Medical Centre: Child Protection Service (CPS) has the lead, and will nominate the key worker/case coordinator.
- Women's and Children's Hospital: Social Work has the lead, and will nominate the key worker.
- Lyell McEwin Hospital: Child Protection Service (CPS) has the lead, and will nominate the key worker.
- Regional birthing hospitals: designated Nurse/Midwife Unit Manager or delegate.
- Child and Family Health Services: designated Nurse/Midwifery Consultant.
- Department for Child Protection: designated high risk infant worker or supervisor.

### 3.4 Information is collated and made available to all professionals involved in the case as per the Information Sharing Guidelines. Actions and allocated responsibility are documented in a case management plan. Risks are identified and communicated to all staff involved.

- Documented information about any security risks (i.e. Domestic Violence and/or Family Violence; Family Safety Framework; Multi Agency Protection Service; Multi Agency Assessment Unit; misuse of drugs and alcohol; mental health issues) are shared between DCP and SA Health and filed in case notes/health record.

- Nominated staff are responsible for ensuring the details of allocated/key workers/case coordinators from both agencies are recorded in the client's case record within both agencies.
- Ongoing review and assessment of risk and protective factors is part of the case management plan and case coordination. Increases of risk will generate an equivalent case managed response.
- Document within the health record that the pregnant woman, parents/carer has been involved in/informed of the case management plan or document reasons for the decision not to involve/inform.
- Where the woman/family involved is identified as Aboriginal or Torres Strait Islander, the allocated/key workers/case coordinators will engage the relevant cultural consultants for support.
- Discharge, transfers and referrals of High Risk Infants between health professionals, (social workers, nurses, midwives, medical staff, Aboriginal cultural consultants), and/or between agencies, (hospitals, DCP, Child and Family Health, General Practitioners, non-government agencies) are to be made to nominated key workers/case coordinators (must include person-to-person hand over, not only a paper/ electronic referral). Note that documentation of referrals must not be delayed by person to person hand over.

### **3.5 Notification of high risk pregnancy**

- Collaborative case conference is the opportunity to engage with the mother and family to increase protective factors for the care and protection of the child and link with available support services.
- It is recommended reports on unborn child notifications be made when a clinician reasonably suspects that the physical or psychological development of an unborn child is at risk.
- It should be noted by staff that reports of risk to unborn children will be accepted by the Department for Child Protection.
- DCP High Risk Infant (HRI) worker or supervisor advises hospital key worker/case coordinator of DCP intentions.

### **3.6 Birth of HRI not allocated by DCP**

- The hospital staff high level of concern and DCP decision not to allocate needs to be documented in the mother and infants health record and communicated to services responsible for ongoing care on discharge.
- When DCP have determined removal is not warranted and hospital staff have significant concerns discharging infant to parents, hospital staff will escalate via internal LHN escalation processes.

### **3.7 Notification of birth of HRI allocated by DCP**

- Midwifery Unit notifies DCP CARL and advises Hospital key worker/case coordinator of infant's birth.
- Hospital key worker/case coordinator notifies DCP case manager of infant's birth.

### **3.8 Removal of infants from parental care**

- Where DCP determines an infant as a High Risk Infant requiring removal from parental care, the DCP HRI worker or supervisor will notify the relevant hospital service staff and commence the coordination of the case plan and removal process within the hospital.
- Where removal is planned prior to birth, it is expected that an interagency plan between SA Health and DCP be developed by 34 weeks gestation. In the event that high risk is present and the plan is not developed this will be escalated to the relevant Regional Director.
- Optimally, the removal of an infant from a parent's care will happen in a planned and coordinated manner and consideration will be given to placement with relatives/kin. There will however, be some situations when removal on an emergency basis is essential for the infant's safety.
- The DCP must consult with a Principal Social Worker and/or Principal Aboriginal Consultant as appropriate, unless the delay involved in consulting would prejudice the child's safety.
- Within SA Health, the designated Aboriginal consultant is the Senior Aboriginal Health Worker/Manager within the Hospital and /or staff from an Aboriginal Health Service for cultural consultation and support for families.
- For Culturally and Linguistically Diverse (CALD) families support and advice in relation to engaging with families, communities and culturally appropriate service providers is available through DCP – Multicultural Support Services or Refugee Health Service.
- DCP has the responsibility to inform parent(s) of intention to proceed with formal care and protection action. DCP will develop a case plan for the child including, where appropriate, supervised contact.

### **3.9 Aboriginal Health Impact Statement**

- This Policy Guideline acknowledges that Aboriginal children and families are over-represented in the child protection system, for a myriad of reasons including being exposed to past trauma and the impact of colonisation. When an Aboriginal infant or mother comes to the attention of DCP and a statutory response is necessary it is important to ensure Aboriginal staff are included in consultation.
- Where the woman/family involved is identified as Aboriginal or Torres Strait Islander, the allocated/key workers/case coordinators will engage the relevant cultural consultants for support.
- Within SA Health, the designated Aboriginal consultant is the Senior Aboriginal Health Worker/Manager within the Hospital and /or staff from an Aboriginal Health Service (such as the Aboriginal Family Birthing Program /AMIC service) for cultural consultation and support for families.
- Aboriginal staff in these programs and services provide specific clinical and cultural knowledge and professional expertise offering advocacy, consultation, cultural advice and representation of views where an Aboriginal child is subject to DCP notification and /or intervention.
- Staff will engage in continuous cultural learning opportunities including Aboriginal Cultural Respect Training to understand cultural influences on family and parenting practices and respond in a culturally sensitive way including use of the Aboriginal and Torres Strait Islander Child Placement Principle for Aboriginal children.

- Staff will understand cultural influences on family and parenting practices and respond in a culturally sensitive way including use of the Aboriginal and Torres Strait Islander Child Placement Principles for Aboriginal children.
- The Vulnerable Infants Working Group led the review and update of the Collaborative Case Management of High Risk Infants in Hospital Policy Directive and Policy Guideline. The working group members included Aboriginal leadership representation from the Department for Health and Wellbeing, CALHN, NALHN, WCHN, SALHN and CHSALHN.
- Aboriginal stakeholders were involved at all stages in the consultation process to ensure that the benefits for Aboriginal people were represented in the process. Work continues across SA Health to continue to improve service delivery to Aboriginal women and their infants under the auspices of this Policy Guideline.

### 3.10 Documentation

#### 3.10.1 Patient Record

- It is important that medical and midwifery staff involved in the care of a woman and her infant are aware of any child protection process.
- DCP will provide information to clearly identify the infant's legal status, including the DCP office and allocated worker contact details and details of the DCP Chief Executive instrument of guardianship or Court order.
- DCP provides the Hospital key worker/case coordinator with verbal and written details of the authority to remove, i.e. letter, copy of Section 41 and other relevant details, are identified by DCP and the Hospital staff for example, contact arrangements and breastfeeding plan.

#### 3.10.2 Key workers / Case Coordinator

A lead professional in each agency (the key worker/case coordinator)

**NB.** The title of this designated role varies between hospitals but the role is common to all hospitals.

- **Hospital**

A key worker/case coordinator will be allocated to work with the woman, liaise with DCP, be responsible for communication about any information or decisions made by DCP and manage the process for the infant leaving the hospital.

The hospital key worker/case coordinator will provide a copy of the discharge summary when a child is removed or when the case remains open.

The hospital key worker/case coordinator will provide a copy of the discharge summary to DCP for the DCP child's file.

The hospital key worker/case coordinator provides information to CaFHS of infant placement arrangement, DCP contact and details of infant's placement.

The hospital key worker/case coordinator will provide required documents, as specified by DCP that will enable DCP to notify Centrelink of the birth and removal of the infant and for inclusion on the child's file.

- **Department for Child Protection (DCP)**

A key worker will be allocated to the case, to liaise with the hospital key worker/case coordinator and take responsibility for the statutory process.

High-risk situations can be identified by either agency, based on the agreed definition and assessment of risk.

### 3.10.3 Coordination of Removals

- **In hours**

The hospital key worker/case coordinator co-ordinates the removal plan in conjunction with DCP and informs key midwifery and medical staff of plan.

- **Out of hours**

Hospital nominated after-hours worker co-ordinates the removal plan in conjunction with DCP.

## 4. Implementation and Monitoring

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4.1 To ensure this Policy Guideline has been implemented and complied with each of the SA Health birthing hospitals will monitor and measure compliance against the following key outcomes:

- evidence of working in partnership between the staff of SA Health and Department for Child Protection and others to achieve the best outcomes for infants (including the unborn) and families where there are child protection concerns is documented in joint case management plans, case discussions and care planning;
- procedural guidelines which describe the roles and responsibilities of staff in each agency are developed;
- a common process from hospital post-delivery to next point of care is established and documented e.g. DCP; CaFHS and other support services;
- audits will be undertaken to identify cases when an unborn child or infant at birth is identified as being at risk and are reported to the Department for Child Protection, CARL;
- staff will engage in continuous cultural learning opportunities including Aboriginal Cultural Respect Training to understand cultural influences on family and parenting practices and respond in a culturally sensitive way including use of the Aboriginal and Torres Strait Islander Child Placement Principle.

## 5. National Safety and Quality Health Service Standards

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The Australian Commission on Safety and Quality in Health Care has developed the [National Safety and Quality Health Service Standards](#) (the Standards).

The Standards provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. They propose evidence-based improvement strategies to deal with gaps between current and best practice outcomes that affect a large number of patients.

Please identify how this policy directive contributes to any of the below listed standards:

 National Standard 1 Clinical Governance	 National Standard 2 Partnering with Consumers	 National Standard 3 Preventing & Controlling Healthcare-Associated Infection	 National Standard 4 Medication Safety	 National Standard 5 Comprehensive Care	 National Standard 6 Communicating for Safety	 National Standard 7 Blood Management	 National Standard 8 Recognising & Responding to Acute Deterioration
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 6. Definitions

In the context of this document:

- **Aboriginal** refers to an Aboriginal or Torres Strait Islander person. When the term Aboriginal is used in this document it should be read as inclusive of Torres Strait Islander people, their culture and Communities while acknowledging that Torres Strait Islander people have a separate and distinct culture, identity and country to that of mainland Aboriginal people.
- **Aboriginal child** refers to a child who—
  - (a) is a descendant of the indigenous inhabitants of Australia; and
  - (b) a young child, is regarded as Aboriginal by at least 1 of their parents.
- The **Aboriginal and Torres Strait Islander Child Placement Principle** is as follows:
  - (a) if an Aboriginal or Torres Strait Islander child or young person is to be placed in care under this Act, the child or young person should, if reasonably practicable, be placed with 1 of the following persons (in order of priority):
    - (i) a member of the child or young person's family;
    - (ii) a member of the child or young person's community who has a relationship of responsibility for the child or young person;
    - (iii) a member of the child or young person's community;
    - (iv) a person of Aboriginal or Torres Strait Islander cultural background (as the case requires), (determined in accordance with Aboriginal or Torres Strait Islander traditional practice or custom);
  - (b) if an Aboriginal or Torres Strait Islander child or young person is unable to be placed with a person referred to in paragraph (a), or it is not in the best interests of the child or young person to do so, the child or young person should be given the opportunity for continuing contact with their family, community or communities and culture (determined in accordance with Aboriginal or Torres Strait Islander traditional practice or custom);
  - (c) before placing an Aboriginal or Torres Strait Islander child or young person under the *Children and Young People (Safety) Act 2017* (the Act) section 12, the Chief Executive or the Court (as the case requires) must, where reasonably practicable, consult with, and have regard to any submissions of, a recognised Aboriginal or Torres Strait Islander organisation.

- **agency** refers to metropolitan and regional Local Health Network birthing hospitals; Child and Family Health Service and the Department for Child Protection.
- **collaborative case planning** is defined as: actively working in partnership to coordinate assessment, planning, intervention and advocacy.
- a reference to **the development of children** will be taken to include a reference to the physical, social, emotional and intellectual growth.
- **High Risk Infants** are defined as:
  - a child up to 12 months of age, including the unborn child where significant risk factors have been identified.

The following factors especially when cumulative, contribute to the infant being assessed and determined as High Risk, including the unborn, are deemed to be at risk of harm when their caregiver demonstrates the following characteristics or behaviours including:

- serious substance misuse;
- domestic/family violence situation;
- a diagnosed mental illness to the degree that it significantly impairs parent/caregiver capacity;
- assessment of intellectual disability to the degree that it significantly impairs parent/caregiver capacity;
- significant attachment issues;
- previous notifications/confirmation of serious abuse or neglect of other children.

Additional factors impacting on parenting capacity which may be associated with increased risk to infants include: experience of abuse and/or violence in childhood; experience of being under Guardianship; poor parent/caregiver skills; young maternal age; financial difficulties; homelessness/transience and lack of social support.

- **infant** is defined as a child up to 12 months of age including the unborn child.
- **meaning of harm**
  - (1) For the purposes of the Act a reference to harm will be taken to be a reference to physical harm or psychological harm (whether caused by an act or omission) and, without limiting the generality of this subsection, includes such harm caused by sexual, physical, mental or emotional abuse or neglect.
  - (2) In this section—
 

psychological harm does not include emotional reactions such as distress, grief, fear or anger that are a response to the ordinary vicissitudes of life.
- **meaning of at risk**
  - (1) For the purposes of the Act, a child will be taken to be at risk if:
    - (a) the child or young person has suffered harm (being harm of a kind against which a child or young person is ordinarily protected); or
    - (b) there is a likelihood that the child or young person will suffer harm (being harm of a kind against which a child or young person is ordinarily protected); or
    - (c) there is a likelihood that the child or young person will be removed from the State (whether by their parent or guardian or by some other person) for the purpose of—

(i) being subjected to a medical or other procedure that would be unlawful if performed in this State (including, to avoid doubt, female genital mutilation); or

(ii) taking part in a marriage ceremony (however described) that would be a void marriage, or would otherwise be an invalid marriage, under the *Marriage Act 1972* of the Commonwealth; or

(iii) enabling the child or young person to take part in an activity, or an action to be taken in respect of the child or young person, that would, if it occurred in this State, constitute an offence against the *Criminal Law Consolidation Act 1935* or the Criminal Code of the Commonwealth; or

(d) the parents or guardians of the child or young person—

(i) are unable or unwilling to care for the child or young person; or

(ii) have abandoned the child or young person, or cannot, after reasonable inquiry, be found; or

(iii) are dead; or

(e) the child or young person is of compulsory school age but has been persistently absent from school without satisfactory explanation of the absence; or

(f) the child or young person is of no fixed address; or

(g) any other circumstances of a kind prescribed by the regulations exist in relation to the child or young person.

(2) It is immaterial for the purposes of the Act that any conduct referred to in subsection (1) took place *wholly or partly outside this State*.

(3) In assessing whether there is a likelihood that a child will suffer harm, regard must be had to not only the current circumstances of their care but also the history of their care and the likely cumulative effect on the child of that history.

- **female genital mutilation** (S18 (4) in the Act) means:

(a) clitoridectomy; or

(b) excision of any other part of the female genital organs; or

(c) a procedure to narrow or close the vaginal opening; or

(d) any other mutilation of the female genital organs,

but does not include a sexual reassignment procedure or a medical procedure that has a genuine therapeutic purpose;

- **sexual reassignment procedure** (S18 (4) in the Act) means a surgical procedure to give a female, or a person whose sex is ambivalent, genital characteristics, or ostensible genital characteristics, of a male.

A medical procedure (S18 (5) in the Act) has a genuine therapeutic purpose only if directed at curing or alleviating a physiological disability or physical abnormality.

- A '**qualifying offence**' is defined under section 44 of the *Child and Young People (Safety) Act 2017* and means any of the following offences where the victim was a

child or young person and offender was a parent or guardian of the child or young person: murder; manslaughter; criminal neglect; causing serious harm; acts endangering life or creating risk of serious harm. It also includes attempt to commit any of the preceding offences and offences under the law of another jurisdiction that correspond to any of the preceding offences.

- **Section 41 of the *Children and Young People (Safety) Act 2017* Removal of child** (as they pertain to SA Health staff)

**S41 (1)** If a child protection officer believes on reasonable grounds that:

- (a) a child has suffered, or there is a significant possibility that a child will suffer, serious harm; and
- (b) it is necessary to remove the child from that situation in order to protect them from suffering serious harm or further serious harm; and
- (c) there is no reasonably practicable alternative to removing the child in the circumstances,

The child protection officer may remove the child from any premises, place, vehicle or vessel using such force as is reasonably necessary for the purpose.

**(2)** The *Children and Young People (Safety) Regulations 2017* (17) pursuant to section 41 of the Act will be taken to be satisfied in relation to a particular child in circumstances where:

- (a) a restraining order under section 99AAC of the *Summary procedure Act 1921* against a particular person is in force; and
- (b) it is a condition of the restraining order that the person not reside with the child; and
- (c) the person is residing with the child.

A newborn child who has not yet been discharged from hospital will be taken to be residing with a person if the child is likely to reside with the person on being discharged.

- **State authority refers to** a public sector agency.
- **Torres Strait Islander child** means a child who:
  - (a) is a descendant of the indigenous inhabitants of the Torres Strait Islands; and
  - (b) a young child, is regarded as Torres Strait Islander by at least 1 of their parents.
- A reference to the **wellbeing** of children will be taken to include a reference to the: care, development, physical and mental health, safety and cultural welfare of children.

## 7. Associated Policy Directives / Policy Guidelines & Resources

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- [Collaborative Case Management of High Risk Infants in Hospitals Policy Directive](#)
- [Interagency Code of Practice – Investigation of suspected child abuse or neglect](#)

- [Child Safe Environments \(Child Protection\) Policy Directive](#)
- [Child Protection Mandatory Reporting of Suspicion that a Child or Young Person \(0 -under 18 years\) is or may be at Risk of Harm Policy Directive](#)
- [Information Sharing Guidelines for Promoting Safety and Wellbeing SA Health ISG Appendix Policy Directive](#)
- [Privacy Policy Directive](#)

## 7.1 Legislative instruction

### Section 43 - Custody of removed child

If the DCP Chief Executive does not already have custody of a child who is removed under section 41, the Chief Executive, by force of this section, has custody of the child until—

- the child is returned to the custody of a parent or guardian, or delivered into the care of a person determined by the Chief Executive, under section 42; or
- the end of the fifth business day following the day on which the child was removed, (whichever is the earlier).

## 8. Document Ownership & History

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07/08/19	V2.1	Director Corporate Affairs, SA Health	Minor amendments
12/10/18	V2	SA Health Policy Committee	Formally reviewed in line with 5 year scheduled timeline for review
19/12/14	V1	SA Health Portfolio Executive	Original SA Health Portfolio Executive approved version.

## Attachment 1. Unborn / High Risk Infant Procedure

This procedure contains detailed information on which role, organisation, or group plays a role in the implementation of this Policy Guideline

Unborn / High Risk Infant Procedure			
Department for Child Protection		SA Health Hospital	
<b>Notification of unborn infant</b>	<ul style="list-style-type: none"> <li>Report on Unborn notification received by Department for Child Protection Child Abuse Report Line.</li> <li>Where the assessment necessitates, the Child Abuse Report Line sends report to local Department for Child Protection office Supervisor.</li> <li>Supervisor reviews information and assesses need for local Department for Child Protection office involvement.</li> </ul>	<ul style="list-style-type: none"> <li>Hospital identifies high risk pregnancy.</li> <li>Report on Unborn Notification to Department for Child Protection Child Abuse Report Line, (13 14 78)</li> <li>High Risk Alert placed on woman's file.</li> <li>Referral to High Risk Infant (HRI) network meeting where available.</li> </ul>	<b>High risk pregnancy identified</b>
<b>High Risk Infant Network Meeting</b>	<ul style="list-style-type: none"> <li>Supervisor/nominated Department for Child Protection worker reviews family history of concerns in preparation for High Risk Infant (HRI) network meeting.</li> </ul> <p>(NOTE: not all hospitals have a HRI meeting, especially in country hospitals.)</p>	<ul style="list-style-type: none"> <li>Hospital nominates a key worker/case coordinator.</li> <li>Hospital key worker/case coordinator liaises with professionals, cultural consultants, key services to discuss appropriate supports services to offer to a woman and her family to strengthen parenting capacity to reduce risk to the infant/unborn infant.</li> </ul>	<b>Pregnancy 12 – 35 weeks</b>
<b>Case discussion and planning</b>	<ul style="list-style-type: none"> <li>Hospital key worker/case coordinator liaises with relevant staff/agencies to review woman's progress, assess risk and parenting capacity and identify appropriate supports and services available to the woman and her family.</li> <li>A case conference is required for families with complex difficulties and who are involved with multiple agencies.</li> <li>Include Information Sharing Guidelines consent process in documentation in case notes.</li> <li>Where identified as needing a statutory response, Department for Child Protection to commence planning/actions required including seeking cultural advice.</li> <li>Birth/postnatal care plan documented and placed in women's notes by 34 weeks gestation.</li> <li>Department for Child Protection to inform Hospital key worker/ case coordinator and parent(s) (<i>unless safety concerns exist</i>) of the intention to proceed with formal care and protection action. Hospital key worker initiates support for mother/parents to address psycho-social issues relating to grief and loss.</li> </ul>		<b>Pregnancy 25 – 35 weeks</b>

Department for Child Protection		SA Health Hospital	
<b>Review, communicate and document</b>	<ul style="list-style-type: none"> <li>Department for Child Protection documents plan in Report on Unborn intake on C3MS and updates Hospital staff with relevant information about the woman's circumstances.</li> <li>Decision made by Supervisor regarding allocation or close.</li> </ul>	<ul style="list-style-type: none"> <li>Hospital key worker/case coordinator documents decision in case plan in woman's file.</li> <li>Hospital key worker/case coordinator informs midwifery and medical staff involved in the care of the woman and infant of plan for removal of infant post birth.</li> </ul>	<b>Duration of Pregnancy</b>
<b>Notification of birth of infant</b>	<ul style="list-style-type: none"> <li>Activate case plan if report on unborn notification recorded for infant.</li> <li>Decision made by Supervisor regarding allocation or closure of case. Department for Child Protection informs Hospital key worker/case coordinator of decision.</li> </ul>	<ul style="list-style-type: none"> <li>Midwifery Unit notifies Department for Child Protection Child Abuse Report Line and advises Hospital key worker of infant's birth.</li> <li>Hospital key worker/case coordinator notifies Department for Child Protection case manager (if allocated) of infant's birth.</li> </ul>	<b>Birth of Infant</b>
<b>Case discussion and planning</b>	<ul style="list-style-type: none"> <li>Where case is allocated by Department for Child Protection, the case manager liaises with Hospital key worker /case coordinator to update information/plans for infant.</li> <li>Hospital key worker/case coordinator initiates a case discussion to review/assess risk and safety issues for infant and where necessary plan the process of removal with parent (s), Department for Child Protection, midwifery and medical staff.</li> <li>Involvement of hospital security staff and/or SAPOL to be considered where safety concerns exist.</li> </ul>		<b>Post-birth to discharge</b>
<b>Infant removal and placement into out of home care</b>	<ul style="list-style-type: none"> <li>Department for Child Protection informs parent(s) and hospital Key Worker/case coordinator of intention to proceed with formal care and protection action.</li> <li>Department for Child Protection will develop a case plan/birth plan for the child including, where appropriate, supervised contact.</li> <li>Department for Child Protection provides Hospital key worker/case coordinator with verbal and written details of the authority to remove and removal plan (i.e. letter, copy of S41 and other relevant details) for example, contact arrangements, birth plan, health care plan, breastfeeding plan.</li> <li>Department for Child Protection records details of plan on C3MS.</li> <li>Department for Child Protection case manager provides Hospital key worker/case coordinator with information regarding details of infant placement.</li> </ul>	<ul style="list-style-type: none"> <li>Hospital key worker/case coordinator places documentation on woman's and infant's file.</li> <li>Hospital key worker/case coordinator provides information to Child and Family Health Service (CaFHS) of infant placement arrangement, Department for Child Protection contact and details of infant's placement.</li> <li>Hospital key worker/case coordinator provides a copy of the discharge summary to Department for Child Protection.</li> <li>Hospital key worker/case coordinator provides required documents(s) to Department for Child Protection that will enable Department for Child Protection to notify Centrelink of the birth and removal of the infant.</li> </ul> <p><b>In hours:</b> Hospital key worker /case coordinator co-ordinates the removal plan in conjunction with Department for Child Protection and informs midwifery and medical staff of plan.</p> <p><b>Out of hours:</b> Hospital after hour's worker co-ordinates the removal plan in conjunction with Department for Child Protection.</p> <p><b>NB.</b> <i>Infants are not to be separated from their mother (other than for Medical reasons) until S41 has been invoked.</i></p>	<b>Discharge</b>