

# Vulnerable Unborn Babies and Infants Strategy

*Developed October 2018*



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## Introduction

*The focus of this strategy is the safety and wellbeing of unborn babies and infants aged 0 to 1 years. Unborn babies and infants are vulnerable. They are totally reliant on the adults around them to protect and sustain them, and to provide an environment in which they can grow and develop physically, emotionally and socially.*

While most Tasmanian children are raised in nurturing environments, some are not so fortunate. Parenting is not easy, and there are many factors and situations that can impact on a parent or carers capacity to care for their child.

In Tasmania in 2017-18, there were 972 notifications to Child Safety Service relating to infants under the age of 1 year. While there are notifications to CSS for all age groups, notifications relating to infants under the age of 1 are more likely to require further investigation. In recent years, of all children and young people who are in out of home care, approximately half were one year old or younger when they were first admitted to care.

Tasmania has a comprehensive network of skilled professionals and supportive services that work in partnership with parents to reduce risks and strengthen family protective factors. These are available for all parents to access; during pregnancy, birth, and the early years.



However, most parents, whose unborn babies and infants come to the attention of CSS, have not received the benefit of these services.

The focus of this Strategy is these families, and these unborn babies and infants.

## Purpose of Strategy

In 2018, the Tasmanian Government released the *Tasmanian Child and Youth Wellbeing Framework*. The framework articulates an agreed, common understanding of child and youth wellbeing and provides a launch pad for a range of future initiatives, including a detailed Child and Youth Wellbeing Outcomes Framework, which will feature a range of indicators against which our progress to improve child and youth wellbeing can be tracked.

There is also work at the national level as a part of the *National Framework for Protecting Australia's Children 2009-2020*. At the same time, there have been several coronial inquests into the tragic deaths of infants in Tasmania.

This Strategy draws together recommendations from recent coronial inquiries and internal reviews, along with initiatives that are already underway within Children and Youth Services (CYS). The name of the Strategy has been revised to reflect the importance of the pre-natal period and work in this space, including Unborn Baby Alerts (UBAs).

It is time for CYS to capture all of this activity that is contributing to protecting vulnerable unborn babies and infants in a clearly articulated Strategy. This will support effective monitoring and reporting on progress.

It is important to note that while this Strategy is CYS specific, it is set in the context of a broader effort and program of reforms across health,

education and human services towards a vision where all Tasmanian children have equitable outcomes and a healthy future ahead of them.

## Vision for vulnerable unborn babies and infants

The vision articulated in the Strategic Framework is still applicable today:

*Vulnerable [unborn] babies and infants are placed at the heart of our efforts to achieve equitable long-term outcomes and life opportunities for all Tasmanian children.*

This will be achieved through a strong focus on the critical importance of the antenatal period and first years of life with the aim of ensuring a secure, safe and nurturing environment for unborn babies and infants and the best start possible to their life and development.

# Strategies

CYS has identified six key strategies that together form our response to the protection of vulnerable unborn babies and infants. These strategies reflect the themes contained within recent coronial inquiries and internal reviews, following the tragic death of a small number of infants.

**Strategy 1:**  
Strengthening  
collaborative and  
integrated service  
responses

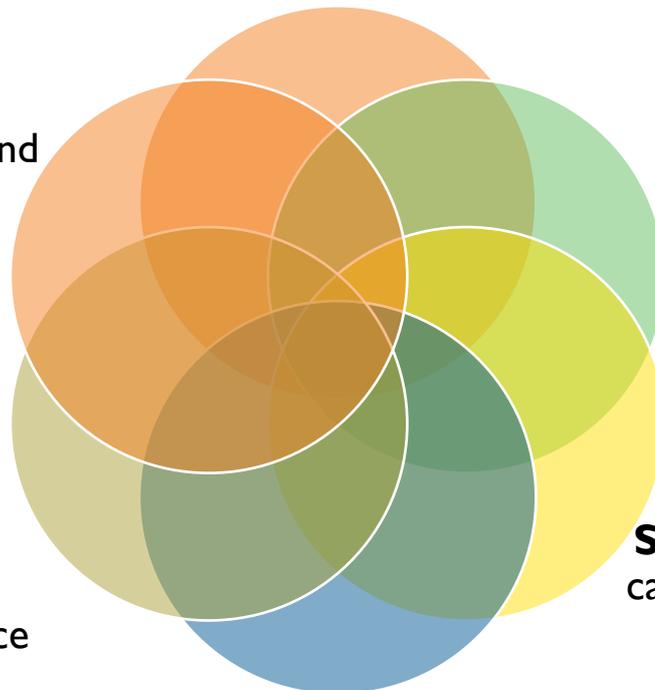
**Strategy 2:** Providing  
quality care to infants

**Strategy 3:** Building the  
capacity of our workforce

**Strategy 4:**  
Improving our  
information systems

**Strategy 6:**  
Improving oversight and  
governance

**Strategy 5:**  
Continuously  
reviewing and  
improving our practice





**Strategy 1:** Strengthening collaborative and integrated service responses

*Ensuring that we identify vulnerable unborn babies and infants early and link families to the support they require to build safety*

**Strategy 2:** Providing quality care to infants

*Giving infants in Out of Home Care (OoHC) the best chance to thrive by ensuring their health and wellbeing needs are met*

**Strategy 3:** Building the capacity of our workforce

*Equipping and supporting our staff to deliver skilled and responsive assistance*

**Strategy 4:** Improving our information systems

*Improving the way we collect and record information to support better analysis and decision making.*

**Strategy 5:** Continuously reviewing and improving our practice

*Applying learnings from past practice to inform the way we work now and into the future.*

**Strategy 6:** Improving oversight and governance

*Holding us to account in our efforts to protect vulnerable unborn babies and infants.*

## Priority Actions

### *Strategy 1: Strengthening collaborative and integrated service responses*

**Ensuring that we identify vulnerable unborn babies and infants early and link families to the support they require.**

What we have done already:

- Agreed on a model for the Children's Advice and Referral Service. This will deliver a more integrated and professionally capable system that focuses on early intervention to vulnerable

families, to build on family strengths for the safety of children.

- Updated the *Unborn Baby Notification and Assessment Procedure (2016)* to support CSS to make assessments of unborn babies at risk at birth, in collaboration with hospitals.
- Introduced a *Safety Planning Procedure (2016)* to provide parents with a genuine opportunity, and the support necessary, to demonstrate that they can provide adequate safety and care for their children.
- Introduced a *Family Meetings using Signs of Safety Procedure (2017)*. A family meeting helps caregivers to work with CSS to talk about what is working well, what is worrying them, and who might support a child who has been harmed or is at risk.
- Amended the *Children, Young persons and their Families Act 1997* to introduce supervision orders (2018). A supervision order allows a child to remain at home. Child Safety Officers make sure the child is safe by visiting them, carrying out casework duties, and making directions which must be followed by the child and their guardians.
- Commenced the delivery of Intensive Family Engagement Services (IFES) as a trial in February 2018. The aim of these services is to intervene early, to build parenting capacity and avoid entry into the statutory system.

- Expanded the membership of the multidisciplinary Three and Under Review Panel in 2017 to introduce a practice and education focus. The panel ensures that, prior to closure, there is sufficient safety for children aged three and under, including Unborn Baby Alerts (UBAs).

What we are going to do next:

- Implement the Children’s Advice and Referral Service by the end of 2018, including establishing referral pathways with government and non-government services.
- Further improve the Children’s Advice and Referral Service by reaching out to partner services to co-locate, where there are mutual benefits to the outcomes of families.
- Undertake an evaluation of current IFES and extend these services to more families in Tasmania.
- Ensure a CSS Admission Plan is completed for each case where an UBA is in place.
- Continue strengthening the operation of the Three and Under Review Panel, as a safety net for vulnerable unborn babies and infants.
- Convene a cross agency forum to confirm common messages and promotional material relating to safe sleeping including revising policies and procedures.
- Identify effective interventions to reduce unsafe infant sleeping, including recommendations for current best practice population level strategies in relation to raising awareness and any potential practice implementation strategies in relation to those populations whose children are most at risk of Sudden Unexplained Death in Infants (SUDI).

- Build parenting capacity early, including for teenage and first-time parent, particularly those identified with an unborn baby alert.

## *Strategy 2: Delivering quality care to infants*

**Ensuring that infants in OoHC have the best chance to thrive by meeting their health and wellbeing needs**

What we have done already:

- Required catch-up immunisations for all infants entering care to protect against a range of childhood illnesses and diseases.
- Required community-based paediatric assessments for all infants, in the South of the State, typically within three months of coming into care. In the north and north west this occurs on a needs basis.
- Established referral pathways to Early Childhood Early Intervention services delivered through the National Disability Insurance Scheme for infants in care with developmental delay or disability.
- Introduced a new *Visiting Children and Young people on Orders Procedure (2017)* to maximise safety and wellbeing by making observations about an infant and their environment.
- Introduced a program of parent access and support in the South. This program is delivered by Child Safety Support Workers in ‘child-friendly’ spaces designed to model age appropriate parent-child engagement.

What we are going to do next:

- Deliver a state-wide model for the Support Worker Program, including extending the access and parenting support program in the South to other regions in the state.



- Review the model of case and care planning, including the role of Care Teams, to align with the health and wellbeing domains. These are: being loved and safe, healthy, participating, having material basics, learning, and having a positive sense of identity and culture.
- Work with the paediatrician on the North West Coast to establish an outpatient OoHC clinic.
- Increase attendance rates at OoHC Clinics through improved information sharing, coordination and appointment management.
- Develop a Permanency Framework which focusses on timely decision making and the ability to secure a permanent placement for infants who can't safely return home.
- Develop a suite of procedures on quality of care, and care investigations, to continue to protect vulnerable infants from risk once they are in OoHC.
- Commence a staged implementation of the Outcomes Framework for Children and Young People in Out of Home Care. The framework utilises population level wellbeing outcomes to identify how infants in OoHC are doing.
- Release a Discussion Paper into Family Based Care to identify how we can improve training and support to family-based carers so that they can provide the care and support needed by infants.
- Recruited nine Clinical Practice Consultant Educators (CPCEs), and a Manager Clinical Practice to support and develop practice through case consultation and mentoring. A procedure on working with CPCEs has also been implemented.
- Recruited Child Safety Liaison Officer (CSLOs) in the North and North West regions in early 2017 in addition to a CSLO previously appointed in the South.
- Recruited additional dedicated resources to develop training materials for CSS staff.
- Developed new Child Safety procedures, to implement best practice in working with vulnerable infants. This includes the *Assessing and Responding to Risk to Infants and Young Children Procedure (2017)*.
- Developed a comprehensive training package on risk assessment, which includes a specialist two day face-to-face module on Child Development and Assessing Infant Risk.
- Developed a training package on Sudden Infant Death Syndrome (SIDS) and Safe Sleeping Practices.

#### What we are going to do next:

- Deliver ongoing compulsory risk assessment training including assessing cumulative harm to all CSS Staff.
- Deliver training to CSS staff on Sudden Infant Death Syndrome (SIDS) and safe sleeping practices.
- CPCEs to develop and implement a strategy to support the strengthening of risk assessment skills within day-to-day CSS practice.
- Develop a specific training module on the *Unborn Baby Notification and Assessment Procedure (2016)* incorporating the learnings from the audit of unborn baby alerts.

### *Strategy 3: Building the capacity of our workforce*

#### **Equipping and supporting our staff to deliver skilled and responsive assistance.**

What we have done already:

## **Strategy 4: Improving our information systems**

### **Improving the way we collect and record information to support better analysis and decision making.**

What we have done already:

- Introduced an online CYS Practice Manual from 1 July 2015 to provide Child Safety staff with easy access to a comprehensive set of policies, procedures and practice requirements for the delivery of services for children, youth and families.
- Introduced major enhancements to the Child Protection Information System (CPIS) in 2015 and 2017 to improve workflow, approvals and alerts.
- Introduced a software tool to support the creation of genograms in order to map complex family relationships.
- Recruited a Business Educator position to support the CSS workforce in the use of CPIS.

What we are going to do next:

- Implement further enhancements to CPIS to support risk assessment across sibling groups.
- Develop a Strategy by the end of 2018 to guide the replacement of CPIS.
- Implement processes to ensure all children in OoHC, with guardianship to the Secretary, have a My Health Record to record and share health information and to support continuity of healthcare, health safety and tracking of health history.

## **Strategy 5: Continuously reviewing and improving our practice**

### **Applying learnings from past practice to inform the way we work now and into the future.**

What we have done already:

- Appointed three additional Senior Quality Practice Advisors (SQPAs), to increase capacity in quality assurance activities. There are now a total of 6 SQPAs in CYS.
- Established state-wide practice meetings of CSLOs and CPCEs to ensure consistent management of UBAs and coordination of multidisciplinary case conferencing.
- Developed a Quality Improvement Framework for the whole of CYS.

What we are going to do next:

- Complete internal audits into UBAs, the application of the Tasmanian Risk Framework and recording of decision making processes, including case notes.
- Establish an issues register to consolidate recommendations from internal and external reviews and investigations to support the analysis of systemic and reoccurring issues.
- Develop a coordinated program of work to address systemic issues currently occurring in practice.
- Develop a Quality Improvement Plan for CSS, including a mechanism for an annual review of case files.

## **Strategy 6: Improving oversight and governance**

### **Holding us to account in our efforts to protect vulnerable unborn babies and infants.**

What we have done already:

- Established Serious Events and Review Team (SERT) independent from CYS operations, to undertake reviews of cases where a child who has had contact with CSS has died or suffered a serious injury.
- Established a Serious Events Review Committee (SERC), which is an independent, multi-agency committee comprised of senior representatives from government agencies external to CYS.



SERC's role is to identify themes and common issues across SERT reports and make recommendations to CYS to improve the quality and safety of services to children and their families, including vulnerable infants.

- Established a new internal governance model for CYS, to facilitate streamlined accountability and reporting to the CYS Executive

What we are going to do next:

- Convene a Policy, Practice and Quality Strategy Group, as part of the new governance arrangements in CYS. This group will have oversight of review recommendations, learning and development priorities and policy and procedure review.
- Develop a mechanism for quarterly reporting on progress against this Strategy through the Department of Communities Tasmania Standards and Performance to the Secretary, Department of Communities Tasmania and the Minister for Human Services.
- Consider whether there is an ongoing need for a dedicated Vulnerable Unborn Babies and Infants response beyond the scope and life of this Strategy.

## Implementation

Children and Youth Services has developed an Implementation Plan for this Strategy which identifies who is responsible for implementing the actions and timeframes for delivery. Progress is reported quarterly.



**Department of Communities Tasmania**

Children and Youth Services

**Phone:** (03) 6166 3800

**Email:** [CYS-DSecDRM@communities.tas.gov.au](mailto:CYS-DSecDRM@communities.tas.gov.au)

**[www.communities.tas.gov.au](http://www.communities.tas.gov.au)**