2.2.16 High-risk infants

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Legislation

- Children and Community Services Act 2004 - Section 3 Terms used in this Act
- Children and Community Services Act 2004 - Section 21(1)(a)(b) CEO to consider and initiate or assist in the provision of social services to children and families
- Children and Community Services Act 2004 - Section 23 CEO may disclose or request relevant information
- Children and Community Services Act 2004 - Section 31 CEO may cause inquiries to be made about child
- Children and Community Services Act 2004 - Section 33A CEO may cause inquiries to be made before child is born
- Children and Community Services Act 2004 - Section 33B Further action by CEO before child is born
- Children and Community Services Act 2004 - Section 123 Authority conferred by warrant (provisional protection and care)
- Children and Community Services Act 2004 - Section 32 Further action by the CEO
- Children and Community Services Act 2004 - Section 33 Access to child for purposes of investigation
- Children and Community Services Act 2004 - Section 34 Warrant (access)
- Children and Community Services Act 2004 - Section 35 Warrant (provisional protection and care), application for and issue of
- Children and Community Services Act 2004 - Section 37 Provisional protection and care without warrant if child at immediate and substantial risk
- Restraining Orders Act 1997

Related Resources

Purpose

This entry provides information and practice guidance on responding to abuse and neglect of unborn infants and high risk infants. A high risk infant refers to an unborn infant or a child between 0-2 years of age considered to be at increased likelihood of significant harm or death due to the presence of risk factors.

Practice Requirements

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- You **must** assess all infants and unborn infants referred to the Department to determine whether there are significant risk factors present.
- When you are completing an Interaction or Initial Inquiry which includes information about an unborn infant or child aged between 0-2 years of age you **must** refer to the resource *Determining risk factors for an infant* in addition to the *Interaction Tool* to assess whether the matter needs to progress to a Child Safety Investigation (CSI).
- If the child is identified as a high risk infant, the CSI **must be commenced within 24 hours (priority 1).**
- All high risk infants **must be actively case managed** until the risk factors have been addressed and there is sufficient safety to close the case. These cases must not be placed on the monitored list.
- When working with Aboriginal infant and family, or infant with parents from a culturally and linguistically diverse (CaLD) background you **must** consult with an Aboriginal Practice Leader or refer to the CaLD Resource Library or a CaLD Department officer to plan for how best to engage the family and deliver culturally informed and responsive practice.

Where concerns about an infant are assessed as requiring no further action, you must document a rationale for this decision in an Assist Interaction or Initial Inquiry.

The rationale must be approved by the team leader.

Procedures

Determining whether an infant 0 – 2 years is at high risk

A high risk infant refers to an unborn infant or a child between 0-2 years of age considered to be at increased likelihood of significant harm or death due to the presence of risk factors.

1. Identify the risk factors that contribute to an infant being at increased likelihood of harm - use the resource *Determining risk factors for an infant* to consider the risk factors that are relevant for the case you are assessing and whether further investigation is required.

2. You must commence a Child Safety Investigation (CSI) within 24 hours (priority 1) when an infant is open for an Interaction or Initial Inquiry and there is information to

suggest they may be at increased likelihood of significant harm, or a determination is made that a CSI is required.

3. Familiarise yourself with the protective factors. Protective factors are observable strengths that equate to safety and provide evidence to mitigate the risk factors present.

PROTECTIVE FACTOR	Description
Attachment to the infant	The presence of strong attachment between the infant and parents, including responsiveness and commitment to the infant's needs.
Social supports and social services	Pre-existing supports that the parents have in place which increase visibility of the infant in the family and community.
Good health care, healthy nutrition and lifestyle	Can include appropriate antenatal care, good nutrition, no smoking, no drug use, no inappropriate alcohol use; these good lifestyle factors decrease the likelihood of premature birth or low birth weight.
Health relationship between parents	A strong, positive relationship can be a buffer to other stressors that arise following an infant's birth.
Parenting skills and understanding of basic child development	Parents with more than one child have previous understanding of infant behaviour and parents who have taken time to learn about what to expect after their infant is born are more likely to be prepared for infant behaviour.
Understanding of risk factors and being motivated to make changes	Parents being responsive to information about risk factors and willing to make lifestyle changes in order to minimise those risks.
Planning for the infant's birth	Sourcing safe accommodation, items for the baby and learning about how to care for an infant gives in indication of the parents' attachment to the infant, their capacity to make arrangements and motivation to care for the infant.

4. Familiarise yourself with the risk factors. A high risk infant assessment takes into consideration three main types of risk factors:

1. **parental** risk factors;
2. **environmental** risk factors; and/or
3. **infant** risk factors.

These are explored thoroughly in the resource *Determining risk factors for an infant* and this resource must be utilised throughout the investigation to assess the risk factors present and the likelihood of harm to the infant.

Consider, in the context of the abuse type your are assessing, which risk factors are relevant for your assessment and what protective factors are present to mitigate the likelihood that the infant will experience harm.

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Infant is assessed as not being at risk

Where concerns about an infant are assessed as requiring no further action, you **must** record the rationale for this decision in an Assist Interaction or Initial Inquiry.

The rationale **must** be approved by your team leader.

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Unborn baby is assessed as high risk of harm after birth

All unborn infants assessed to be at risk of significant harm after birth and high risk infants **must** be actively case managed until the risk factors have been addressed and there is sufficient safety to close the case.

Where you have assessed that an unborn infant is at risk of significant harm after birth, you **must** refer the case for pre-birth planning and to Best Beginnings Plus (BB Plus). Before the infant's birth (where possible) or at the first home visit,you must give parents and/or carers verbal information about:

- the effects of shaking on an infant (Abusive Head Trauma). You **must** document this discussion in the case notes; and
- the risks associated with co-sleeping practices via the related resource, *BB Plus safe infant sleeping checklist* - the discussion **must** be documented in case notes.

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Infant is assessed as high risk – Child Safety Investigation

Commence a Child Safety Investigation.

Use the resource *Determining risk factors for an infant* to complete an assessment – you **must** consider the:

- parent's understanding of the infant's needs and how they must respond
- parent's ability and willingness to provide appropriate nutrition and stimulation
- parent's previous parenting role models
- impact of stress on the parents and their capacity to meet the infant's needs
- impact of family and domestic violence on family functioning and whether power, control and violence is preventing the infant from having their needs met, and
- parent's strategies for attempting to deal with difficult feeding issues or other complications, which can result in an unsettled or distressed infant.

During the course of the Department's involvement, sufficient protective factors may be demonstrated that mitigate the risk factors. These protective factors may provide the necessary evidence that the infant is not at increased likelihood of harm and/or that the risk factors have been addressed.

You **must** clearly document the protective factors alongside any rationale for closing the Department's involvement.

The following actions must be taken as part of assessing the risk factors present for the infant; these may be undertaken as part of a CSI or Intensive Family Support activity.

Where guidance dictates that an action **must** be taken, but due to resources, availability or other reasons you are unable to

undertake the action, then **you must provide** written rationale or planning documents to support this.

Actions include, but are not limited to the steps below:

1. Notify both parents that a CSI is being undertaken. You should use an internal Signs of Safety mapping to document clear harm statements (where applicable), danger statements and safety goals.

2. Consult with the local Best Beginnings Plus (BB Plus) team leader and forward a referral. If this is unsuccessful, you **must** discuss this with the team leader and consider whether, in the absence of BB Plus' involvement, there is sufficient safety for the infant. Specific consideration **must** be given to whether further actions are required to increase the infant's safety.

3. Sight the infant as soon as possible after commencing the assessment.

4. Discuss the reported concerns with both parents, and provide them with information about the effects of shaking an infant, risks of co-sleeping and assess the infant's sleeping area to make sure it is a safe sleeping environment.

Signs of Safety meetings must be undertaken when:
- a child has suffered significant harm, or is likely to suffer harm as a result of abuse and/or neglect
- the child's parents have not protected or are unlikely or unable to protect the child from harm, and
- a safety plan is required.

5. Commence safety planning to address the reported concerns.

6. Continue to sight the infant at least weekly for the duration of your involvement.

7. Consult with other relevant internal and external staff e.g. Aboriginal Practice Leader, Senior Practice Development Officer, General Practitioner, Child Health Nurse. Information **must** be gathered from multiple sources – the parents during home visits, other professionals and the safety network, etc.

8. Refer to services where appropriate, such as BB Plus, drug and alcohol services and mental health services.

9. Document your investigation and the outcome, and notify the parents of the outcome where appropriate.

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Culturally responsive practice

When conducting an investigation and the child or their family identify as Aboriginal or Torres Strait Islander, you **must** consult with an Aboriginal Practice Leader.

When working with culturally and linguistically diverse families, you **must** gather information relevant to the family's culture by first consulting with the family or their community, via online research, from the *CaLD Resource LIbrary*, and/or consultation with a CaLD officer.

If the Aboriginal Practice Leader from your district is not available then you must seek out another Aboriginal Practice Leader, starting with your adjacent district.

Cultural identity means different things to different people and there is not one correct way to ask about it. You **must** show respectful and culturally safe practices when talking to families about their culture and seek advice from other practitioners as required. It is important that you talk to families about their culture and what it means for them.

The Department is committed to making active efforts which are purposeful, thorough and timely, and are supported by legislation and policy to enable the safety and wellbeing of Aboriginal and Torres Strait Islander children.

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Notifying the parents

You **must** notify the parents if you commence a CSI. You should do this with the intention of developing a working relationship and in the interests of procedural fairness.

1. Review the referral information and re-contact the referrer, where required, to clarify the reported concerns.

You should use an internal Signs of Safety mapping to document clear harm statements (where applicable), danger statements and safety goals.

2. Ensure you have the correct contact details for the parents.

3. Contact the parents and notify them of the nature of the referral and your role in conducting an investigation.

"Hi ....., my name is ..... and I work for the Department of Communities. Is it safe for you to talk at the moment?"

"I'm calling because we've received a report relating to your children that I need to talk to you more about. The report is in relation to ..... abuse, do you already know anything about why I might be calling?"

"My role is to undertake a Child Safety Investigation in relation to the referral we have received. I'd like to talk to you more in person about this if that's possible..."

"I know this can be a stressful time but I want to reassure you we are keen to hear your perspective and make a balanced assessment of the information I have."

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Talking to parents about co-sleeping and Abusive Head Trauma

You **must** talk to the parents about the risks associated with co-sleeping and the effects of Abusive Head Trauma (AHT) (shaken baby syndrome) at your first home visit/contact.

You must provide parents of infants with the Department of Health's *Safe Infant Sleeping Brochure*.

For futher information and brochures for families, including about Abusive Head Trauma, please refer to the NAPCAN website.

Abusive Head Trauma (shaken baby syndrome)

Abusive Head Trauma (AHT) overview	Abusive Head Trauma, also known as shaken baby syndrome, refers to any injury to an infant's skull or intracranial contents as a result of blunt impact (infant being hit in the head or having their head hit against something) and/or shaking (whiplash).
Possible consequences	This type of injury can result in severe consequences, such as permanent disability or death.
Risk factors	Infants aged less than six months are most vulnerable to trauma from shaking due to the combination of a heavy head, weak neck muscles, soft and rapidly growing brain, thin skull wall and lack of control of the head and neck.
Age of greatest risk	The greatest risk period for this type of injury is between six weeks and four months of age, when continuous crying can be particularly stressful for parents.

If you suspect that an infant has experienced AHT follow the prompts in the section 'Abuse types requiring a specific response' below.

Safe infant sleeping (co-sleeping and Sudden Unexplained Deaths in Infancy (SUDI)

Co-sleeping overview	Co-sleeping is defined as the practice of a parent (or any other person) being asleep on the same surface as an infant.
Possible consequences	That the person or bedding will accidentally suffocate the infant or that a mother may fall asleep while breastfeeding the infant, smothering the infant with her breast or body.

Where you are concerned that co-sleeping is occurring you should utilise the
Best Beginnings Plus Safe Infant Checklist.

You can also provide the following resources:

- *SIDS and Kids WA: Reducing the Risk of SUDI in Aboriginal Communities*
- *SIDS and Kids webpage: Safe Sleeping in Other Languages*, and
- *Quitnow webpage: Pregnancy and Quitting* for information on:
  - the impact of smoking during pregnancy
  - the effects of second-hand smoke on infants, and
  - smoking and SIDS.

Child protection workers and Best Beginnings home visitors may also provide the family with additional information and resources from the SIDS and Kids WA - Safer Sleep website.

Factors increasing co-sleeping risks

There is evidence that co-sleeping is associated with a greater incidence of SUDI. The risks associated with co-sleeping are increased when:

- the parent or carer has consumed alcohol or used illicit drugs
- the parent or carer has taken any medication which may alter consciousness or cause drowsiness
- either the parent or the carer is a smoker, and/or
- the mother smoked during pregnancy.

Other factors that increase the risks associated with co-sleeping include:

- either the parents or carers are experiencing extreme tiredness to the point where they may find it difficult to respond to the baby
- sleeping with the baby on any soft surface (for example, on a sofa, couch, waterbed, bean bag or sagging mattress)
- excessive bedding on the bed (risk of smothering and/or over-heating)
- the baby is less than 11 weeks of age, and/or
- the baby is preterm or small for gestational age.

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Sighting the infant

You **must** sight the infant as soon as possible after commencing the CSI. Where an infant has been assessed as being at high risk, and a safety plan is developed with the parents, you must see the infant at minimum of once per week.

At each visit, you and/or other appropriate professionals, such as a Best Beginnings Plus worker or Child Health Nurse, must engage with the infant by holding them, interacting with them and ac

You should use an internal Signs of Safety mapping to document clear harm statements (where applicable), danger statements and safety goals.

Steps:

1. Ask the parents if you may hold the infant. You should let the parents know that the Department has an increased role in assessing infants due to their vulnerability and increased risk.

Where parents prevent you from seeing the infant, you **must** persist and attempt to see the infant, regardless of whether the infant is sleeping.

If you are unable to see the infant you **must** consult with your team leader **on the same day** about the next steps to take.

2. While holding the infant, interact with the infant by talking to him/her in a playful way. Speak softly and engage in eye contact.

3. Observe the infant throughout the contact, including during your direct interactions and the parents interactions.

4. Document your observations and analysis of the relationship between the infant's behaviours, parent's behaviours and the abuse type you are investigating.

At each visit observe and assess the infant's:

1. Level of eye contact (mutual gaze)

- Mutual gaze (eye to eye contact) is critical for infants, to promote optimal brain development, support a rich sense of self in the infant and promote attachment between the infant and caregiver.
- You should explain the benefits of eye contact to parents.

2. Responsiveness to stimuli

- How does the infant respond to sound and light?
- Does the infant follow the sound of people's voices?
- Does the infant respond to his/her name?

3. Fatigue, sleepiness, and disinterest

- Is the infant unusually fatigued? Can the infant hold his/her own head?
- Are the parent's reports consistent with your observations of the infant sleeping?
- Is the infant unusually/consistently disinterested in engaging with his/her parents?

4. Gross motor skills and development

- Have you observed changes in development in the infant?
- Is the infant showing development consistent with his/her age?
- Can the infant suck, point, hold his/her head? Is the infant starting to sit up/crawl/walk?

5. Weight

- Did the infant have a low birth weight?
- Is the infant consistently gaining weight?

- Does the infant appear dehydrated? (Watch for sunken eyes and/or fontanel (Soft spot on the head) and strong smelling urine)

6. Cleanliness

- Does the infant have clean and healthy skin? Are his/her nails dirty? (Dirty nails on a non-mobile infant indicate the infant may not be being kept clean)
- Check under the infant's chin. Fluff and dirt build up in between the skin here when not bathed regularly.
- Does the infant have an odour?
- Does the infant suffer from nappy rash? If so, how is this being treated?
- Is the infant dressed in clean clothing which is appropriate for the weather?

7. Interaction between parents and infant

- Do the parents play with, show affection and communicate with the infant?
- Does the infant seek comfort from the parents and do they reciprocate in providing comfort?
- Do the parents speak about the infant with love and admiration or harshness?
- What are the parents current feelings towards the infant? How do they feel about the changes the infant has brought to their life?

8. The environment

- Who lives in the home? Is the environment overcrowded?
- Is the environment hygienic? Have you observed any environmental dangers?
- Is the home chaotic?
- What are the sleeping arrangements for the other occupants? Does the infant have their own uncluttered bassinet or cot?

In regional and remote areas, you may need to rely on other professionals or even safety network members to sight the infant, due to distance and availability.

Where this occurs you must document the rationale for this and provide appropriate feedback to the person who sighted the infant. Where possible, you should make a plan for when a child protection worker can sight the infant.

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Abuse types requiring a specific response

There are several abuse types relating to high risk infants that require a specific response from the Department. They are:

1. Physical abuse - Bruising or injury to a non-mobile infant

2. Physical abuse - Abusive Head Trauma (AHT) or shaken baby

3. Neglect - Non-organic Failure To Thrive (FTT), and

4. Neglect - Co-sleeping and risk of accidental suffocation

- Infants with bruising, injuries, burns and/or other symptoms of injury such as vomiting, seizures, rigid appearance, a lack of response to stimuli, alterations in breathing/temperature, poor feeding, irritability or lethargy must be medically assessed immediately, via an ambulance if necessary.
- If you suspect that an infant may have been harmed, or where an infant is found to have any injury or symptoms of injury, the infant must be medically assessed on the same day by a paediatrician, preferably with child protection experience. If a decision is made not to take the infant for a medical assessment, this decision must be made in consultation with a team leader and the rationale clearly documented in case notes.
- When parents do not consent to an infant with symptoms of injury being medically assessed, you must consider whether the infant is at immediate and substantial risk. You must advise the parents that you need to consult with your team leader, and move to a private place away from the parents immediately (e.g. out the front of the house or in the car).

Physical abuse

Bruising or injury to a non-mobile infant

Bruising is not common in infants because they are non-mobile. As such, any bruising or symptom of injury located on a non-mobile infant must be further assessed by a paediatrician, preferably with child protection experience. Ensure you are familiar with the resource *Accidental and Non-Accidental Injuries.*

Abusive Head Trauma or shaken baby

If you suspect an infant as suffered AHT, urgent medical attention **must** be sought for the infant - call for an ambulance.

Abusive Head Trauma (AHT) refers to an injury to the skull or the intracranial contents (e.g. brain) inflicted by a blunt impact (infant is hit in the head or has their head hit against something) and/or shaking (whiplash). This type of injury can result in the most severe consequences for the infant's future wellbeing and is the leading cause of death amongst infants who have been abused.

Infants aged less than six months are most vulnerable to AHT from shaking through the combination of a heavy head, weak neck muscles, a soft and rapidly growing brain, thin skull wall and lack of control of the head and neck.

The greatest risk period for infants is between six weeks and four months of age when continuous crying can be particularly stressful for parents. If you suspect that an infant has suffered AHT, you **must** seek urgent medical attention and call for an ambulance.

Severe symptoms of AHT:

- a bulging and/or spongy forehead
- rigidity
- seizures
- loss of consciousness, and/or
- difficulty breathing or alterations in breathing or temperature.

Non-specific signs and symptoms of AHT:

- irritability
- tiredness
- loss of appetite
- poor feeding
- vomiting
- poor sucking or swallowing
- lack of smiling or vocalising
- poor muscle tone, or
- pinpointed, dilated or unequal pupil size.

If you suspect that an infant has been harmed, you must conduct a visual check for injuries and bruising by engaging and respectfully inviting the parents to undress the infant, including removal of nappy, as follows:

1. Explain to the parents your concerns and respectfully ask the parents to undress the infant, including the nappy.

If...	Then...
The parents refuse	You **must** advise the parents that you need to consult with your team leader, and move to a private place away from the parents immediately (e.g. out the front of the house or in the car).

2. Explain to the parents that you are looking at the infant for any physical signs of injury, such as bruising, cuts, scratches, burns or bite marks.

3. Look at the infant's body, and ask the parents to move the infant if required.

If...	Then...
You are satisfied with the explanation provided by the parents	Thank the parents for cooperating and continue your investigation.
You are **not** satisfied with the explanation provided by the parents	You **must** tell the parents and request that the infant is medically assessed on the **same day** by a paediatrician, preferably with child protection experience.
You observe **significant injuries** such as, bruising, burns, bites and/or other symptoms including vomiting, seizures, rigid appearance, a lack of response to stimuli, alterations in breathing/temperature, poor feeding, irritability or lethargy	You **must** consult with a team leader and seek an immediate medical assessment, including considering calling an **ambulance.**

Neglect

Non-organic Failure to Thrive (FTT)

Non-organic Failure to Thrive (FTT) is "significantly prolonged cessation of appropriate weight gain compared with recognised norms for age and gender..." (Block & Krebs 2005, Failure to Thrive as a Manifestation of Child Neglect).

Non-Organic FTT is caused by environmental factors and/or the actions or inactions of the parent or caregiver. Organic FTT occurs when there is an underlying medical cause for the condition. Your role is to ascertain from medical professionals if the FTT has resulted from non-organic causes and if so, to facilitate services and supports to assist the infant's parents to better care for them.

Symptoms of FTT include:

- lack of weight gain
- dehydration
- delays in reaching developmental milestones such as rolling over, carwling and talking
- learning disabilities
- lack of emotions such as smiling, laughing or making eye contact
- delayed motor development
- fatigue, sleepiness, disinterest, and/or
- irritability.

Failure to Thrive is often diagnosed by child and/or community nurses in conjunction with other health practitioners, who will conduct a medical assessment to exclude underlying medical conditions.

Co-sleeping and the risk of accidental suffocation

Where there is a suspicion that an infant has been harmed as a result of neglect then you **must**:

1. Explain to the parents your concerns and respectfully ask to see and hold the infant.

2. Observe the infant including noticing:

   - Does the infant have clean and healthy skin?
   - Are their nails dirty?
   - Does he or she have an odour?
   - Is the infant's clothing appropriate?
   - Does the infant appear dehydrated, have sunken eyes and/or fontanel (soft sport on the head)?

3. Talk to the parents about what you have noticed about their infant and the routines they have in place, including sleeping arrangements and feeding routine.

4. Observe the area where the infant sleeps.

5. Observe the parents engagement with the infant. Take into consideration:

   - Do the parents play with, show affection and communicate with the infant?
   - Does the infant seek comfort from the parents and do they reciprocate by providing comfort?
   - Do the parents speak about the infant with love and admiration, or harshness?

6.

If...	Then...
You observe no indications of neglect	Thank the parents for cooperating and continue your investigation.
You observe physical injuries or other symptoms that you believe may be the result of neglect	You **must** point the signs out to the parents immediately and seek an explanation.

7.

If...	Then...
You are satisfied with the explanation provided by the parents	Thank the parents for cooperating and continue your investigation.
You are **not** satisfied with the explanation provided by the parents	You **must** tell the parents and request that the infant is medically assessed on the **same day** by a paediatrician, preferably with child protection experience.

You observe **significant injuries** such as, bruising, burns, bites and/or other symptoms including vomiting, seizures, rigid appearance, a lack of response to stimuli, alterations in breathing/temperature, poor feeding, irritability or lethargy	You **must** consult with a team leader and seek an immediate medical assessment, including considering calling an **ambulance.**

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The medical assessment

When an infant presents with bruises or symptoms of injury, or you suspect injury, you **must** attend the medical service in person with the infant (and where possible, a parent or relative of the infant), or telephone the service and provide the paediatrician (or the hospital social worker), with details of your concerns.

If at any time you become concerned about the child's immediate safety or the parents are unwilling to engage then you must consult with your team leader immediately and consider whether the child is at immediate and substantial risk requiring action under s.37 of the *Children and Community Services Act 2004* (the Act).

Metropolitan area

1. Infants must be referred to the Perth Children's Hospital (PCH) Child Protection Unit (CPU).

2. You should phone ahead and make an appointment.

   - During business hours, PCH CPU services can be requested directed through the CPU Acute Service **6456 0089**.
   - For after-hours, the duty social worker can be contacted through the PCH Switchboard on **6456 2222**.

3. You should accompany the infant to the appointment, unless there are exceptional circumstances. If you are not able to, you **must** (at minimum) brief the paediatrician or social worker with complete details of the concerns.

4. The medical assessment is expected to:

   - provide treatment for the infant's injury and recommendations for further medical treatment;
   - exclude any underlying medical conditions leading to the bruising or injury;
   - document the current injury (written and photographic);
   - conduct an in depth health assessment including blood tests, bone scans, x-rays (where necessary), and an ophthalmological assessment (where necessary – an eye exam to identify retinal haemorrhages indicating abusive head trauma or shaken baby) in order to identify other possible injuries or indicators of previous injuries;
   - provide a medical opinion on the child's injuries, including the degree to which the explanation/mechanism matches the injury and whether the bruising is due to accidental or non-accidental causes, by considering:
     - age and developmental stage – can the infant do what the parents are saying?

- consideration of the location of bruises - face, back, abdomen, arms, genitalia/perineum, buttocks, head, neck, torso, hands and feet are uncommon in accidental injury;
- number of bruises; and
- size, shape or pattern – fingertip bruising, tramline bruising, pinch marks, slap marks, implement bruising.

You **must** seek clarification from the paediatrician as to whether the injury has been deemed to be accidental or non-accidental (also referred to as an inflicted injury).

5. You **must** seek clarification from the paediatrician as to whether the injury has been deemed to be accidental or non-accidental (also referred to as an inflicted injury).

	If...	Then...
	The infant is assessed by a medical practitioner who is not a paediatrician e.g. nurse, General Practitioner, junior medical officer	You **must** ask the medical practitioner if they have consulted with a paediatrician linked to their service or 'on call'.

6. If there has been no consultation with a paediatrician, either you or the medical practitioner **must** consult with PCH CPU on the same day.

7. When an infant is hospitalised as a result of a non-accidental or suspicious injury you **must** commence safety planning.

8. If at any time you are not sure of the next step to take or the parents are unwilling to engage in safety planning, you **must** consult with a team leader.

Regional and remote area

1. When a paediatrician may not be available on the same day, you **must** arrange to attend either the local medical service (GP or hospital) with the infant and request that they consult with the on call paediatrician.

2. You should phone ahead and make an appointment.

3. You should accompany the infant to the appointment, unless there are exceptional circumstances. If you are not able to, you **must** (at minimum) brief the paediatrician or social worker with complete details of the concerns.

4. The medical assessment is expected to:

- provide treatment for the infant's injury and recommendations for further medical treatment;
- exclude any underlying medical conditions leading to the bruising or injury;
- document the current injury (written and photographic);
- conduct an in depth health assessment including blood tests, bone scans, x-rays (where necessary), and an ophthalmological assessment (where necessary – an eye exam to identify retinal haemorrhages indicating abusive head trauma or shaken baby) in order to identify other possible injuries or indicators of previous injuries;
- provide a medical opinion on the child's injuries, including the degree to which the explanation/mechanism matches the injury and whether the bruising is due to accidental or non-accidental causes, by considering:

- age and developmental stage – can the infant do what the parents are saying?
- consideration of the location of bruises - face, back, abdomen, arms, genitalia/perineum, buttocks, head, neck, torso, hands and feet are uncommon in accidental injury;
- number of bruises; and
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Priority responses to the physical abuse of infants

When an infant has been hospitalised as a result of a non-accidental or suspicious injury, safety planning **must** be implemented, monitored and tested, so that any future contact between the infant and the parents and/or possible perpetrators will not pose any continuing risk to the infant (e.g. supervision of contact between parents and the infant). Safety planning **must** also consider the safety of siblings and other children in contact with the parents or possible perpetrators.

When dealing with the suspected physical abuse of an infant you should familiarise yourself with the resource *Accidental and Non-Accidental Injuries*.

If at any time you suspect that there is an immediate and substantial risk to the infant's wellbeing then you **must** notify a team leader and consider intervention action under s.37 of the Act.

Metropolitan response

1. Any non-accidental or suspicious injury to an infant **must** be referred to the WA Police. This may have occurred prior to the matter being allocated to you, but you **must** ensure that this has occurred.

2. You **must** complete a review of any history the Department has with the infant and his/her family; this information is critical in informing any patterns of behaviour or previous recorded harm of the infant or other children.

3. Consult with a team leader.

4. You **must** make contact with the hospital staff immediately following receipt of the concerns and ascertain the current status of the infant and the parents. You should also ascertain what contact they have had with WA police and any immediate plans that may have been developed.

5. When infants are admitted to the Perth Children's Hospital (PCH), the Child Protection Unit (CPU) usually organise a Serious Injury Planning Meeting (SIPM). The SIPM is held at PCH, and the Department, WA Police and relevant hospital staff are invited to attend, discuss the injury and develop a plan to investigate the concerns. Fiona Stanley Hospital also conduct SIPMs as required.

6. A plan should be developed that addresses:

- The presenting injuries and the outcome of any medical assessment already conducted.
- Any further treatment the infant requires, including possible discharge timeline.
- Who has already spoken with the parents and/or perpetrator and what they have been told.
- Who is going to speak with the parents and/or perpetrator about the concerns; consider whether this can be done jointly by agencies e.g. the Department and WA Police together.
- Any current safety plan and possible safety network members.
- Clear next steps by each agency in addressing the concerns for the infant.
- How the agencies will communicate with each other during the course of the investigation.

7. Ensure that any meeting that is held is documented and distributed appropriately.

Regional and remote response

The following steps should be taken in the context of a **priority 1 response (within 24 hours)** to a referral of physical abuse of an infant:

1. Any non-accidental or suspicious injury to an infant **must** be referred to the WA Police. This may have occurred prior to the matter being allocated to you, but you **must** ensure that this has occurred.

2. You **must** complete a review of any history the Department has with the infant and his/her family; this information is critical in informing any patterns of behaviour or previous recorded harm of the infant or other children.

3. Consult with a team leader.

4. You **must** make contact with the hospital staff immediately following receipt of the concerns and ascertain the current status of the infant and the parents. You should also ascertain what contact they have had with WA police and any immediate plans that may have been developed.

5. You **must** verify that a paediatrician conducted the medical assessment of the infant or that the 'on call' paediatrician for the medical service was consulted. Perth Children's Hospital Child Protection Unit can also be consulted at any time in relation to regional or remote matters.

6. You **must** develop a coordinated, planned response with the relevant organisations involved. This may require you to arrange a local strategy meeting between WA Police, hospital staff and the Department.

7. Devleop a plan that addresses:

- The presenting injuries and the outcome of any medical assessment already conducted.
- Any further treatment the infant requires, including possible discharge timeline.
- Who has already spoken with the parents and/or perpetrator and what they have been told.
- Who is going to speak with the parents and/or perpetrator about the concerns; consider whether this can be done jointly by agencies e.g. the Department and WA Police together.
- Any current safety plan and possible safety network members.
- Clear next steps by each agency in addressing the concerns for the infant.
- How the agencies will communicate with each other during the course of the investigation.

8. Ensure that any meeting that is held is documented and distributed appropriately.

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Safety planning for high risk infants

Safety plans involving high risk infants **must** be rigorous and consider:

- Increasing the infant's visibility in the community and decreasing parental stress via the use of childcare services, parenting and respite services.
- Increasing parenting skills and providing strategies to manage the infant crying (such as Best Beginnings Plus, Ngala or Child Health Nurse-led services).
- A schedule of home visiting to ensure that the infant is seen by a member of the safety network, daily if necessary, to monitor the infant's safety and to provide support to the parents.
- Safe sleeping practices are monitored and tested by the safety network, daily if necessary.
- Family and domestic violence, assessment of risk and support to the adult victim.
- Parents and caregivers are assisted to manage their anger and improve impulse control via referral to services if necessary.
- Parents and caregivers are referred to drug and alcohol and mental health services as necessary.

You **must** review safety planning weekly with the parents, their network of support people and professionals undertaking both a monitoring and supportive role.

For a safety plan to be considered valid it **must** be documented.

Related resources for specific safety plans:

If...	Then...
Physical abuse High risk infant assessment	*Dynamics and Context of Fatal or Serious Injuries to Infant and Children* *Building Safety When Harm is Denied*
Emotional abuse – family and domestic violence (FDV)	*Emotional Abuse - Family and Domestic Violence Assessment Toolkit* *Emotional Abuse - Family and Domestic Safety Planning Toolkit* *Building Safety When Harm is Denied*
Neglect	*Child Development and Trauma Guide* *Building Safety When Harm is Denied*
Sexual abuse	*Building Safety When Harm is Denied*

You should complete a Signs of Safety meeting with the family before conducting safety planning, in order to determine the level of safety for the child and whether safety planning is actually required.

For more information about Signs of Safety, including developing harm statements, danger statements and safety goals and safety planning in specific circumstances refer to Chapter 2.2 Signs of Safety - child protection practice framework.

What is safety planning?

- Safety planning is a proactive, structured and monitored process that provides parents with an opportunity to demonstrate that they can address the Department's concerns by providing safety for their child.
- You may have heard people within the Department refer to safety planning in different ways, for example, immediate Safety Plan, interim Safety Plan, verbal Safety Plan and FDV Safety Plan.
- It is essentially a meeting between the Department, the parents, the safety network and the child (where appropriate) during which a written plan is developed that addresses the harm statements (where applicable), danger statements and safety goals.

Authority to safety plan

- Section 32(b)(i)(ii)(iii)(iv) of the Act outlines the actions you, as an authorised officer, can take in arranging or facilitating a meeting in order to safeguard or promote a child's wellbeing. You can invite:
  - a parent or other relative of the child;
  - a person who is significant in the child's life;
  - a representative of a service provider; and/or
  - a representative of a public authority.

- The purpose must be to develop a plan to address the ongoing needs of the child in a way that ensures the best outcome for the child.
- You cannot prevent parents having contact with their child or mandate conditions of contact.
- You cannot use your statutory powers or coercive influence to move a child away from their parents or keep a child away from their parents.
- You can approve a safety plan where parents have developed a plan to address the Department's concerns. If the parents' plan involves a change of residence then they should be referred for legal advice with respect to Family Court proceedings.
- You can state your concerns if an action, such as contact, occurs and possible consequences from the Department, for example consideration of intervention action.

If you are unsure about your authority or role in safety planning, consult your team leader or consider contacting the Child Protection Legal Unit.

Preparing for safety planning

- Before commencing safety planning, you must develop clear danger statements and safety goals, and should attempt to reach a shared understanding of these with the family.
- Explain to the family and other relevant people what the safety planning process is and what is expected of them.
- Think about who should attend the safety planning meeting, including family members, the children and relevant professionals. Ensure that the professionals understand their role in the process.
- Organise the meeting at a suitable location, establish who will facilitate the meeting and who will document and distribute what is agreed.
- Ensure you are aware what, if any, possible consequences the Department is comfortable to include in the safety plan.

If you don't feel confident in facilitating a safety planning meeting then utilise other members of your team or a team leader who is not a decision-maker in relation to the case.

What is a safety network?

- A safety network is a group of people who care for the child and are willing to engage with the Department in addressing the concerns for the child's safety.
- You should always encourage the parents to bring along as many people as they can to a safety planning meeting to participate in the safety network. A robust safety network can be an indication of the level of support available to the parents and/or child and may mitigate the Department's concerns.

- Not all members of the safety network will be able to provide the same level of support. In assessing safety network members you should consider:
  - their availability to the parents and/or child;
  - if they will listen if contacted as part of the safety plan;
  - if they will respond, as agreed, if contacted as part of the safety plan; and
  - if they are willing to engage with the Department.
- There may be people who the Department deems unsuitable to be a part of the safety network, such as a person convicted of child sex offences. You must communicate this clearly and appropriately as part of the safety planning process.

What happens at a safety planning meeting?

- The facilitator should chair the meeting and ensure that focus is maintained throughout the meeting.

The harm statements (where applicable), danger statements and safety goals should be discussed to ensure that everyone present understands the concerns for the child.

The parents and safety network should be invited to come up with rules for the safety plan that they believe will ensure the safety goal is achieved. Questions to elicit this could include:

- "*What do you think you, you partner, your family or the safety network can do to increase safety for the children?*"
- "*In your opinion, what would it take to make your child safer?*"
- "*If we asked your children what would make them feel safer, what do you think they would say?*"
- "*How did you make sure your children was safe before the Department was involved?*"
- "*As a parent, what would you like to learn about this situation?*"
- "*If you had exactly the sort of support you needed to deal with these concerns, what would that support look like?*"

The rules **must** adhere to the SMART principles:

- Specific - Who does what, when and how?
- Measurable - Who is making sure that everyone is doing what they say? How will we know?
- Achievable - Is the plan achievable? Can the people who are a part of the plan realistically achieve what they say they are going to do?
- Relevant - Are the actions in the plan from the family and network relevant to the danger statements and safety goals?
- Time-Limited - How is this going to be reviewed? By whom? How often? When will the case be closed? Once safety is demonstrated, how long will we ask them to keep demonstrating it.

You may want to use a scaling question to measure, over time, the effectiveness of the safety plan.

Discuss the consequences that the Department is including in the safety plan in the event that it is not followed or breached:

"*In the event that this safety plan is not followed, the Department will convene everyone for a review meeting and may consult with*

the district director about intervention action".

What needs to be in a safety plan document?

Safety plans should document in writing the following elements (refer to the related resource *Elements of a Safety Plan*):

- Date of safety plan meeting.
- Purpose of the safety plan e.g. to plan unsupervised contact or to address the Department's worries about 'dad' hurting 'mum'.
- Who attended the safety planning meeting.
- Child's name and date of birth.
- Facilitator of the meeting.
- Genogram (optional).
- Details of the safety network and their role e.g. Sally Smith (maternal grandmother).
- Harm statements (where applicable), danger statements and safety goals.
- Agreed rules of the safety plan.
- Consequences if the rules are broken or the plan is breached.
- Who is going to tell the children about the safety plan and how.
- Date to review the safety plan.
- Signature of participants (optional).

Distributing a safety plan

- The safety plan must be distributed in a timely fashion. Ideally it should be available to the safety network on the same day.
- It's critical that the entire safety network or anyone with a role in the safety plan receives a copy.
- Think about how the child will receive their safety plan and who will ensure that they do.

You can get creative with how people receive a copy of the safety plan, there may be members of the safety network who are happy to take a photograph of the plan and have it on their phone, while others may want a typed hard copy.

Reviewing a safety plan

- In cases involving high risk infants, you must review safety planning weekly with the parents, their network of support people and professionals undertaking both a monitoring and supportive role.

- Where a safety plan has been developed to address emotional abuse - family and domestic violence it must be reviewed regularly to respond to the dynamic nature of the risk.
- When developing a safety plan you should agree upon, and document a timeframe for review.
- A review of a safety plan should examine its effectiveness and whether changes are required. A good way to review the effectiveness is through the use of scaling questions to examine whether safety for the child has improved.
- Not all safety plans require review as some a time-limited, however, where a case is being closed and a safety plan remains in place you should consider who will continue to monitor the safety plan in the Department's absence.

When a safety plan is breached

- In cases involving high risk infants where the parents do not comply with a safety plan, or the risk to the infant and their siblings is so great that a safety plan may not prevent further harm, you must consult with their team leader regarding whether intervention action is necessary to promote the infant's safety.
- When the safety plan is developed it should include considerations about what will happen if it is breached, for example a review meeting being called immediately with the safety network.
- A breach of the safety plan does not automatically mean that it has failed, it may provide an opportunity to revisit the details of the safety plan and make changes so that the safety plan is more effective.

Where a breach is considered to pose an immediate and substantial risk to the child involved then consultation with a team leader and district director should occur to determine whether intervention action is required.

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Consulting with others or referring to services

Where referrals are received from medical professionals and hospital social workers regarding safety concerns for unborn infants or infants, the referrer **must** be consulted and the concerns thoroughly assessed.

Assessment should not solely rely on telephone contact or parents self-reporting their progress. Information **must** be gathered from multiple sources e.g. parents during home visits, other professionals and the safety network.

Working with medical practitioners

- Where an infant presents with bruises or symptoms of injury, you **must** attend the medical service in person with the infant (and where possible, a parent or relative of the infant), or telephone the service and provide the paediatrician (or the hospital social worker), with details of the concerns.
- You **must** seek clarification from the paediatrician as to whether the injury has been deemed to be accidental or non-accidental (also referred to as an inflicted injury).
- Where an infant has been assessed by a medical practitioner who is not a paediatrician, for example a nurse, General Practitioner or junior medical officer, you **must** ask the medical practitioner whether they have consulted with a paediatrician linked with their service or 'on call' in their region. If this has not occurred, you and/or the medical practitioner **must** consult with the Perth Children's Hospital Child Protection Unit on the same day.

Engage respectfully with medical practitioners to build a working relationship for the child's benefit.

Best Beginnings Plus

- When you have assessed that an unborn infant is at increased likelihood of significant harm after birth, the matter **must** be referred for pre-birth planning and to Best Beginnings Plus (BB Plus).

Where BB Plus are unable to accept a referral, discuss whether they have capacity to be consulted during the life of the case. You **must** document your actions and any rationale as to why the referral was not successful.

- When an unborn infant or a child aged 12 months or younger is identified as being at increased likelihood of significant harm, you **must** consult with the local BB Plus team leader and forward a referral.

It is important that the BB Plus worker is included in the Signs of Safety planning meetings and safety planning.

- If parents do not engage with BB Plus, BB Plus will use alternative strategies and/or active efforts to engage the parents. If this is unsuccessful, you **must** discuss this with the team leader and consider whether in the absence of BB Plus's involvement, there is sufficient safety for the infant.

Referrals

- Through the Signs of Safety planning process, parents and families should be assisted to manage through referral to services if necessary.
- Referrals to services should be considered in consultation with the parents, family and the service to determine whether the referral is appropriate.
- You should consult with a team leader prior to completing a referral to a service.

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When to consult your team leader

Consulting a team leader is a critical process throughout the lifetime of a case. The team leader is the first point of escalation in relation to decision making that might impact the life of a case.

You **must** consult a team leader at any critical decision making points or when you are unsure about your next step.

You should follow these steps when consulting a team leader:

1. Come prepared - know the case you are going to discuss, bring any documents you think are essential.
2. Have a suggested action plan - this can include a list of options.
3. Document the consultation - if it isn't on Objective/Assist, it didn't happen.

Consultation can occur during regular case supervision or by separate appointment.

Below are some points in a case where consulting a team leader should occur. Under each item you will find possible practice situations, possible actions you can take (where appropriate) before a consult, discussion ideas and possible next steps.

1. Unable to notify the parents

You have made attempts to contact the parents and notify them of an investigation but have been unable to make meaningful contact. This might mean that you have been unable to contact them at all or that they have declined to engage with you when you have attempted to contact them.

Have you:

- Tried to call the parents at least three times, on different days/times of day.
- Conducted an unannounced home visit.
- Sent a letter to the parents with an appointment time or requesting contact.
- Confirmed that the contact details you have are correct from the original referral/referrer.
- Tried to contact each parent individually.
- Confirm the location of the infant.
- Confirm who the primary carer is.

Discussion ideas:

- What were the reported concerns? How significant are the harm concerns?
- What is the Department's history with the family? Is there a reason they are trying to avoid us?
- What actions have we already taken to try and engage the parents?
- What response has the Department received (if any)?
- Who else have we tried to contact as part of the investigation?

Possible next steps:

- Unannounced home visit.
- Letter to parents.
- Contact with other family members.
- Contact with services involved with the family.
- Consultation with a district director.

2. Unable to sight an infant or child

You have made attempts to sight an infant or child but have been unable to do so. You may have initially been able to engage parents and notify them of the investigation, but you have been unable to engage them further.

OR

You believe that if the parents were to know in advance about you wanting to sight the infant or child that the investigation would likely be jeopardised.

Have you:

- Attempted to re-contact the parents and explained the importance of sighting the infant or child.
- Conducted an unannounced home visit.
- Sent a letter to the parents with an appointment time requesting they bring the infant or child along.
- Tried to contact each parent individually.
- Made contact with other family members or services that may have sighted the infant e.g. Child Health Nurse.
- Developed a rationale as to why the parents should not be notified in advance about your proposed access to the infant or child.

Discussion ideas:

- What were the reported concerns? How significant are the harm concerns?
- What is the Department's history with the family? Is there a reason they are trying to avoid us?
- What actions have we already taken to try and sight the infant?
- Who else have we contacted who may have sighted the infant?
- Could we organise a joint home visit with another service?
- Do we meet the legislative requirements to utilise s.33 of the Act to access the infant or child?

Possible next steps:

- Unannounced home visit.
- Letter to parents.
- Contact with other family members.
- Contact with services involved with the family.
- Sight the infant or child under s.33 of the Act at either a school, hospital or place where a child care service is provided.
- Consultation with a district director.
- Intervention action.

3. No consent for medical assessment

You suspected an infant may have been harmed or has an injury. With parent's permission you have conducted a physical check of the infant and sighted significant bruising which the parents cannot explain. You ask parents to attend Perth Children's Hospital (or a local medical service) with you to have the infant medically assessed, they have not given consent.

You have moved to a private place away from the parents (e.g. out the front of the house or in the car).

OR

You suspect that a child has a non-accidental injury and the parents have declined to arrange a medical assessment or take the child to hospital.

Have you?

- Identified the injury to the parents and allowed them an opportunity to explain the injury.
- Been clear with the parents about your concerns and the possible impact on the infant or child.
- Explained the medical assessment process.
- Notified the parents that you are consulting a team leader about your next steps.

Discussion ideas

- What exactly did you observe about the infant or child that made you so concerned?
- How exactly did the parents respond to your concerns? What explanation did they provide?
- How were the parents engaging prior to the physical check of the infant or child?
- What history do we have with the family?
- Does the suspected injury you have sighted on the infant or child match the reported concerns?
- If the parents do not consent, what further actions might we take?

Possible next steps

- Return to the parents and make further attempts to explain the importance of the medical assessment and seek consent.
- Consultation with a district director.
- Intervention action.

4. Suspected non-accidental injury

You have received confirmation as a result of a medical assessment that an infant or child has a suspected non-accidental injury. It is alleged that one or both of the parents are responsible for inflicting the injury to the infant or child.

Have you:

- Liaised with relevant services e.g. WA Police, Department of Health.
- Received detailed information about the harm to the infant and suspected cause.
- Ascertained the parents' explanation of the injury to the infant.
- Developed draft harm statements (where applicable), danger statements and safety goals.

Discussion ideas:

- What is our opinion of the medical assessment?
- What information do we have so far about the parents explanation?
- What is our assessment of the parents' explanation and the injury to the infant?
- What information is missing so far?

- Can we identify any possible safety network members?
- Are our harm statements, danger statements and safety goals clear? Do they directly relate to the abuse types? Is there only one per abuse type?
- Are we able to interview the child? Do we have consent to do this? Do we need to consider using s.33 of the Act?
- Is there an immediate and substantial risk to the infant's wellbeing? Should we consider intervention action under s.37 of the Act?

Possible next steps

- Meet with the parents to explain the Department's concerns, discuss the harm statements (where applicable), danger statements and safety goals and commence safety planning.
- Interview the child.
- Meet with the safety network and parents.
- Reiterate the harm statements (where applicable), danger statements and safety goals so the family and their safety network can develop a safety plan.
- Consultation with a district director.
- Intervention action.

5. Parents unwilling to develop a safety plan

You have received information that one or both parents are unwilling to develop a safety plan.

Have you?

- Confirmed what the parents have said about why they don't want a safety plan.
- Attempted to engage with the parents directly and confirmed they don't want to engage in safety planning.
- Liaised with relevant services e.g. WA Police, Department of health.
- Developed draft harm statements (where applicable), danger statements and safety goals.

Discussion ideas:

- What were the reported concerns? How significant are the harm concerns?
- What is our history with the family?
- What information do we have so far about the parent's explanation?
- What is our assessment of the parent's explanation and the injury to the infant?
- What information is missing so far?
- Can we identify any possible safety network members?
- Are our harm statements, danger statements and safety goals clear? Do they directly relate to the abuse types? Is there only one per abuse type?
- Is there an immediate and substantial risk to the infant's wellbeing? Should we consider intervention action under s.37 of the Act?
- Do we have sufficient grounds? Has the infant, or is the infant likely to suffer, harm as a result of abuse (s.28 of the Act) **AND** are the infant's parents not protecting the

infant or unable to protect the infant from further harm?

Possible next steps

- Meet with the parents to explain the Department's concerns, discuss the harm statements (where applicable), danger statements) and safety goals and attempt safety planning.
- Seek out a safety network for the infant and bring them to a meeting with the parents.
- Reiterate the harm statements (where applicable), danger statements and safety goals so the family and their safety network can develop a safety plan.
- Consultation with a district director.
- Intervention action.

6. Breach of the safety plan

You have received information that the agreed safety plan has been breached.

Have you?

- Talked to the parents about their explanation of the breach.
- Talked to members of the safety network about the breach.
- Liaised with relevant services e.g. WA Police, Department of Health.

Discussion ideas

- Was the safety plan actually breached or was it just tested? Did the parents and/or safety network respond as per the agreed safety plan or not?
- What is the significance of the breach? What does it tell us about the parents?
- What do the safety network members think about the breach?
- What consequences were built into the safety plan if it was breached?
- Will it be sufficient to review the safety plan? Do we need more members of the safety network?
- Are our harm statements, danger statements and safety goals clear? Did the family actually understand what was expected of them?
- Was our safety plan created by the family or did we act coercively to develop the safety plan?
- Is there an immediate and substantial risk to the infant's wellbeing? Should we consider intervention action under s.37 of the Act?
- Do we have sufficient grounds? Has the infant, or is the infant, likely to suffer harm as a result of abuse (s. 28 of the Act) **AND** are the infant's parents not protecting the infant or unable to protect the infant from further harm?

Possible next steps

- Meet with the parents and safety network to review the safety plan, safety network and explore what led to the breach.
- Document the reviewed safety plan.
- Seek out more members for the safety network.
- Consultation with a district director.
- Intervention action.

7. Ready to write your Child Safety Investigation outcome report

You have completed sufficient actions within the Child Safety Investigation and believe that you can make a determination about whether or not the infant or child has experienced harm as a result of abuse, the parent's capacity to protect the infant or child and whether or not further action is required to safeguard the infant or child.

Have you:

- Notified the parents of the investigation?
- Sighted and/or interviewed the infant and/or child?
- Given the parents and/or perpetrators the opportunity to respond to the concerns?
- Consulted with other people or services as required?
- Commenced safety planning if required?
- Gathered credible evidence to form your analysis and decision?

Discussion ideas:

- What actions have you undertaken to collect evidence?
- How credible is the evidence that you have gathered?
- What did the child have to say?
- What have other people or services had to say about the abuse type and possible harm to the child?
- What do you think will be your recommendation in relation to whether or not the child have has experienced harm?
- Does a team leader verbally agree with your recommendation?

Possible next steps

- Further actions to gather credible evidence, as recommended by a team leader.
- A meeting to notify the parents and/or perpetrators of the likely outcome of your investigation.
- Write your investigation outcome report and send to a team leader for approval via Assist.

8. Considering referral to external services

You or the family have identified that there is an appropriate support service that may assist in addressing the concerns or the complicating factors affecting the family.

Have you?

- Researched the support service and confirmed it is appropriate for the needs of the parents, child or family?
- Discussed the referral with the parents or family and sought their agreement and consent?
- Established from the support service whether the Department has to remain involved in order for them to accept the referral?
- Established any waiting period that may exist to access the support service?
- Confirmed the referral process?

Discussion ideas

- What is the Department's expectation of the support service? Can the support service fulfil our expectations?
- What role does the Department want to have with the family following the referral? What role is the Department expected to have?
- What is the waiting period for the support service? Does this affect our referral?
- What services can the Department offer?
- Do we expect the parent's behaviour to change as a result of the service? Do we need to see that change for u to close the case, and have you told the parents this?

Possible next steps

- Further contact with support service.
- Informal referral to support service - provision of information to the parents.
- Formal referral to support service - referred by the Department.
- Consultation with a district director.

When an infant is at risk of significant harm and all attempts to support the infant to safely remain with the parents have been exhausted, consultation must occur with the district director to consider intervention action.

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2.2.13 Signs of Safety - child protection practice framework

Last Modified: 26-Jul-2019
Review Date: 02-Jan-2019

Legislation

- Children and Community Services Act 2004

Purpose

To guide child protection workers use of the *Signs of Safety Child Protection Practice Framework* (the Framework) including the assessment and investigation of concerns of abuse and/or neglect, provision of child centred family support and responding to children in the CEO's care.

Note: CEO refers to the Chief Executive Officer of the Department of Communities (Communities).

Practice Requirements

- Child protection workers must apply the Framework from the point of duty interaction to case closure. This includes cases relating to children in the CEO's care and child centred family support.
- When a child protection concern is received, child protection workers must discuss with the referrer: what has happened to the child that worries you; what do you think is going well for this family and/or child; and what do you need to happen to be satisfied the child will be safe in the future?
- Child protection workers must develop harm and danger statement when actual significant harm has occurred (or danger statement when there is likelihood of significant harm but actual harm has not occurred).
- The Signs of Safety map (Assessment and Planning Form) must include harm statements and/or danger statements, complicating factors (if any), existing strengths, existing safety, safety scale (judgement), safety goals (family and Communities'), and next steps.
- Child protection workers must prioritise capturing the child's voice and consider the use of Three Houses, Fairy and Wizards and Words and Pictures to engage with children.
- Signs of Safety meetings must be undertaken when:
  - a child has suffered significant harm, or is likely to suffer harm as a result of abuse and/or neglect
  - the child's parents have not protected or are unlikely or unable to protect the child from harm, and
  - a safety plan is required.
- Signs of Safety meetings must occur on a regular basis in the initial period when a child enters the CEO's care, to determine, in a timely manner, whether there is enough safety for the child to be reunified with their parent(s).

Related Resources

Policies

- Signs of Safety Child Protection Policy

Standards

- Better Care Better Services - Standards for Children and Young People in Protection and Care

Practice Requirements

- During the Signs of Safety meeting the child protection worker must discuss all relevant information with both parents to the extent possible without compromising the safety of the child or a parent, disclosing the notifier's identity and/or the criminal investigation as agreed with the Western Australia Police (WA Police).
- Prior to commencing safety planning, the child protection worker must develop danger statements and safety goals, and should attempt to reach a shared understanding of these with the family.
- When violence is still occurring and a joint meeting could increase the danger to a partner and/or child, the Signs of Safety meetings (including safety planning) must occur separately with both parties. Refer to Chapter 2.3: Safety planning - emotional abuse - family and domestic violence.
- When Communities is working with families to achieve the safety goal(s), child protection workers should involve the parents and the children to develop a 'Words and Pictures' to explain to the child what has happened that led to the serious child protection concerns.
- All safety plans must be based on straight forward behavioural safety goals that describe what we need to see the parents doing to keep their child safe.
- Safety plans must be written in clear and straightforward language that is understood by all children and adults involved in the safety network.
- Safety plans must state how the plan will be monitored and reviewed in relation to the safety goals.
- The team leader and/or district director must endorse the safety goals and plans.
- Contact plans must support the safety/family goals and safety plan.
- When working with children in the CEO's care, child protection workers must develop a 'Words and Pictures' explanation with the parent(s) within three months of the child entering provisional protection and care to explain to the child the reasons for Communities' and the Children's Court's (the Court) decision that the child could not live with their parents.

Process Maps

Not applicable

Procedures

Questioning approach

The questioning approach is used in all aspects of the Framework, including signs of safety mapping, safety planning, working with children and Appreciative Inquiry.

Refer to the following (in related resources) for further information:

- *EARS prompts to develop a questioning approach*
- *Types of questions and examples*
- *Suggested questions when working with Aboriginal people, and*
- *Skilful use of authority.*

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Signs of safety mapping

A Signs of Safety (SofS) meeting is a process of ongoing assessment to gather information, undertake analysis and reach a judgement at a point in time.

A SofS meeting can be undertaken:

- as an internal process to clarify what Communities is worried about before going out and talking to the family, and/or
- as an external process with the family and/or key stakeholders.

When planning a meeting with a child's parents and/or extended family, child protection workers must consider family dynamics, participant safety and how this may impact on the person's capacity to participate in the meeting.

The meeting process generally starts with 'what's working well' and moves back and forth between 'what are we worried about' and 'what's working well'. At the joint meeting with the family in particular, it may be helpful to open with the questions 'why do you think we are here?', 'what do you think our concerns might be?' This will get Communities' main concerns (what the worries are in relation to harm/danger to the child) on the table and make space to talk about 'what's working well' where we begin to identify existing strengths and safety.

During the process further information should be gathered to clarify if missing information and complicating factors are harm/danger or existing strengths/safety. A judgement is made against the safety scale to determine the level of safety for the child. This informs what needs to happen next and whether safety goal(s) and safety planning is needed. Refer to the SofS map (Assessment and Planning Form two columns Form 254 and three columns Form 255).

Refer to the following (in related resources) for further information:

- *Considerations for supervisors when internally mapping a case*
- *Facilitation – facilitating a Signs of Safety meeting with families*
- *Solution focussed scaling questions*
- *Practice principles that build partnerships*
- *Genogram*
- *Developing family trees with Aboriginal families*
- *Developing social network maps with Aboriginal people*
- *The family map (ecomap), and*
- *Signs of Safety Meeting brochure*.

What's working well? (existing strengths/safety)

To identify what is working well (on the right hand side of the two columns map and the middle column on the three columns map) involves assessing:

- existing strengths and observable behaviours that indicate protection and safety for the child, including those directly relevant to the danger statement, and
- existing safety including actions taken by parents and caring adults to make sure the child is safe when danger is present.

The use of exception questions such as 'tell me about a time when the problem could have happened but didn't?', 'what did you do instead?' and 'when was the last time you did this?' should be used.

During this process child protection workers should also consider who within the family network may be able to participate in safety planning at the next meeting.

What are we worried about? (in relation to harm and danger to the child)

To identify what Communities is worried about in relation to harm involves sorting the concerns into the following categories:

- past harm to the child
- future danger for the child
- complicating factors (aspects of the situation that make it more complicated), and
- missing information.

Since past behaviour is a predictor of future behaviour, child protection workers need to have a clear understanding of what has happened to the child in the past, including the risk of harm.

Child protection workers may begin by asking: 'what are the worries regarding the child that makes this an open case to Communities?' or 'What has happened to the child that worries us?'

Questions need to be asked that make explicit the behaviours that are impacting/affecting the children and how these behaviours of the parent(s) or caregiver(s) are causing harm or creating danger for the children. The worries and harm should be articulated in simple, clear and behavioural words including details of the history and severity of what has or is happening for the children.

Where there are a significant number of incidents that may overwhelm the process to develop a map, workers should focus on the first, worst and last incidents, including a description of frequency.

Questions should be asked to ascertain:

- the type, pattern, degree or severity and opportunity of harm
- significant and/or persistent nature of the abuse and/or neglect, and
- likely effect and impact on the child's safety and wellbeing.

For more information refer to:

- Chapter 2.1: Assessing and Responding to Child Protection Concerns for Children in Care, and
- Chapter 3.4: Planning

In cases of family and domestic violence identifying harm and future danger to the child requires an understanding of the harm and possible future danger for the non-abusive adult victim. Refer to Chapter 2.3: Family and Domestic Violence for further information.

Harm statement (actual harm)

A harm statement is the description of who (name of person/s if known) caused harm (describe the behaviours) to whom (child) and the impact of that harm on the child. Also include relevant statements of past harm that have been substantiated.

Danger statement

A danger statement is a description of what Communities and others at the meeting are worried might happen to the child in the future if nothing changes. The danger statement must be based on the harm statements where significant harm (actual harm) has been substantiated.

Where Communities has determined that a child is likely to suffer significant harm (future danger), child protection workers must only

develop a danger statement (a harm statement is not required because there is no evidence that actual harm has occurred).

Complicating factors

Complicating factors are issues that are identified that may make a case more difficult. Examples could include mental health issues or alcohol and drug use. These are not the actual abuse or neglect, but make the abuse worse, or stop the parents addressing the danger. Child protection workers should seek further information to assess if it is a danger/worry.

Child protection workers may need to consult with the team leader or senior practice development officer to distinguish if the complicating factor is a danger/worry.

Missing information

Missing information can be related to the complicating factor and child protection workers should seek further information to assess whether it is a danger/worry or strength/safety. A frequent example is who else is in the house with the child.

Safety scale (judgement)

After completing harm statements and/or danger statements, complicating factors, existing strengths and existing safety, a judgement needs to be made to determine the level of safety for the child.

The judgement is undertaken using a safety scale where participants are asked "on a scale of 0 to 10, where 10 means that there is sufficient safety for the child to stay with the parents and Communities will close the case, and 0 means if nothing changes in the current situation, the child will be taken into care, where would you rate the situation right now?"

Other examples of safety scales can include:

- On a scale of 0 to 10, where 10 means that there is sufficient safety to return the child to the parents' care, and 0 means the recurrence of similar or worse abuse for the child is certain, where would you rate the situation right now?
- On a scale of 0 to 10, where 10 is their life is on track and they have everything they need emotionally, socially, educationally and practically to continue to grow up as well as they and you could hope, and 0 means the child's life is out of control, there are no good supports in or around the child and their life is going backwards fast, where would you rate the situation for this child right now?
- On a scale of 0 to 10, with 10 meaning the problems are solved, and 0 means you are certain the child will be abused again and you believe we should take action immediately, where would you rate the seriousness of this situation?

Following this, the worker can then ask, "You rated the situation a 3, what can be done to increase the situation to a 4?" The use of a scaling question here could give information about possible actions that may lead to immediate progress.

When asking a scaling question child protection workers should:

- write down the parameters of the scale, and
- in a group situation, make sure the same question is asked of each person and note down each individual judgement.

Child protection workers can use the questioning approach when undertaking safety scaling to determine what needs to change to move up the scale. Child protection workers may ask a supplementary question such as "what makes this a number 5 for example rather than 4?"

Child protection workers should consider the following when using scaling questions:

- Scaling questions can cause confusion as participants may get 'stuck' in the number, rather than the desired outcome
- The description of what the number means in behavioural terms is the important part of scaling
- Participants can be asked to imagine what it would look like to be a 10 on the scale and describe it, and
- The scaling should be presented verbally or visually. Options for presenting the question visually include: using a whiteboard; butchers paper; post it notes or physically positioning people on an imaginary line.

Child protection workers should consider using the same questions over time to map movement/progress. The same questions can be asked of the parents, the child, the safety network and the other workers involved. When progress has been made, child protection workers can ask the participants "what has improved to lift your/their rating to a XX on the scale?"

Other uses for scaling questions

Child protection workers can use scaling questions as an engagement tool at duty, during an assessment, safety planning, Appreciative Inquiry or to formulate and review case and care plans. Scaling questions can be asked of children, parents, the safety network, workers in Communities and in other agencies, and those referring a concern to Communities. In cases of family and domestic violence scaling questions can be used to elicit and monitor the non-abusive adult victims' assessment of the level of risk posed by the perpetrator.

Scaling does not have to be from 0 to 10. For children, scaling can be completed by the use of diagrams and pictures such as a line which goes from a sad face (0) to a smiley face (10). Workers can be creative in how they construct scales and they can also take other forms, for instance a dart board score with 0 being off the board and 10 being a bullseye. Refer to *Solution Focussed Scaling Questions* (in related resource) for further information.

What needs to happen?

If there is not enough safety and protection for the child, the child protection worker should translate the danger statements into safety goals.

Safety goals and family goals

The safety goals are developed out of the danger statement and include:

- Communities' safety goals - the specific behaviours that need to be seen for us to be confident that the child is safe, and
- Family safety goals - the family's ideas about what needs to happen to keep the child safe.

'Words and pictures' safety explanation

Child protection workers should involve the parents and the children to develop a 'words and pictures' to explain to the child the following for:

- Children in the CEO's care: why Communities and the Court decided the child could not live with their parents, and
- Children with a safety goal: what has happened that led to the serious child protection concerns.

Refer to *Words and Pictures Article*, *Words and Pictures Example*, *Checklist*, *Questions for the Child* and *Questions for the Parent (*in related resources) for further information.

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Next steps - safety planning

Child protection workers must develop a safety plan based on the safety goals that were developed with the family, safety network and Communities, to establish how foreseeable danger and threats to a child's safety will be managed. The safety plan should describe the next steps in working with the family towards building future safety for the child.

Safety planning can also be used for children in the CEO's care when assessing for reunification and planning contact. For further information on safety planning refer to *The Signs of Safety Child Protection Practice Framework* - Chapter 9: Safety Planning (in related resources).

When developing safety plans, child protection workers should give the family choices and options where possible. The goals of the safety plan need to be realistic and achievable for the family. It is important to foster a sense of family participation and choice. It is easier to help people start something new rather than to stop something.

Wherever possible, talk to each family member about what we are looking for, rather than what must be stopped. Providing specific information to the family about how aspects of the plan can be demonstrated is helpful. This also allows child protection workers to clarify with the family when they say they have met points of the plan with questions such as: 'When did it happen?'; 'Who saw this?' and 'What did you do?'

The ongoing identification of realistic goals is a way of deciding on the particular indicators for building safety and reducing risk. Even if some family members do not agree with the facts of the case, it is possible that they will agree that ongoing safety is a worthwhile goal. Child protection workers should focus on safety in the future to minimise the opportunity for families to get stuck in discussions about what happened in the past.

Taking time to define what ongoing safety will look like ('how will we know when we get there?') helps families know the end point and have some ownership in defining it. This process aims to build our relationship with the family to facilitate cooperation.

Safety network

After the child protection worker has engaged the immediate family in a shared understanding of the danger statement(s) and safety goal(s), the family will then be asked to identify people who might be able to be part of a safety network.

The aim of developing a safety network is to develop a network of people who can respond to and manage the foreseeable threats and

dangers to a child. The family must identify who can be part of the safety network so that the child can be safe.

The family must tell the safety network in detail why a safety network is necessary, what the safety goals are and invite them to be part of that network to keep the child safe. The safety network will then be involved with the family to develop the safety rules. Telling people in the safety network what has happened or is likely to happen to the child is a difficult task and families will need support from the child protection worker to do this. Refer to *Helping families to develop a safety network*, *Roadmap: Family-Owned Safety Planning* and *Building safety when harm is denied* (in related resources) for further information.

Allowing families and the safety networks to develop and manage their safety plans requires child protection workers to develop confidence and competence in working with risk. Team leaders should take into consideration child protection workers' confidence and competence when managing complex cases.

Safety plan

A safety plan is developed from the safety goal(s)/family's safety goal(s) and must:

- be developed from straight-forward statements about the dangers that are understandable by everyone, including children (danger statement and safety goal)
- involve an extensive network of informed friends and family
- describe specific behaviours that address the dangers, keep the child safe and protect the alleged perpetrator from further allegations
- be created together and cover in-the-home, in-the-car (bus, train), at-the-school and at-the-park as necessary
- be developed, refined and implemented successfully over time, and
- be endorsed by Communities.

Safety plan rules must be:

- specific
- measurable
- achievable
- realistic, and
- time limited.

The safety plan rules must articulate:

- how the abuse/neglect will stop or be managed
- what will happen instead, and
- how the network/family will know that the child is safe in relation to the danger statements.

Refer to *Elements of a safety plan* (in related resources) for further information.

The safety planning process gives the family the opportunity to show how they can put actions into practice and allows child protection workers to review this with safety network members on a regular basis.

As part of the safety planning meeting, the child protection workers must clarify the expectations of people in the safety network, including their roles and responsibilities in relation to the safety plan. Child protection workers, with their team leaders, must continually assess the suitability of the safety network involved in a safety plan and determine if these people make it safer for the child or not.

The plan must include the non-negotiable safety rules, different levels of consequences and how this will be acted on.

Considerations that may be helpful when developing a safety plan for allegations of sexual abuse cases could include:

- ability of the primary caregiver to be protective and acknowledge, understand and take action in response to the risk posed by the alleged abuser
- identification of other people in the network who may be able to increase safety
- alleged abuser not being left alone with any children at any time, and
- daily care of the child by the primary caregiver including toileting, bathing etc.

Considerations that may be helpful when developing a safety plan for allegations of physical abuse cases could include:

- strategies to manage/reduce stress at trigger times, such as feeding, night waking, financial difficulties, anniversaries of previous injuries or deaths, unexpected illness
- management and monitoring of medical care and treatment for injuries or illness, and
- agreement to minimise the use of rough play.

Considerations that may be helpful when developing a safety plan for allegations of abuse and neglect cases where family and domestic violence is still occurring and/or escalating could include:

- strategies to increase safety for the non-abusive adult victim and child in the home and external environments
- mechanisms for monitoring and changing or containing the behaviour of the perpetrator
- developing a personal safety plan for the non-abusive adult victim
- partnering with other agencies and non-government organisations (where appropriate) to manage the identified risks, and
- carefully planning and managing risks around separation, particularly if there is Family Court involvement and/or child contact arrangements.

Reviewing the safety plan

Child protection workers must review the plan and consider actions taken by the family to reduce danger and improve safety.

Child protection workers and the family need to consider:

- the age and vulnerability of the child in determining how often the plan needs to be reviewed
- how progress, both positive and negative will be tracked, and
- what to do if there are immediate concerns for the safety of the child prior to the next review date.

The frequency of the review will be determined based on the needs of the case. When new information is received the safety plan will need to be reviewed

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Working with children

There are some useful resources available for child protection workers to involve the child in the assessment and in case planning for children in the CEO's care. Refer to Talking with Children (in related resources) for

further information on the considerations of working with children and complete the consent form on the last page.

The following related resources should be used to help children understand why professionals are intervening in their lives and in safety planning. The working with children resources include:

- Fairy and Wizard tools: a variation of the Signs of Safety assessment and planning form and the *Three Houses Forms*. The focus remains on what worries the child, what is good in their lives and what would they like to see or have happen. For further information refer to:
    - *Fairy and Wizard – prompts and considerations,* and
    - *Fairy and Wizard Form*.
- Words and Pictures: a process for explanation about serious child protection concerns to children and young people that involves the use of words and pictures that the child understands. This process is used with children who have come into care or have a safety plan in place. For further information refer to:
    - *Words and Pictures - Article*
    - *Words and Pictures - Example*
    - *Words and Pictures - Checklist*
    - *Words and Pictures - Questions for the Child,* and
    - *Words and Pictures - Questions for the Parent*.
- Three Houses tools: a practical method of undertaking child protection assessments with children and young people. For further information about three houses and the alternative turtle form refer to:
    - *Three Houses – a tool for gathering information*
    - *Three Houses Version 1*, and
    - *Three Houses Version 2*.

When interviewing Aboriginal children or those from culturally and linguistically diverse (CaLD) backgrounds, references to mystical or magical imagery such as wizards or fairies may cause fear or confusion, due to different cultural and spiritual beliefs. Child protection workers should check for culturally appropriate or relevant symbols and adapt their interview scripts accordingly.

Where English language barriers exist, asking children about their 'dreams' may cause confusion or anxiety if they only understand this in the context of sleep. Explain the purpose of the questions to the interpreter beforehand and ask them to provide an accurate translation with the right context. Use simple and clear language when asking about wishes or hopes for the future, to minimise confusion. For further information refer to *Language and Interpreter Information* in related resources.

Child protection workers should refer to the *CaLD Resource Library* (in related resources) for additional resources in identifying significant cultural and/or religious information for engaging effectively with CaLD communities.

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Appreciative Inquiry

Appreciative Inquiry (AI) assumes that there is something good/positive/successful that has occurred when working with the

family. The process involves the search for specific details regarding what happened to lead to the positive outcome and the role of the person involved.

Signs of Safety utilises the AI technique as a tool for enabling family experience and worker's practice wisdom to inform the ongoing growth and development of practice depth. Using the *EARS prompts to develop a questioning approach* (in related resources) child protection workers, colleagues or supervisors ask questions that help child protection workers or family members reflect on and describe in increasing detail what they have done well, how they came to do it and what challenges they have overcome.

Purpose of an AI

The purpose of AI is to:

- encourage reflective practice to build practice depth by exploring what happened, what behaviours took place and what strategies were involved, in an effort to do more of the same and build on this for the future
- share good practice within a team to promote team learning and best practice
- acknowledge what is going well, as a way of building relationships that enable everyone to talk more constructively about the difficult things, and
- build hope, energy and confidence for working on the difficult things.

Planning and participating in an AI

AI can occur as part of supervision, in team meetings, or in a separate meeting. AI involves an interviewee and facilitator and is enhanced by the participation of others as observers.

Recording and consent

Consideration should be given to video recording an AI to promote learning. A video recording provides a useful reflection tool for the interviewee and facilitator and can be used as a staff training tool.

Informed consent must be sought prior to video recording an AI and agreement on the future use of the video should be discussed and noted. It should also be acknowledged that the interviewee and facilitator have the option to withdraw consent at any stage. A notation should be included on the AI video acknowledging consents have been received and who the target audience is.

Facilitator

An effective AI relies on the skill of the facilitator asking the questions and managing the process. For further information on the questioning approach refer to the following related resources:

- *EARS prompts to develop a questioning approach*
- *Types of questions and examples*
- *Suggested questions when working with Aboriginal people,* and
- *Solution Focussed Scaling Questions*.

The facilitator needs to set and provide a safe environment for all staff. Facilitators should refer to *Appreciative Inquiry Guide* (in related resources) for further information about the role of a facilitator and considerations when planning an AI.

The facilitator may find it helpful to have a support person who can provide advice and guidance.

Observers

Observers play a critical role, identifying good questions asked and good descriptions of behaviour. Observers are active participants and should make notes by using the resource *Appreciative Inquiry Participant Notes* to help provide feedback at the end.

Undertaking an AI with children, family members and key stakeholders

Undertaking an AI with children, family members and key stakeholders needs to be comprehensively planned, with consideration given to the purpose of the AI and any individual needs. If the AI is to be recorded child protection workers should complete Form 141. Where the child is in the CEO's care, a director of case practice needs to provide approval for filmed material to be shown.

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Documentation

All SofS work undertaken by the child protection worker must be recorded on the child's file. This can include scanning handwritten documents to Objective or typing up exact copies of handwritten documents. Refer to Objective Naming Conventions for Signs of Safety Documents (in related resources) for further information.

Documents which should be saved on the file include:

- SofS map (Assessment and Planning Form)
- pre-birth or pre-hearing mapping
- review of SofS mapping
- safety planning
- review of safety planning
- Words and Pictures
- Three Houses
- Fairy and Wizards, and
- other information documented in a file note.

Documentation should include an analysis of the information captured and can be written by the child protection worker or the facilitator of the meeting. The analysis of the information should be shared with the family/key stakeholders and placed onto the child's file.

When undertaking a review of a SofS meeting (including safety planning), the review should be recorded as a new stand-alone document and references made to the previous map or plan where relevant.

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