COMMISSIONER FOR
ABORIGINAL CHILDREN
& YOUNG PEOPLE

TRANSCRIPT OF PROCEEDINGS

April Lawrie, Commissioner for Aboriginal Children and Young People

Denise Rieniets, Counsel Assisting

Hearing for the Inquiry into the application of the Aboriginal and Torres Strait Islander Child Placement Principle in the removal and placement of Aboriginal children in South Australia

Thursday, 9 November 2023 at 11:00am

Department for Health and Wellbeing, South Australia

Witnesses:

- **Heather Baron – A/Chief Child Protection Officer, Department for Health and Wellbeing**
- **Ben Thomas – Manager, Child Protection and Policy Unit, Department for Health and Wellbeing**

Denise Rieniets, Counsel Assisting:
Heather and Ben welcome and thank you for joining us this morning. I'll just ask Commissioner to do a, an Acknowledgement of Country before we start, please.

Commissioner April Lawrie (Chair):
Thank you. I'd like to acknowledge we are meeting on Kaurna Country, pay my respect to Kaurna Elders past and present and those who are emerging, and I also want to acknowledge all our Aboriginal children and young people who we want to make a better future for. So thank you.

Counsel Assisting:
Thank you. Now I ask you to affirm your evidence before we start as well, please.

Carla Ringvall, Assistant to Counsel Assisting:
If you'll repeat after me, I solemnly affirm that the evidence I will give will be the truth, the whole truth and nothing but the truth.

Ben Thomas:
I solemnly affirm that the evidence I will give will be the truth, the whole truth and nothing but the truth.

Assistant to Counsel Assisting:
Thank you and please state your full name, occupation and workplace address.

Ben Thomas:
Ben Thomas, I'm the Manager of the Child Protection and Policy Unit in the Department for Health and Wellbeing and that's in the City Centre building 11 Hindmarsh Square in Adelaide.

Assistant to Counsel Assisting:
Thank you. And Heather if you could also repeat after me, I solemnly affirm that the evidence I will give will be the truth, the whole truth and nothing but the truth.

Heather Baron:
I solemnly affirm that the evidence I will give will be the truth, the whole truth and nothing but the truth.

Assistant to Counsel Assisting:
Thank you. And please state your name, occupation and workplace address.

Heather Baron:
Heather Anne Baron, I'm currently acting Chief Child Protection Officer for SA Health and work in the Child Protection and Policy Unit, Department for Health and Wellbeing, 11 Hindmarsh Square, Adelaide.

Assistant to Counsel Assisting:
Thank you.

Counsel Assisting:
Thank you. Heather if we can just start with you, would you please give us a rundown of what the structure of SA Health is in terms of the Local Health Networks and and your unit where you sit with that, please.

Heather Baron:
Sure. So, SA Health is comprised of 10 Local Health Networks, six of those are in country regions. Each have a governing board and are responsible for the governance over their local health service delivery, which allows decisions to be made closer to communities, closer to clinicians etc. The LHN CEO's are responsible for the day-to-day management and operations of the LHN, and the CEO reports to and is appointed by the governing board. The Department for Health and Wellbeing compliments and supports the LHNs through high level system direction and performance

management, as well as its government departmental role in supporting the Minister and the Chief Executive in in exercising their responsibilities, and we also have SA Ambulance Service that sits within SA Health and that reports through to the Department for Health and Wellbeing. I can list the LHNs if you want me to but.

Counsel Assisting:
Yes if you don't mind, yes please.

Heather Baron:
So there's three geographically based ones in the metro area, so Central Adelaide, Northern Adelaide and Southern Adelaide Local Health Network and then there's the Women's and Children's Health Network. And in the regional areas there's Barossa Hills Fleurieu Local Health Network, Eyre and Far North, Flinders and Upper North, Limestone Coast, Riverland Mallee Coorong and the Yorke and Northern Local Health Networks. So that structure it came into being with the previous government changed from where there was one country service before now there are six LHN's. We also have a Wellbeing SA, which is a state government agency working across primary and secondary prevention to lead system change and better support community health and wellbeing, and the Commission on Excellence and Innovation in Health and they provide leadership and advice on clinical excellence and innovation with a focus on maximizing health outcomes for patients improving care, championing evidence-based practice and clinical innovation, and supporting collaboration.

Counsel Assisting:
Thank you. This Inquiry is focused on the Aboriginal child and, sorry the Aboriginal child placement principle in its application in the state of South Australia, in particular with the the child protection sphere and we've heard quite a lot of evidence being put to the the Inquiry about the experience of Aboriginal young women in particular and their experience of having notifications made of unborn child concerns through the health network and that's a particular interest to the Inquiry in terms of it appearing from the numbers and the statistics that we've seen from the BetterStart data that that the number of young women,, Aboriginal women, who are reported as unborn child concerns seems simply disproportionate in terms of the number the the regularity of pregnant Aboriginal women having those reports being made through the health system. Can you tell us please how many Aboriginal business units or advisory units exist in the Local Health Network?

Heather Baron:
So at the Department level there is a department for Aboriginal health and then each of the LHNs have a Director or an Executive Director of Aboriginal Health and teams that support their functions. Some don't have service delivery as their component, some just have oversight and a strategic direction and so on for the network, and and others also have service delivery as part of their portfolio.

Counsel Assisting:
So I'm sorry, can I just interrupt you there, when you say service delivery, what is that service that they.

Heather Baron:
Oh well I, for example, there there may be, so for example the Aboriginal Family Birthing Program in one LHN might sit with sit under the Aboriginal Health Service but in another it might sit within Midwifery services, so there would be differences in the way that those services are, and broader than this just about children, I'm I'm talking broadly about Aboriginal Health Services across Health. So there are policies and guidelines at SA Health level that govern the development of Aboriginal health programs, so we have the, you know, Aboriginal health impact statement policy so that this sort of higher level policy direction is set by the Department and then and then the LHNs are expected to develop guidelines, develop programs etc in line with those policies. So there's, yeah, Aboriginal health impact statement policy and the program development guideline and the health impact statement guideline, so they're things that the LHNs are you know are meant to work within. When there are new policies or updates and revisions of policies, there there is communication sent to all staff about that but, to provide input, but there is also targeted contacting of various areas for their input and feedback about revisions and updates that need to be made. So an effort is made to contact the relevant people to have input to those policy directives and guidelines when they are up for review. So in terms, so then your question about how many as well as the Department then we'd say that there would be 10 Aboriginal Health units because there would be one in each LHN but they would all be structured differently, that would be an LHN level detail that you would, if you want that, that you would we would need to go to the LHNs around that.

Counsel Assisting:
Sure, thank you. Can I ask you please then because we would like some information about each one of those and in particular how many Aboriginal staff members each of those Aboriginal units have?

Heather Baron:
Okay, so will you ask us those questions after this, or do you want us to keep a record of those questions as we go along?

Counsel Assisting:
We'll we'll keep a record of that, and we'll let you know at the end. Thank you.

Heather Baron:
Thank you.

Counsel Assisting:
With respect to the the care for pregnant Aboriginal women and or high-risk infants, is there a policy model in terms of the the care to be offered to pregnant Aboriginal women within the state?

Heather Baron:
There is no single model of care for high-risk infants and as far as I'm aware there's no single model of care for the Aboriginal Family Birthing programs. Certainly there is a recommendation by our team, and I remember now that I forgot to highlight that at the beginning, but the Child Protection Policy Unit where we're from has been in existence for about two years, so followed a review of the Health Child Protection Services and a recommendation was made to have a child protection portfolio within Health as recognition that that that was something that was required. So yeah, we've been around for two years, the focus has been on developing a model of care for the Child

Protection Services in Health, plus we have responsibility for the child policy domain within Health and a range of other things that we we do. So, sorry, that's just an aside because I forgot to mention that but certainly through our work looking at the model of care for the Child Protection Services in Health, it's clear that there isn't an a single model around high-risk infant management and that is recommended as a as a next step. We have, there are, individual programs across the metro LHNs that that have birthing hospitals and there are high risk infant pathways in the regional birthing hospitals that are level three and four hospitals, but there's no single approach at this stage. So I think it would be a valuable next step to have a have an agreed model of care across the state, and pick out best practice from those models that currently exist and the evaluations or learnings from those to develop an an updated model rather than probably a entirely new model but a best practice model.

Counsel Assisting:
And in the development of that, I'm sorry I'm going a bit offline here, would there be any consultation with Aboriginal communities or Aboriginal workers?

Heather Baron
Absolutely, yes.

Counsel Assisting:
Right.

Heather Baron:
There would absolutely be consultation with and also with inter-agency partners as well to develop that whether that's, that would be DCP and DHS as well as Aboriginal services and within the LHNs and external to the LHNs so yeah, definitely.

Counsel Assisting:
Thank you.

Commissioner Lawrie:
Was that in reference to the model of care.

Heather Baron:
That's in.

Commissioner Lawrie:
For Child Protection Services?

Heather Baron:
That's in ref, well it's really in reference to the high-risk infant pathway, the high-risk infant program. So at NALHN and SALHN, their high-risk infant programs or pathways probably is a better way of describing them sits under the governance of their child protection services, but at Women's and Children's and in the country LHNs they don't. So that's really just more who provides oversight of them. So it's really that they, the oversight probably it isn't essential that it sits under the Child Protection Services, it's a pathway that is really important that SA Health has has a pathway and has a a more standardised best practice approach, how you know that's operationally governed is probably up for the LHNs to work out but there does need to be an agreed model.

Counsel Assisting:
Thank you.

Commissioner Lawrie:
And that that's the aim of the model of care for Child Protection Services across the whole of the health system?

Heather Baron:
That's the aim for having a high-risk infant pathway. So that's been sort of uncovered in the work we've been doing.

Commissioner Lawrie:
Okay.

Heather Baron:
In looking at a model of care for the Child Protection Services that there isn't a consistent model for high-risk infants but we don't think it needs to sit within the Child Protection Services as such. It needs to be in each LHN, but it doesn't need to be under the governance of the of the CPS.

Counsel Assisting:
And who determines what the definition of a high-risk infant is? Is that each individual health service?

Heather Baron:
That's a good question, yes, I don't I don't I guess it's, yes it would be up to the determination by the clinician who's working with that woman, you know looking holistically at a range of risk factors around their presentation. I don't know if that's defined on paper but you know high-risk factors around domestic and family violence and drug and alcohol misuse and a range of those kind of factors would be typically the things that would trigger a response to think about that infant in a high-risk situation.

Counsel Assisting:
And that would then trigger an automatic referral to DCP?

Heather Baron:
A notification you mean.

Counsel Assisting:
A notification.

Heather Baron:
And I know that's a question that comes later isn't it? Not, not necessarily, I think it, I think there needs to be you know there needs to be a holistic look at that at that situation. Health workers are mandated notifiers and need to report concerns about suspicion of abuse and neglect to DCP. DCP make the determination ultimately whether that's an unborn child of concern.

Counsel Assisting:
Sure.

Heather Baron:
Certainly we, we recognise the need and working towards strengthening the response that Health makes, that it's not just report and we've done our job, but that there's report and support. So that if a notification is made, that then what are the supports that Health needs to wrap around that situation because realistically it doesn't mean that there'll be, that DCP or other agencies are going to do anything, you know, to pick up that the risk for that woman, that what can Health do. I think we've got a long way to go but that's that's what that's an area that we can see there's there's a great need.

Counsel Assisting:
Right so that would be more of a public health sort of response to risk than an incident-based response to risk that we've got at the moment, would that be fair to say?

Heather Baron:
I don't, yeah, I don't think there's necessarily an incident that triggers a notification, I think I think it's the assessment of risk that that would prompt someone to make a notification to DCP because because that's what the mandatory reporting guidelines, policy rather, require SA Health staff to do.

Counsel Assisting:
In the staff making that assessment is there a consideration by them of the supports that are already in place for a young pregnant woman?

Heather Baron:
Yes and I think it's well recognised that there's probably insufficient resources for high-risk women in the preventative and early intervention space. We know DHS provide a range of Intensive Family Support Services but they can't meet the need. So there, it is difficult to refer people on to other services because there's just not a lot of services to provide that support. So that's a gap in our system and I think Health probably, you know, in previous times where there was more of a preventative focus may have had a bigger footprint in this space and there's, you know we're talking more about health prevention and early intervention that's coming back in a, whether it's a cycle or a, you know we need to return to doing more preventative work. You know we have Wellbeing SA that's a recognition of that, but we need to be, that's broadly across all of Health, we we recognise the need for early intervention services for all high-risk women and and Aboriginal women are overrepresented in in that.

Counsel Assisting:
Thank you. In relation to the Aboriginal Maternal Infant Care Program, where is that workforce situated?

Heather Baron:
So there is an Aboriginal Family Birthing Program at NALHN and Women's and Children's Health Network, so in metro, so.

Counsel Assisting:
So can I just stop you there, NALHN is the northern?

Heather Baron:
Yes NALHN is northern, WCHN is Women's and Children's, I shouldn't use acronyms.

Counsel Assisting:
Right. Yep.

Heather Baron:
Southern Adelaide Local Health Network is looking to how it can better support Aboriginal women across these care pathways. In regional areas, Flinders Upper North, Eyre and Far North, River Mallee Coorong, Limestone Coast have Aboriginal Family Birthing Programs, so or or pathways, but the makeup of those in terms of which you know how many staff etc all of that again will vary across LHNs and particularly in regional areas where recruitment and retention of staff is more complicated, you know, capability and capacity will depend on on that. But all of those programs, and they're called Aboriginal Family Birthing Programs, AMIC are the staff within them, the Aboriginal Maternal and Infant Care workers, obviously all of those programs aim to improve the birth outcomes for Aboriginal women and their families and provide culturally appropriate and clinical, clinically excellent care for antenatal birthing and postnatal care. And when you asked me before about models of care and while we don't, I've answered that we don't have a consistent model, there are a range of documents that guide perinatal care there's the perinatal practice guidelines and so on, so there are a range of things that guide practice but and there are, each of those high-risk infant programs in the metro LHNs have documentation about how they operate there's just no standardised approach.

Counsel Assisting:
Thank you.

Commissioner Lawrie:
So can I just ask a question then, with with those guidelines and with the clinician's basically doing the assessment of risk, do they, do those guidelines direct the clinician to consult with the Aboriginal professionals like the AMIC workers?

Heather Baron:
I know that some of the perinatal practice guidelines have been developed for Aboriginal women in mind. I think I'd have to I'd have to check whether there's reference to that referral pathway but certainly there are multiple options when a a woman comes into antenatal care about how they wish to receive that care and one of those is the Aboriginal Family Birthing Program if they are Aboriginal or having an Aboriginal baby. So those options are prevented, you know, presented, so you know GP shared care, midwifery led care, Aboriginal Family Birthing Program, so the various options of care are provided to the to the individual.

Commissioner Lawrie:
All right then so who, so the clinician is a very broad term, so who is the clinician? Is it a midwife? Is it, you know, a doctor that does the assessment of high-risk? Which which clinician, which which professional group?

Heather Baron:
It would be midwifery and it would also be medical, both would make that assessment. Again the

detail of that you, we would need to check with the LHNs about the pathway into antenatal care in the public hospital setting and the the medical the clinical condition of the woman would also determine some of that.

Counsel Assisting:
So in terms of the the Aboriginal Maternal Infant Care Program, what specifically, are you able to to tell us, what specific supports they are able to provide for Aboriginal parents and families and and children that's makes them anything different from the mainstream maternal care?

Heather Baron:
Well I think the main difference would be that there are Aboriginal staff, so the Aboriginal Maternal Infant Care staff, within the service that provides support to the the woman so there's that cultural support, so I think that would be the distinct difference.

Counsel Assisting:
So do each of them have Aboriginal staff involved in?

Heather Baron:
Yes, the AMIC workers are Aboriginal staff who've done particular training to achieve that qualification and they work alongside midwifery staff, and they do clinical and non-clinical tasks.

Counsel Assisting:
So when you say they've done specific training are they nurses, all, do they all require nursing qualifications?

Heather Baron:
No not necessarily, I, I don't believe so. I think the, I'm not sure how the training is delivered, but no I don't believe they have to be nursing staff.

Counsel Assisting:
Right. Thank you.

Heather Baron:
They could be but don't have to.

Counsel Assisting:
Sure and then in terms of engagement with with patients with the AMIC, is that, do do, are patients able to ask to be referred into that or is that a referral through the hospital? How do they become engaged in that do they have a choice in in that?

Heather Baron:
Yes, I believe that there is a choice about which pathway, and I said before the different types of care I believe they can choose to opt into that service, yeah. I believe that's the approach across all of them but again we can check, we can check that.

Counsel Assisting:
Thank you. As I've said earlier the Inquiry has heard that the Unborn Child Concern notifications have have been identified as a fairly significant trigger point for Aboriginal families, Aboriginal

women coming into contact with the Department, do you have any any data about the sources of the unborn child notifications within SA Health?

Heather Baron:
In short no compiled data. I mean notifications to DCP could come from anywhere across Health whether that's in an antenatal clinic, could be an outpatient appointment, it could be anywhere across SA Health, community hospital, any notification could be made, so so no is the short answer other to other than to say it would be many and varied.

Counsel Assisting:
Okay. One of the the triggers for notifications and and pregnant Aboriginal women being being brought to the attention of the Department, appears to be quite consistently that if they don't attend three antenatal appointments, that being a trigger. From what the Inquiry has has seen, there is no legal requirement for attendance by anybody at antenatal appointments is there?

Heather Baron:
No, no, that's correct, there is there is no legal requirement to attend an antenatal appointment. I suppose non-attendance would be seen as a as a potential flag in any in any appointment. So we have failed to attend policies or guidelines for appointments within Health because and and that's linked to policies around neglect and fabricated and induced illness, that's the policy title, because it is good health care, you know, to follow up people and ensure that they are receiving the care that they need. So and then there's good evidence that attending antenatal appointments leads to better health outcomes for the mother and the infant in the end, but in in and of itself it is not a legal requirement, it would be an assessment made by the clinician about whether there are other risk factors associated with that presentation to raise concern about the health and wellbeing of that mother and infant as to whether that would prompt a notification to DCP.

Counsel Assisting:
Is there any capacity at all for any outreach from the AMIC to to the to a young woman to address, there may be a lot of reasons why she's fearful of coming to a hospital.

Heather Baron:
Yes.

Counsel Assisting:
Is there anything other than her requirement to attend those appointments that can address those concerns?

Heather Baron:
Yeah, look I I don't know where those all those services are delivered, I would be surprised if there were no off-site, off hospital site, deliveries of those programs. I know other antenatal clinics are delivered in the community, we do have some that take place in CAFHS centres or Children's Centres, so I would be surprised if there wasn't any AMIC service delivery or in a a community based setting but I I can't answer that for individual LHNs but and absolutely acknowledge that there would be multiple reasons why someone wouldn't attend an appointment, transport, having other children to care for, the whole range of things that add complexity to people's lives that make attendance, not to mention the fear of attending a hospital etc so yeah.

Counsel Assisting:
Thank you. We've spoken you, you commented before about the lack of early intervention and prevention services, the the forums have heard quite quite a lot even from your South Australian Health staff that there is a a significant lack of early intervention prevention services for Aboriginal women and their families both pre and post birth. Would you agree with that?

Heather Baron:
Yes and I think I touched on that before that I think yeah we, there aren't sufficient support services in an early intervention space for families to access. DHS have their Intensive Family Support Services, but they don't have sufficient resources to see everybody that is needed, you know, Health has some level of service in that in that area but it's it's not very extensive.

Counsel Assisting:
Do you see that as a role that Health could and should be playing?

Heather Baron:
I think there I think there is scope for Health to have a broader role across the the spectrum of child safety and I think certainly the unit that we are in, that is something that we see as an important piece of work is to look at how is Health placed across the spectrum with health, with the safety of children. So we we have universal services that anybody can access and we do have targeted services that tend to be down the the tertiary end and then there's quite a bit of a gap in between where there are targeted services are needed but there aren't aren't a lot of those to meet to meet the need. So, you know, CAFHS, Child and Family Health Service, for example is a universal service, it also delivers some targeted services for families who have additional need, but, and the Yarrow Place have a My Place Program that work that's in collaboration with DHS and they support young people who have either been under guardianship previously or are currently and and are at risk of having a child removed or have had a child removed and work with that with that woman to support and prevent, you know, future removals etc and to to build up up their capacity to to parent or prevent further removals etc. So there are, there's pockets of things that we're involved in but I think across the spectrum of Health there is scope to be more involved in the safety of children and I think if we look at say from the maltreatment study results, that I'm sure you're aware of, you know the vast proportion of people who have have experienced abuse as children and then the the mental health impacts that that has in their adult life, you know, that's that's got to be seen in our mental health system, you know, which is under health and I don't know how well do our Adult Services recognise this, you know, from back here in in childhood and how well are we connecting all of this together to work down here to try to have an impact on our health system in the long term. So I think Health, Health is involved but I think we need to have a have a greater understanding of the impact of trauma on health outcomes, life trajectory and long-term health outcomes and its impact on the health system.

Counsel Assisting:
Certainly, thank you. I'll ask you a question, I got something I'll ask you about that in a moment, come back to that. When young women attend to give birth at at one of our hospitals and they've been identified as a risk within the hospital setting or the antenatal program, I think you probably

just covered off on most of it, but what what supports or wraparounds are offered to them in the hospital setting to provide them with an alternative to having their baby removed at birth?

Heather Baron:
Umm.

Counsel Assisting:
I guess what I'm asking is, does Health see itself as as dealing with the health as such or is there any holistic attitude within the health system that maybe if we provided and brought in other services that we could address this as a a rather holistic view rather than we're here to deliver this baby the baby's at high-risk we've identified, pass it on to DCP and then it's DCP's problem.

Heather Baron:
I think, I think that's the the overarching purpose of those high-risk infant pathways is to provide support to those women. There's recognition that we probably need to provide therapeutic kind of intervention and earlier, so rather than just noting the risk and monitoring and surveilling the the situation, that there actually needs to be support but it needs to be delivered quite early on not at 36 weeks or when it's probably getting a bit late in the pregnancy to really make a shift. So earlier intervention and it needs to be therapeutic as well as case management in that sense.

Counsel Assisting:
And is that available in this state?

Heather Baron:
I know in the, and I can't speak for all the LHNs, but I do know the SALHN model has done some evaluation around that and has really looked at trying to provide earlier support for women and have found that those with moderate level risk are more willing to engage in services than those at the very severe high-risk end and and that they've, you know, had some positive outcomes with that group of women. And so where I was saying before about developing a state-wide model for high-risk infants I think we need to pick out the the best of each and the evaluations that have happened. I know NALHN is doing a project currently, a northern based, can't remember what it's called, but as part of their high-risk infant program and they're evaluating that and they've said that already with you know a particular cohort of women, they've had some really good outcomes. So I think there are things to be learned from what is is happening. The the the unit we work in, we're just working with DCP around this because we're aware that you know it isn't isn't necessarily always best practice the process of the removal from the birthing hospital. I think from a Health point of view we would probably prefer those removals not to happen in a in a birthing hospital and if, but if they do need to happen there, we'd want to ensure that again that there is best practice around that, ensuring that the the parents are aware of what is going on and that support is provided to those parents. And in the very early stages of that we're reviewing the can't remember the name of the policy.

Ben Thomas:
Collaborative Case Management of High-Risk Infants.

Heather Baron:
Thank you, collaborative management of high-risk infants, and we're also just commencing an audit of of cases where infants have been removed at birth, to just start looking at what has happened in

those individual cases, to pull that together to kind of look at okay where are the but you know anecdotally we know of what I've just described but over the course of say 12 months of of data what can we pull out from that to make change in that bit.

Counsel Assisting:
Right.

Heather Baron:
That bit alone, that's not the whole high-risk infant pathway, but that was one area that was identified that we needed to sort of do something about, but that fits in the the bigger picture. And each of the LHNs are doing quality improvement work in this space and we're also just trying to map that at the moment. I know there, the Aboriginal Health Division at the department is leading through the LHNs the continuity of care protocols for Aboriginal children, 0 to 4 I think it is, and so as well as that and other research that's going on we're trying to map all of the high-risk infant space to kind of then say okay well these are the pieces of work that that's happening, we will do this particular project around the the removals the section 41s and and see what else needs to you know develop out of that.

Counsel Assisting:
That is very interesting to hear because we've heard from a number of of people giving evidence at this Inquiry that there is another additional layer of trauma laid over young women who are not even told their baby's about to be removed and and, trauma has brought them to where they are and then that's laid over it and they're left in the hospital without a baby with no services to deal with their grief, no trauma counselling, nothing, and so it just heightens their already particularly high trauma response.

Heather Baron:
And I think that makes a lot of Health staff feel very uncomfortable.

Counsel Assisting:
I'm sure it would. In terms of that is there any any counselling and support offered to your your staff because I imagine that would be a very traumatic thing to be involved in?

Heather Baron:
So I guess through our employee assistance programs and things there is access to counselling all the time. Sometimes particularly traumatic events you know prompt a debrief locally in a health service whether whether that’s managed by social work or someone else within the the team within those services, those hospitals, to manage that around particular events and you know critical incident debriefing, that's yeah that's what I'm aware of.

Counsel Assisting:
Thank you. My question at number seven, the, whether Aboriginal women and their families who've been identified at risk within the hospital are then given a choice of a referral to support services that may be Aboriginal-led, is there a connection in the health system with those sort of services that might be able to offer assistance that may not necessarily be health services but?

Heather Baron:
Yeah, I think the initial point of contact in most of the LHNs would be the social work departments who would then make you know provide that initial support and then make referrals out. What services they access and where and whether they're Aboriginal-led probably varies across each LHN. So that would be an LHN detail question I think.

Counsel Assisting:
Right. OK, thank you.

Heather Baron:
Yeah.

Counsel Assisting:
One of the very strong issues that has been coming through in the Inquiry from the public forums and from various forums within the community, is that Aboriginal people feel that they are subjected to increased scrutiny within the Health system, as compared to non-Aboriginal people. From, and and this may well be a question that we need to to pose to each of the LHNs in terms of the practice on the ground, but a number of the the SA Health staff indicated that the first point of call was not not to ask what somebody needed for support but to make the put in the call to DCP to ask should they should they make a notification. And it's particularly noted in the Aboriginal community, Aboriginal women felt that that was particularly their experience that that just their presentation at a hospital was enough to, particularly if they have in the past been in any way involved in the Department, seems a tick in the box if you've been a child of, child in care or removed from your own parents, that in itself is a risk factor, you're then not considered a safe parent for the baby that you're you're about to give birth to, can you comment on that?

Heather Baron:
I mean my comment would be that being Aboriginal in itself should not be the risk factor, it should be looking at the whole picture around that presentation.

Counsel Assisting:
That's not what we're hearing from Aboriginal people that that, that is, a risk factor in itself is Aboriginality, is considered within the hospital system.

Heather Baron:
I mean we know Aboriginal people experience higher levels of disadvantage etc, you know, that lead to poorer health outcomes etc but without looking holistically at the context it shouldn't on its own be a reason to make a notification and you know an assessment of of that woman and the strengths and supports around her should be considered. I think, you know, perhaps in Health where we, Health has a disease focus a, you know, we focus around the the deficit that's how we deliver our support, you come in with an injury and that's how we're funded as well. Whether that creates a bit of a mindset I don't know, I think this is a broader issue about systemic racism probably and judgments that are made by people about other individuals. So I think the assessment needs to be made holistically about what what the strengths are against, what the risks are, but obviously from what you're saying that's not the experience of of people, of Aboriginal women. We have you know frameworks and so on that support access to services and support those people who are

experiencing complexity and have the most need etc, but people shouldn't be discriminated against because they're Aboriginal.

Counsel Assisting:
And Heather on that point is there specific policy and training within the Health system to address that sort of systemic racism or those attitudes that that lead to that over representation of Aboriginal women in there?

Heather Baron:
Umm well we have within Health there's Aboriginal Cultural Learning Framework and that provides guidance for the LHNs about their own learning and development programs for staff. All staff are required to do some basic level of of training in awareness of Aboriginal culture etc and history, what the specific requirements of every LHN staff member couldn't couldn't comment but and there would be levels of of training there would be a base level for everybody plus more in-depth training and certainly acknowledging that, and I don't know the right term because I've used cultural competence and people to said you never be competent, it's a lifelong learning, so it's not a tick in the box thing like learning hand hygiene and you know washing washing your hands etc, it is something that we all need to take personal responsibility for in learning and understanding and and growing our understanding across the life course and not just a one off thing. But at a policy level yes, we have we have a policy and we have framework a framework around that that guides what the learning and development should be. And I I know that some services across the LHNs also where they work with Aboriginal families, receive some cultural supervision as well, that's not a broad, that wouldn't be everywhere, I suppose services that are more aware of their need to understand Aboriginal culture recognise that they need to be supported to help grow their understanding and learn ways of supporting Aboriginal people. In the the work that we've been doing in the unit around the model of care for Child Protection Services it was really clear that the Health Child Protection Services there was scope to improve the way they worked with Aboriginal children and families and we've engaged KWY in a project to develop tools and, you know, better approaches in in how those services engage with Aboriginal families, children and families, who engage with our Child Protection Services. So that project's sort of just beginning but that will involve some community consultation but also looking at, you know, how can we build a workforce in the Child Protection Services that is including Aboriginal staff, I know there was a question about that also so.

Commissioner Lawrie:
Was that was that put out to tender or direct approach?

Heather Baron:
Direct direct approach.

Counsel Assisting:
So why was KWY chosen?

Heather Baron:
Because of their their work in the child protection area, working with children and families really. We we engaged with SNAICC initially to have a conversation about, you know, where we might put

out feelers and so on as well as talking with our own Aboriginal Health Division, which is where the funding has come from, and that's how we've ended up with KWY.

Counsel Assisting:
Right.

Commissioner Lawrie:
So three sources of advice about where to go to. SNAICC SNAICC and..

Heather Baron:
SNAICC and the Aboriginal Health division. Two I guess.

April Lawrie:
Two.

Counsel Assisting:
Thank you. I've covered off on. The, in the public forums with the SA Health workers they described a pervasive risk averse attitude, which contributes to notifications being made to the Department and they've also described a focus on the deficit, as you talk, spoke of, of that being the focus for Health is something's wrong that needs to be fixed. Is there a way that the strength basis of families, Aboriginal families, and their differences in terms of parenting approaches and connection to their children, could be prioritised and and included in in the health approach for Aboriginal families in South Australia? Is that something that KWY project is likely to be looking at?

Heather Baron:
Certainly for for the scope of their project, yes that's not all of Health, that's just for the for the Child Protection Services in Health. I think it's about education, I think you know our interpretation of what we see and assessment of risk is based on our Western, you know, understanding of health and our healthcare models and so through education about Aboriginal culture and their connection to family and their land and language and all those things that provide them strength and resilience, I think as non-Aboriginal people we need to build our understanding of that so that we have a a better frame of reference in in how we assess risk and and have a more of a strengths based look at families when they present to us.

Counsel Assisting:
So where does that education fall? Is that in the training in universities? Is that within SA Health? Is that within the hospitals? And who would assess that you know education works if you can see a change. Who then, is it just that people are asked to read this information and tick the box that they've read it? How do we assess that change has come in attitudes, in particular because as we're talking about attitudes here, through that education that's offered to people?

Heather Baron:
Well firstly I think education should be offered at every level and the earlier the better. You know at a whole of community level if we want to make change it it needs to happen at all levels and certainly undergraduate level would be a great thing to happen rather than just once people graduate and get into health services, you know, or if they've grown up with that level of understanding that's surely got to be better than trying to retrofit understanding. But so there are

you know as we said before the framework and protecting children is everyone's business, we've recently completed an update of that mandatory training that is required for staff and that highlights the importance of recognising and responding to child safety concerns and we're also looking at the at reviewing the next level training, level two and three, around child safe environments, which aim we will be aiming to strengthen that understanding of culturally appropriate responses, better understanding of trauma, history for Aboriginal people and what that means in terms of their presentations, and and taking more of a strength based approach. So there's some education that we are sort of directly involved in having an influence over in child safety. In terms of assessing its effectiveness, it's very, of individuals, that's that's a hard thing to answer, I think we can assess the effectiveness of the training in terms of meeting its requirements or how it meets the framework or that kind of thing you know how effectively did the training set out to deliver what it was meant to. But on an individual level have we changed attitudes and yeah I don't know I can how I can answer how do we do that, I'm not I'm not sure. Hopefully over time you would see a shift in attitude pre and post testing of individuals, looking to see the way a culture in a service might change over time. There're things that I guess you could set up evaluations about but on the whole of Health, at a whole of Health level, that would be complicated to do but probably at a targeted level you could you could do that amongst groups of staff.

Counsel Assisting:
And how with the education program that you're you're establishing, how is it going to be delivered?

Heather Baron:
It's delivered online.

Counsel Assisting:
Right.

Heather Baron:
This particular training.

Counsel Assisting:
Okay.

Heather Baron:
A lot of our mandatory training is done that way. I do know for some of the Aboriginal cultural training it is done face to face, and again that probably varies across LHNs, but some you know provide a three-hour training block around things to have a much more you know interactive, immersive kind of experience as opposed to reading something on the screen.

Counsel Assisting:
Sure, okay thank you. What guidance instruction is provided to the Local Health Network staff about how to support high-risk families outside their role of mandatory notification? This may be something that the Local Health Networks individually might need to answer as well. But again it's about looking at how we scaffold families rather than just have the Health network sitting in a a vacuum and, you know, families being expected to find their own supports when they're identified within the health system as high-risk or or vulnerable families. Does the health system see itself holistically as part of that?

Heather Baron:
Yeah like if through the high-risk infant programs, they involve the other agencies in those meetings and then.

Counsel Assisting:
So what other agencies?

Heather Baron:
Like DCP and DHS.

Counsel Assisting:
Right.

Heather Baron:
So they will attend those meetings to discuss individual cases and how how to best manage those.

Commissioner Lawrie:
Are the AMIC professionals involved?

Heather Baron:
I don't know, I'm not sure about that, yeah.

Commissioner Lawrie:
Something to ask.

Heather Baron:
Yeah. There's the child family safety network meetings that are across the geographical spread of the state and Health attends those. That's not just around high-risk infants but that would be around high-risk families more broadly and how as as agencies we're helping to support those families. So that interaction between DHS, Health and DCP can happen at those forums. I think there's scope to improve those forums as well as, as said before, having enough services to refer people to to get the support they need, so we don't end up just talking and monitoring, that there's doing.

Counsel Assisting:
So what do you see as the the hindrance to enough services? Is it funding?

Heather Baron:
Well funding is always a factor but it's also having adequate workforce, you know, we're facing workforce challenges across all areas of Health or across many industries, it's not just Health is it, and that's been talked about for a long time. With our aging population, you know, we knew we would reach a point where we we weren't going to have sufficient workforce to manage demand, so I think we're sort of here there we're approaching that. So just throwing more money at things isn't necessarily going to solve the problem and we need to look at other creative ways and some of the examples that have been, you know, were talked about at a symposium yesterday, which have been around, but, you know, were other peer support, you know other lived experienced workers people working alongside you know families by family, you know, helping to support. We need to look at other ways of providing support to families in communities because official Health Services or DHS Services can't can't deliver at all.

Counsel Assisting:
Thank you. I think we've answered the question about the infant removals within the hospital causing trauma for all parties. The difficulty is, one of the difficulties we've identified, is that sometimes even the staff of SA Health are not informed of a section 41 removal until the very last minute and that leaves them very vulnerable as well and and they're then left to deal with an angry distressed grieving parent who had no notice of this. What would be what would be your recommendation for how those urgent removals should be managed within a hospital setting?

Heather Baron:
So that's something that we're hoping to address through this project that I talked about earlier, where we review the policy and the practice across health and DCP and work together on that. You know DCP make the decision about the removal and enact that and we're party to it and yes, it doesn't necessarily follow the way that that Health feels comfortable with. I think that, you know, there needs to be greater transparency with families and ensuring that they are aware and involved in those discussions that affect them intimately. So I think the fact that that happens would be against the policy and practice guideline, and so we need to address we need to address that. Which is why this has been identified as a high priority, you know, project to to look at and we're starting to gather that information now.

Counsel Assisting:
And when when those removals occur, that's completely out of out of the control of anybody in the Health system? You don't get any input into that at all?

Heather Baron:
I think again it probably varies across LHNs in how how that occurs. There are, there are DCP staff who are placed in, have been sort of like joint appointments, I think they're funded by DH- DCP but have been placed in the hospitals to work in the high-risk infant space and umm.

Commissioner Lawrie:
Wasn't aware of that. Has that been a long-standing arrangement or a more recent initiative?

Heather Baron:
No. You know in the last five or so years but I don’t.

Commissioner Lawrie:
That's not really recent is it, yeah.

Heather Baron:
But I don't know whether they're still happening, but that was to try to bridge some of that, bridge that gap and have that. I don't think they were permanently like full-time placed in the hospital but they would be there routinely in the, would be in the birthing area, the midwifery area. So I know Women's and Children's did have a position at one stage, I think NALHN does, but I that would be a question for the LHNs and I don't think that any of the regional LHNs would have that but you know I'm not sure.

Counsel Assisting:
Sure okay, thank you.

Heather Baron:
And I don't know whether any evaluation was done about that arrangement, to see how effective it was in in trying to facilitate that relationship and working around those section 41s.

Counsel Assisting:
Sure, thank you. For your staff in Child and Family Health Services, the non-Aboriginal antenatal care social workers, child protection paediatric services, what cultural competency training are they provided if any?

Heather Baron:
I think I probably covered that previously by saying that there is a requirement for all staff to do at least a baseline level of training around cultural awareness and hopefully more than just that superficial level. And certainly people who work with Aboriginal families would be expected to do more training and likewise working with children have greater levels of training that they need to undertake around child safety, so that's guided by that cultural learning framework and those programs are developed. I don't know whether each LHN has their own brand of that but yeah, each LHN would be expected to deliver that training yeah. So yeah staff across so non-Aboriginal staff would all do that training.

Counsel Assisting:
And who if anybody checks that that training is actually undertaken?

Heather Baron:
So the LHNs have to record compliance against mandatory training and that's an important KPI particularly for accreditation. So that is collected routinely and individual departments receive information about their department's compliance in completing mandatory training and some of that does flow through to, we can request some of that, for example if we want to look at child safe environments what is the level of compliance across the state, we can request that information from the LHN. So yeah that is part of their service level agreements I believe.

Counsel Assisting:
Thank you. I imagine that again the the question about the number of Aboriginal staff in the workforce would be something that the local LHN is going to have to provide us with information?

Heather Baron:
Across their entire LHN, do you mean?

Counsel Assisting:
Yes.

Heather Baron:
Or more specifically in child protection?

Counsel Assisting:
In child protection.

Heather Baron:
Yeah, so in the Child Protection Services themselves as far as I'm aware the only Aboriginal staff are

in NALHN, NALHN Child Protection Service, where they have two Aboriginal wellbeing officers. So the the service at NALHN is the newest Child Protection Service and that came out of the Nyland Royal Commission. Umm so yeah they they have been deliberate in creating those positions in their unit. I don't believe that SALHN or Women's and Children's so the South or Women's and Children's Health Network have any Aboriginal staff in their services. We, that's a question we can confirm but that's my understanding.

Counsel Assisting:
And I'll I'll also ask you to confirm in that whether that's because they haven't attempted to or whether that's because they haven't been able to find Aboriginal staff who've who would be appropriate for those positions.

Heather Baron:
Yeah it's probably it's probably both things. I think and certainly through the model of care development for those services we have recommended an Aboriginal workforce for their services but that's not without its challenges. And and Aboriginal people can apply obviously for non-Aboriginal specific roles in social work or psychology or medicine, that's the complement or admin in those teams, of course. In terms of dedicated positions, I'm only aware of the the two in NALHN but I think there are also that, is the challenge for Aboriginal people wanting to work in a a service associated with removing, with the removal of children, so not that the Child Protection Service themselves makes that call but they also they work with children who have been removed and are in care, out-of-home care, through their out-of-home care clinics, and they work with children who have been harmed through assault and neglect, and for some Aboriginal people that might may be quite a challenging space to work in for them personally and so I think that also has created issues, I know that the teams have certainly attempted to work in Aboriginal Health Services based services in the community for their child protection and NALHN, NALHN does that, and I think Women's and Children's but it has taken quite a while to work even at, to work on those arrangements to have, for that to be culturally safe I suppose for those for those Aboriginal staff in those Aboriginal services to have a Child Protection Service based there with them and I think the same challenges probably apply in attracting a workforce. So that's something that would need to, needs to be thought of really carefully and I think you know we shouldn't have isolated positions, we should have multiple positions where there's support for those Aboriginal staff. Does that make…

Counsel Assisting:
Yep.

Heather Baron:
Did I explain that?

Counsel Assisting:
One of the things we've heard.

Heather Baron:
I feel like I haven't explained that properly.

Commissioner Lawrie:
Well I'm I'm I'm for me I'm looking at an organiaation like DCP who have a recruitment campaign for

an Aboriginal workforce in that organisation and obviously Health does an Aboriginal recruitment program around improving and increasing Aboriginal employment levels. So I'm trying to understand then with an area where Child Protection is a sensitive area in which to work for anybody but there are really good measures in place in a sector like Health to actually attract Aboriginal people into those into those roles.

Heather Baron:
Yeah.

Commissioner Lawrie:
So I am struggling to understand about why they haven't been deployed and cause I actually think it's a it's actually a resource issue that there hasn't been a decision to create…

Heather Baron:
Oh absolutely.

Commissioner Lawrie:
Aboriginal identified positions to actually attract Aboriginal people into that particular field.

Heather Baron:
Yes, yes. Yeah so that's why I said I think it's both, I agree with that, I think there hasn't been a a a workforce plan around let's let's recruit people and that's that is one of the recommendations in the for the service model, but based on feedback I've received, we've received, and conversations that we've had, that's that's the information that I've been told, so that's what I'm sharing back to say that it's, you know, that might be one of the barriers to that as well. But I don't think they're insurmountable.

Commissioner Lawrie:
Mmm cause you develop strategies to mitigate those barriers.

Heather Baron:
Yes, yeah because obviously yes other agencies do it quite successfully.

Commissioner Lawrie:
Yes.

Counsel Assisting:
One of the other issues that we've heard quite consistently with the Inquiry, is the difficulty that Aboriginal people might have in getting a Working with Children Check because of, one of the things we're looking at here is the statistics, of the number of Aboriginal people who've come into contact with the Department themselves and so that may well then prevent them obtaining a Working with Children Check, then their capacity to get into a hospital and work with families is blocked. Do you see a way around that?

Heather Baron:
Working with Children Check is not, yeah not something I'm well across, I mean I understand the the practice yeah. I guess, yes, I guess there are ways to work around things, it would be identifying a means to do that, yeah, we would need to work at a whole of government level across that to to

identify how would how would we overcome some of those barriers for for people to to enable them to access a a Working with Children Check, yeah, I I don't know the answer really but I I assume that yes there would be ways of doing that would just require the brains trust to come together.

Counsel Assisting:
The will.

Heather Baron:
And the will to do it, yeah absolutely.

Counsel Assisting:
You mentioned earlier the assessments that are made, one of, a quite clear problem that's been identified is the parenting assessments and the psychological assessments that are undertaken when a family comes into the sphere of of Department of Child Protection and those assessments are not done by anybody who's had any Aboriginal competency training and so they're done through a white lens of what's appropriate parenting, what's appropriate bonding with children, what's appropriate in terms of attachment. In terms of the the social workers and the psychologists within the system, the Health system, is there any specifically family, Aboriginal family training done and competency done to address what looks like very strong Western bias in those psychiatric and and psychological assessments that are then used in the Youth Court to remove people's children from them?

Heather Baron:
This is something that we've asked KWY to look at for the Child Protection Services.

Counsel Assisting:
Right.

Heather Baron:
Is to look at the tools that are used and, you know, are there, what other culturally appropriate tools might be used instead of what we're currently using in those services. I think the staff the staff will have done Aboriginal cultural competency training at some level and probably in those services at a more detailed level than some other staff. But yes it is acknowledged that you know there probably are many tools that aren't really appropriate from a an Aboriginal family point of view and how family rearing practices differ from from Western approaches, so that's something we've asked to look at. Wherever possible I think tools are used across Health I know that the ASQ track is used to assess child development so that would be in some child health and development teams and in Child and Family Health Service, so the ASQ track, assume you're familiar with that, you know, has been developed, it's been around for several years now and it goes across many domains up to about age five I think, so that is a that's a child related tool. And I know that DASSA, so Drug and Alcohol Services SA, has been doing research around what tools they use, now that's not a Child Protection Service but they obviously work with people who have drug and alcohol issues, so they are currently looking at appropriate, Aboriginal appropriate tools for their service. So I think it's something that we're increasingly aware of and needing to to look to to improving. Yeah where they exist I think they would be used it's now how do we find and develop more more tools that are appropriate.

Counsel Assisting:
Thank you. Again another overwhelming theme that we're hearing in the evidence that that's been

provided to the Inquiry, is the power imbalance that is perceived or is perhaps real between the Department of Child Protection and all other external agencies, in that they have information about families that is garnered and not necessarily shared with other agencies, and one of the the comments made was that as an Aboriginal person you're the mouse and the Department's the hawk watching all the time and and has, then brings in all the other eyes to watch and surveil you and see that as Health doing that in the hospital sitting and all the other agencies that people might connect with, they feel that that they're agencies for the Department that is just waiting and watching. What would you say to that comment?

Heather Baron:
Well I think I think DCP does direct at some level and have some legislative power to do that, to direct other agencies to provide information, obviously working in within information sharing guidelines but the section 152 requests that come to Health, for example, where we are required to provide them with information about children and families. We've tried to, you know, improve that process, that's probably more from a workload and efficiency point of view, from a Health end and work with DCP about how we can provide more, do that in a more streamlined way, but yes we do provide that information to them. And I think in line with the comments made earlier that there's probably scope to make sure that, or improve the way that we provide information perhaps with more of a strengths focus rather than a deficit focus, which is what DCP would you know well that would be the information that they would would focus on. But yes I…

Commissioner Lawrie:
Is that your understanding that the information they're requesting from you, well not from you as an individual but from Health and health services is to gain information that is strength based? Is that is that your understanding, when they supply section 152?

Heather Baron:
Well they're usually after information about what what has been the interaction with the Health system, so it's about attendance at appointments and things like that. I I personally haven't completed one, so I I I haven't, you know, pulled information together. I've seen, I've certainly seen them and it's information about, you know, attendance at various appointments or failure to attend at various appointments etc and we've tried, as I said, the the LHNs have tried to streamline that as much as possible because it's quite time consuming to pull information together from case notes and it can be quite difficult too because people might be called upon to do that who haven't actually themselves worked with that family, that child or family, because of the time that's passed or whatever. So it's it's quite a time consuming piece of work that we are involved in and I say it's usually just meant to be a collation of of information that we provide back to the Department, yeah.

Counsel Assisting:
And the Department define what information you give, they're not asking you to provide strengths-based information?

Heather Baron:
No it's really more whether they, there is a particular pro forma that is used. I think it's really more general about what and and they identify which services within the LHN they want to know if there's

been engagement with, it's usually at that level, like what's the engagement being with these particular areas tick these boxes and then it's sent to those areas to report in on that information.

Commissioner Lawrie:
So you got, so the system doesn't know what its information is being used for?

Heather Baron:
It's usually for a court process, I understand, and that's you know sometimes the timeframes are quite tight to provide that information.

Commissioner Lawrie:
Thanks.

Counsel Assisting:
Do you have any more questions April?

Commissioner Lawrie:
I do have a question, you might not be across it but I'm going to ask the question. So Family Group Conference is something that the Department can request in relation to a child and their family and in which decision-making can happen. We have heard from some of our, you know, some of the people that have been providing evidence about the importance of Health being in a position to actually request a Family Group Conference for, you know, an Unborn Child Concern or you know high-risk infant. It is something that has been been raised, you know, at various, I guess, times. I'm wanting to know from yourselves whether you're aware of those coming from, whether it be from the Aboriginal Community or from others across government, about the role in which Health can have in convening, not convening, in requesting a Family Group Conference, particularly if there's engagement that you have with a mother through an Unborn Child Concern? Are you aware and.

Heather Baron:
I'm certainly aware of Family Group Conferencing as a as a concept, I'm not aware, I wasn't aware that Health could request that.

Commissioner Lawrie:
Well I don't think you are, but I think there's been lots of calls for opening up to other agencies to actually make referrals to Family Group Conferencing as an early intervention strategy.

Heather Baron:
Okay. Yep, yep okay. I prob yeah I can't answer on behalf of the staff in the service delivery about whether they're aware of that and whether they have ever done that or been involved in that. But I'm I'm aware of of what the Family Group Conferencing is and that seems like a, you know, a positive early intervention strategy that would be great to make use of.

Counsel Assisting:
Thank you.

Commissioner Lawrie:
Yeah that's my question.

Counsel Assisting:
Thank you. We'll finish that there, thank you, for the recording. Thank you very much for your your information.

END