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Removal of Aboriginal infants in a hospital setting: Examining practices

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ABSTRACT

Background: In Australia there are disproportionately higher rates of Aboriginal infant removals often occurring in a hospital-setting. It is a highly sensitive and traumatising time for mothers, fathers, families, and communities.
Objective: This study explored the social and cultural care practices within a hospital in the lead up to and following the removal of Aboriginal Australian infant/s.
Population and setting: This study involved the review of 71 mother's casefiles involving all 75 Aboriginal infants removed in a South Australian specialist birthing hospital in Australia from 2019 to 2022.
Methods: Decolonising critical research, employing a multiple-case study design was conducted through case-file review. This allowed for questioning practices and assessing the impact of broader societal factors on individual cases. The data extraction tool was co-developed by researchers and the Aboriginal Health team. Cross-case analysis was reported using frequency distributions and a decolonising critical lens was used to interpret the data examining how voices may be silenced or excluded.
Results: The study found even though 60 % of mothers presented to the hospital in the first two trimesters of their pregnancy, mothers were rarely advised of the possible or imminent removal of the Aboriginal infant. There were patterns of deficit-based assessments and documentation. There was a lack of documented evidence that attempts were made to engage the mother, Aboriginal kinship systems or Aboriginal Healthcare Providers in the provision of cultural and social care throughout the mothers' perinatal journey, suggesting systemic racism.
Conclusions: This has implications for the provision of patient-centred care respecting the rights and dignity of the mother and the attachment needs of the Aboriginal infant.

1. Introduction

For Aboriginal peoples' connection to family, community, culture and country are fundamental to their identity, belonging and sense of wellbeing (Davis, 2019). In Aboriginal health, social and emotional well-being is a holistic and multi-dimensional concept including the physical, social, emotional and cultural wellbeing of individuals and their communities (Dudgeon et al., 2014). The social and emotional wellbeing of Aboriginal people is reflective of a history of profound dispossession, exclusion, discrimination,

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marginalisation and inequality (Dudgeon et al., 2014). Links have been established between the impacts of history, racism and the health and wellbeing of Aboriginal Australians; with racism being significantly associated with poor overall health (Priest et al., 2011). Racism can occur at the level of an individual (overt or subtle) and/or at an institutional or cultural or system level. As stated by psychologist and Bardi woman Professor Dudgeon et al. (2014) it is important to recognise: 'an institution can engage in racist practices without any members being individually racist' (p.15). The ways society's economic, justice, educational and healthcare systems are applied can disadvantage or marginalise certain groups which is made obvious through high rates of, for example incarceration or unemployment, depending upon the system (Dudgeon et al., 2014). In South Australia (SA) following advice from both Aboriginal health consumers and Aboriginal leaders, the Health Performance Council monitored institutional practices contributing to racism and perpetuating diminished social and emotional wellbeing and intergenerational trauma across health services (HPC, 2019). This provides a valuable opportunity for SA Health services to consider endemic racism within their organisations and service delivery.

The disproportionate removal of Aboriginal infants and children is reported to be contributing to another 'Stolen Generation' further threatening the social, emotional and spiritual wellbeing of Aboriginal peoples (Australian Human Rights and Equal Opportunities Commission, 1997; Chamberlain et al., 2022; O'Donnell et al., 2019) with lifelong effects for the infants, their families, and the collective trauma shared by Aboriginal communities (Funston & Herring, 2016). The Commissioner for Aboriginal Children and Young People in SA (2020) reported one in every three Aboriginal children is subject to an unborn child protection notification, compared to one in 33 non-Aboriginal children. A study examining infant removals in Western Australia found there was disparity between Aboriginal children being removed compared with non-Aboriginal children, 157.6 per 1000 children compared with 22.0 per 1000 respectively (O'Donnell et al., 2019). Taplin (2017) from the Institute of Child Protection Studies found Aboriginal women in the Australia Capital Territory were over-represented among those who were reported during pregnancy. The removal of an infant at birth is undertaken by child protection services and is often the result of complex decision-making processes involving Healthcare Providers (HCPs) through provision of information and reporting (Chamberlain et al., 2022). Despite commitments to reduce this over-representation, from 2017 to 2018 Aboriginal children in Australia were placed in out-of-home care at a rate of eleven times more than non-Aboriginal children, with one third being placed with non-Aboriginal carers (Chamberlain et al., 2022; Harnett & Featherstone, 2020). Across Australia, SA has the second highest rate of Aboriginal entry into out-of-home care (SNAICC, 2023). Given these rates, there are concerns racism is embedded and institutional policies and practices may be influencing this rate of removal (Funston & Herring, 2016; Harnett & Featherstone, 2020; Long & Sephton, 2011).

In an Australian study of prenatal reporting, the most frequent reporter to child protection was the health sector (Taplin, 2017) and yet the practices within health services remain unexplored. This study focuses on the intersection between health and child protection on the site of the hospital, with a focus on healthcare providers. In this context, professional bodies such as Australian Health Practitioner Regulation Agency have strategies supporting the elimination of racism within heath systems (AHPRA & National Boards, 2020). In SA a combination of child protection legislation (SA Children and Young Peoples (Safety) Act 2017, herein known as the Act; SA Children and Young People (Safety and Support) Act 2025) coupled with the Royal Commission into Child Protection Practices (Child Protection Systems Royal Commission, 2016) provides a unique legislative and policy context for this research. Chapter 5 of *the Act* outlines the legal requirement to report a suspicion an unborn child, child or young person may be at risk. *The Act* specifically names: prescribed health practitioners, social workers, employees or volunteers in an organisation providing healthcare. Hence HCPs have a legal obligation to report suspicions of risk. *The Act* also outlines the circumstances under which they 'need not' report a suspicion (s.31.2). For example, if a) they believe another person has reported, or b) their suspicion was solely a result of being informed by the police or a child protection officer. In the context of this study, internal hospital policies also play a role in governing this work.

This project was conceived by the Director of Aboriginal Health in the Local Health Network, in response to Aboriginal community concerns about birthing at the hospital and concerns regarding disproportionate rates of Aboriginal infant removals. This project was designed to explore the contributions of healthcare providers' (HCP) practices to the disproportionately high rates of Aboriginal infant removals. While not representative this study may have relevance and generalisability to hospitals in other colonised nations with disproportionately high rates of infant removals. Through casefile review, this research aimed to explore the HCPs role, interpretation and assessment of risk, decisions to make a mandatory notification and their contributions to the child protection social workers decision to remove Aboriginal infants 2019–2022 at Women's and Children's Health Network (WCHN). We cast the gaze on the practices by HCPs contributing to Aboriginal infant removals. We seek to identify examples of best practice and challenge and uncover deficit practices during the reporting and removal process. This area of practice is sensitive and emotive with life-long effects. Aboriginal children, women, families and communities' wellbeing is at risk.

2. Methodology and methods

2.1. Research design

This empirical study employed exploratory multiple-case study design grounded in an 'advocacy' or critical worldview (Creswell, 2009) with sensitivities to decolonising epistemologies (Tuhiwai Smith, 1999). An advocacy approach seeks to empower marginalised groups, promote social justice and drive change (Creswell, 2009). Decolonising practices (Tuhiwai Smith, 1999), ensured Aboriginal identity was respected throughout including conception of the study, participants (casefiles), researchers and research governance. The casefiles (mother and infant/s) formed the single source of data from which data collection was undertaken. Sequential analysis was undertaken, reported herein is the analysis focusing on the quantitative elements. Descriptive quantitative analysis sought to explore objective patterns of disparity when compared to best practice healthcare. Multiple-case study design (Titscher et al., 2000; Yin, 2018). was adopted (for e.g. see Fig 2.5 p.105 in Yin, 2018) to enable in-depth analysis of context-dependent knowledge and practice (Keddell, 2013). This was top and tailed with Participatory Action Research (PAR) to support the development of a data collection protocol and instrument to collect and analyse the casefiles. The use of a mulitple-case study design is not about reaching representativity but enhancing theoretical generalisations and understandings of complex interacting dynamics leading to an outcome. While every 'case study' is unusually rich and complex, individual case analyses were conducted but are not reported. The intention was not to portray any single one of these cases, risking identifiability, the intent was to report the cross-case analysis focusing on the healthcare providers and synthesizing patterns in their practices and learnings. Yin (2018, p. 308) reports multiple-case studies may consist of reporting cross-case analysis citing Kaufman (1981) as an example of not portraying any single case, rather 'synthesizing the lessons from all of them' (Yin, 2018, p. 310). As a result, knowledge emerges (Titscher et al., 2000) about practice while the outcome for the Aboriginal infant, their family and community are firmly at the centre (Chambon, 1999). As a data source, the case files 'bring detailed accounts of the experiences of some of the most stigmatised and socially excluded groups to the forefront of public awareness' (Stanley & Manthorpe, 2004, p. 1). Case studies using case-file review provide a valuable vehicle through which these dynamics can be investigated and identified. When processes are identified in individual case studies, there are grounds to believe similar processes or dynamics are in operation in similar situations, 'working [themselves] out in similar ways and indeed everywhere that similar outcomes are noted' (Ackroyd & Karlsson, 2014, p. 24). It is for this reason multiple-case study research design is invaluable to the study of organisations and social practices such as infant removals, recognising the focus is not the voices or narratives of the mothers or infants but the 'texts of power and officialdom' (Radford & Radford, 1998, p. 324).

2.2. *Understandings of healthcare*

We recognise healthcare has three components – medical, social and cultural care. Medical care was not assessed within this study. Social care is understood as supporting adults who are disadvantaged or marginalised and/or have specific needs, or those 'adults needing a high level of support with many aspects of their daily life who relies on a range of health and social care services' (NICE, 2022, p. 6). Complex needs may result from illness, disability, broader life circumstances or a combination of these, they may be present from birth or develop over the life course, and may fluctuate (NICE, 2022). Social care was assessed by examining bio-psychosocial assessment processes and practices. Cultural care was understood as: 'the effective care of a person/family by a HCP who has undertaken a process of reflection on their own cultural identity and recognises the impact of their own culture on their practice' (Withall et al., 2021, p. 202). While not engaging directly with the Aboriginal health consumer, in our casefile review this definition was operationalised by Aboriginal health researchers as the presence of one or more of the following: mother consistently involved in her care; transparent processes and practices, extended family/community involved and concerns raised with them; mother was supported by an Aboriginal HCP or support person; evidence kinship structures were considered; strength of culture acknowledged (including living arrangements with extended family; presence of kinship support); recognition grandmothers and aunts have central role in rearing Aboriginal children; healthcare occurred at time and place of relative safety; cultural strengths identified; culturally safe tools used; evidence of establishing relationships with family to seek possible kinship care. These items are reflective of questions within a survey to assess the experience of Aboriginal cultural safety in Australian hospitals (Elvidge et al., 2020).

2.3. *Population*

All identified cases of Aboriginal infant removals in the participating hospital across a four-year period (2019–2022) were included in the study. Identifying the case files where there was an Aboriginal infant removed proved to be a more complex task than anticipated. Two sources were used to identify the relevant patient unique record (UR) numbers. One source was an informal internal list based on the knowledge of practitioners and the second source was accessed through a search conducted using the Clinical Information Systems. Based on the figures reported by both systems, the annual number of removals was consistent. However, upon closer inspection of the UR numbers, unique UR numbers were identified. This process revealed greater numbers of Aboriginal infants removed per calendar year. Both sources rely on the identification of the infant or mother as Aboriginal, which is not consistently reported or captured in part due to concerns about the cultural safety of reporting cultural identity in health services to reduce the experiences of racism (Goodman et al., 2017) and the assumption black skin is required to identify as Aboriginal (Bennett, 2014). There were incomplete UR numbers and there were UR numbers which were identified as cases of Aboriginal infant removals, who upon closer inspection were either not a removal (resulted in safety plan) or not an Aboriginal infant (neither parent Aboriginal). These cases were excluded from the study. This means there is a high chance we have under-reported the number of Aboriginal infant removals.

2.4. *Instrument development*

Font and Maguire-Jack's (2015) social ecology of decision-making in child protection together with the hospital's Collaborative Case Management of High-Risk Infants in Hospitals Policy Directive (SA Health, 2019) informed the development of the data collection instrument. The instrument was co-designed over several months with researchers and the Aboriginal Health team. Discussions included a focus on best practice medical, cultural and social care for mothers of Aboriginal infants. The instrument supported the examination of 'pregnancy health journey' from antenatal care through to postnatal care. This also followed the progression of the casefile. The instrument focused on the decision-making practices and pathways, assessment of risk and processes undertaken by HCPs. The instrument was uploaded into REDCap, an online secure database, to ensure consistency in data collection and security of the extraction of the data. As part of her investigation into the application of the Aboriginal Child Placement Principle (Tilbury, 2013) consultation was held with the SA Commissioner for Aboriginal Children and Young People and two items were added to the casefile review tool e.g. is there an alert on the mother's file and 'was a psycho-social assessment conducted prior to the removal of other infants?'. The instrument was tested on two case files and minor modifications were made as a result e.g. addition of categories unknown and not recorded to 'who attended the case conference?'

2.5. Procedure and data collection

Data relevant to the aims of the study were extracted from sections of the mother and infant's casefiles including the pregnancy handheld record, social work and midwifery notes, birth plans, perinatal care plans and reports made to Child Abuse Report Line (CARL). The infant's file was primarily used to confirm Aboriginality and the mother's access and provision of post-birth care. The data collection team was provided training in the use of REDCap and provided with a data dictionary of the key concepts for extraction. To undertake the data extraction an initial reading of the casefiles was undertaken firstly to confirm the infant's Aboriginality and removal and secondly to become familiar with the structure and content of the file. From June 2023–March 2024 data were collected by the Aboriginal data collectors and research team, providing a cultural lens using the data collection instrument. Researchers and data collectors often worked in pairs to achieve consensus when coding items.

2.6. Data analysis and reporting

Together the mother and infant casefiles formed a case. Case file review coupled with a multiple case study approach allowed for the examination of many cases over time and the exploration and identification of trends, the operation of power relations (Radford & Radford, 1998) and patterns in perceptions and biases of HCPs when assessing and interpreting child safety and risk. Descriptive analysis including frequency distributions were calculated using excel. Small cell sizes of less than 5 % reporting personal health information have not been included. However small cell sizes reporting HCP practices and processes are included.

2.7. Authorship

The first author is a non-Aboriginal woman, fifth generation settler with origins from England, Scotland and Wales. She was born and raised on Ngadjuri Nations, a mother and social work academic living and working on Kaurna yerta, where this study occurred. She is a social worker with 30 years of experience spanning practice, teaching and research. The second author is a Dharug/Gabrigal woman. She is a mother, grandmother, auntie and carer living and working as a Manager at the participating health network on Kaurna yerta. She has more than 15 years' experience working in Aboriginal health and 20 years in early childhood care and education sector. She is involved in Aboriginal research across the Statewide health network including co-chair of Aboriginal Communities and Families Health Research Alliance (ACRA) and Chair of the Aboriginal Families Study Aboriginal Governance group. The third author is a proud descendant of a Warramunga woman and Waayni man. She conceived the design of the study and was the Director of Aboriginal Health at time of the study. She has worked in Aboriginal health in the government and non-government sector for the past 34 years. The last author is non-Indigenous. She has worked in SA Health for 25 years, working for 15 years in a rural community health service. She has worked with regional Aboriginal Health teams, Aboriginal Community Controlled services supporting children and young people, and has supported Taikurrinthi, Aboriginal Liaison Unit, for the past 7 years. She is responsible for Allied Health Services, including Social Work.

While not involved in authorship, a team of data collectors from various Aboriginal language groups were involved in the study. Cultural supervision and support for data collectors was provided by Aboriginal social worker Shirley Young who is a descendent from the Nukunu people.

2.8. Research governance, data sovereignty and ethics approvals

To protect the privacy of those involved in this study we have not identified individual Aboriginal peoples with lived experience of infant or child removals, however all Aboriginal Australian peoples are or have been impacted by infant removals in this or past Stolen Generations. This project was conceived by Aboriginal peoples and overseen by monthly research governance meetings with Aboriginal peoples from Aboriginal Health, and non-Aboriginal peoples from Allied Health and University. An Aboriginal Elder and the then Commissioner for Aboriginal Children and Young People endorsed the conduct of the study. Reports on progress and findings were presented to the Hospital Board including an Aboriginal Board Member. As has been established, Aboriginal infant removals impact the whole family and community.

In Australia the healthcare provider who created the medical records owns the record (Breen v Williams, 1996) and the patient has a right of access to their information in the record (*Freedom of Information Act (SA)*, 1991). The focus of this study was on improving health services through exploring the conduct of the HCPs as represented through the medical record. No personal information identifying patients or HCPs was collected. Concerns have been raised about discrimination and oppression resulting from sharing the data from marginalised peoples (Walter et al., 2021). Data collected as part of this study will not be shared as part of Open Data. At the time of study initiation neither this study, the hospital nor universities had Aboriginal Data Sovereignty policy or plans as required within Framework for Governance of Indigenous Data (Commonwealth of Australia, 2024).

The provision of consent allows for the exercise of self-determination. To seek consent Aboriginal researchers would have needed to re-contact mothers who had their Aboriginal infants removed. Concerns were raised by Aboriginal researchers regarding the risks of re-traumatising Aboriginal mothers following their infant removal and hence a waiver of consent was sought. The research was reviewed and approved by Women's and Children's Health Network Human Research Ethics Committee (HRE00291), Aboriginal Health Research Ethics Committee (04-21-952), Flinders University Social and Behavioural Research Ethics Committee and University of South Australia Human Research Ethics Committee (5448/206346). Aboriginal Health Research Ethics Committee located within an Aboriginal Community Controlled Health Organisation ensured the research complied with NHMRC Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities (National Health and Medical Research Council, 2018) and AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research (AIATSIS, 2020).

3. Findings

We begin with a description of the demographics of the sample followed by reporting the mother's perinatal journey from antenatal through to postnatal care.

3.1. Case demographics

3.1.1. Infants and mothers

There were 71 cases involving 75 Aboriginal infants who had been removed over 2019–2022, 65 (92 %) Aboriginal mothers, 5 (7 %) non-Aboriginal mothers and one (1 %) case where the mother's cultural status was not recorded (Table 1). Where the mother was non-Aboriginal we sought confirmation the father was Aboriginal. One case involved siblings across subsequent years in the time-period reviewed. The mean age of the mother was 27.1 years and ages ranged from 16 to 40 years (Table 1). There was inconsistent information recorded about the father. This birth was the first child for 9 (13 %) mothers, most 62 (87 %) had previous children. Of those women who had previous children, 49 (69 %) had an experience of a previous child being removed from their care. Care leaver status, someone who has left the care of the State, is not routinely collected by the SA Health system. Previous contact with child protection was determined by reports in the handheld record psychological issues section, where 44 (62 %) mothers in this sample reported previous contact with child protection (Table 2). The mothers often had complex social/psychological history with anxiety/depression (34, 48 %), and accommodation (24, 34 %), or financial issues (13, 18 %). High levels of substance use (50, 70 %), smoking (35, 49 %) and/or alcohol use (14, 20 %) were reported. Not recorded in this section were experiences of domestic and family violence or disability. We estimate 5 (7 %) of the mothers had an intellectual disability however there was inconsistent reporting of disability within the case files. Our estimates are conservative and were based on the reasons for removal being reported as 'maternal intellectual disability'. This meant mothers with an intellectual or learning disability may not have had this considered in the assessment of their parenting capacity or healthcare needs e.g. additional health literacy and support required in the identification of when baby needs to feed or needs their nappy changed.

Table 1
Sample characteristics ($n = 71$).

		N (%)
Infant	Aboriginal[1]	75
Mother	Aboriginal[1]	65 (92 %)
	Non-Aboriginal	5 (7 %)
	Not recorded	1 (1 %)
Mother's age	16–25	33 (46 %)
	26–35	29 (41 %)
	36–45	9 (13 %)
	Not recorded	0
Pregnancy Trimester first presented	First (≤12 wks)	18 (25 %)
	Second (13–27 wks)	25 (35 %)
	Third (28–40 wks)	21 (30 %)
	Full term (in labour)	4 (6 %)
	Not recorded	3 (4 %)
Number of women with children in their care	N/A First time mother	9 (13 %)
	0	55 (77 %)
	1 or more	5 (7 %)
	Not recorded	2 (3 %)
Mother had previous children removed from care	Yes	49 (69 %)
	No	18 (25 %)
	Not known	4 (6 %)

[1] In this paper we use the term 'Aboriginal' and 'First Nations' interchangeably, unless a source refers directly to 'Indigenous' or 'Aboriginal and Torres Strait Islander'. This research was conducted in South Australia where the Indigenous peoples of the land self-identify as Aboriginal, hence we use the term in consideration of the preference of the Aboriginal people involved in this research. First Nations was used, where there were multiple Aboriginal groups or nations.

Table 2
Mother's psychological and social issues reported (n = 71).

	N (%)
Psychological/Social issues[a]	
Anxiety/Depression	34 (48 %)
Post-Traumatic Stress Disorder	5 (7 %)
Postnatal Depression	16 (23 %)
Other psychiatric disorders	17 (24 %)
Emotional issues	16 (23 %)
Major life stressors, Life changes, loss	15 (21 %)
Relationship Issues	11 (15 %)
Contact with child protection	44 (62 %)
Accommodation Issues	24 (34 %)
Financial Issues	13 (18 %)
Other	16 (23 %)
Not recorded	11 (15 %)
Alcohol consumption	14 (20 %)
Use of illicit drugs	50 (70 %)
Smoking	35 (49 %)
Other	29 (41 %)
Information not recorded	6 (8 %)

[a] More than one response per person.

3.2. *Perinatal care*

3.2.1. *Antenatal care*

Most mothers 43 (60 %) attended the health service in the first or second trimester of their pregnancy (Table 1). The most frequent forms of antenatal care reported (Table 3) were calculation of date of gestation (49, 69 %), healthcare documentation (43, 61 %) and attendance at antenatal appointments (38, 54 %). Reports were made identifying if the mother agreed or not to complete the Antenatal Risk Questionnaire (ANRQ) and the Edinburgh Postnatal Depression Scale (EPDS).

Table 3
Frequency distribution of healthcare provided.

Stage of care			N (%)
Antenatal Care	Date of gestation		49 (69 %)
	Health care documentation		43 (61 %)
	Antenatal appts attended		38 (54 %)
	Ultrasound		32 (45 %)
	Names HCP listed		32 (45 %)
Antenatal Screening	EPDS		33 (46 %)
	ANRQ		36 (51 %)
Pregnancy Monitoring	Referral to Strengthening Links program		51 (72 %)
Reporting UCC	Raised in casefile		65 (92 %)
	Reported to CARL		53 (75 %)
	Mother advised of CARL report		2 (4 %)
	Key Social Worker allocated[a]		52 (71 %)
Psychosocial Assessment	Conducted[a]		26 (37 %)
	Assessments conducted by (n = 26)	*Social Work*	*22 (85 %)*
		PIMHS	*4 (15 %)*
	Mother involved		19 (28 %)
	Culturally safe		4 (6 %)
Perinatal Care Plan	Case discussions held		26 (37 %)
	Mother involved in case discussions		4 (6 %)
	Completed and recorded[a]		54 (76 %)
	Mother involved in PCP		4 (6 %)
	Culturally safe[a]		7 (10 %)
	Open and transparent discussions with mother if removal in PCP		10 (14 %)
Birth of baby	Cultural support provided		7 (10 %)
Post-birth contact	Spent time with baby		33 (46 %)
	Breastfed baby		19 (25 %)
	Supported to breastfeed		25 (35 %)
Post-removal support	Culturally safe		3 (4 %)

HCP – Health Care Provider; EPDS – Edinburgh Postnatal Depression Scale; ANRQ - antenatal risk questionnaire; CARL – Child Abuse Report Line; PIMHS – Perinatal Infant Mental Health Service; PCP – Perinatal Care Plan.

[a] Required in Policy Directive.

3.2.2. *Early intervention/prevention*

Just under three-quarters of the mothers (51, 72 %) names were shared with Strengthening Links, a monitoring and information sharing meeting (Table 3). Most mothers were referred without their knowledge or consent, even if they declined social work involvement in their care. Mothers were not referred if they presented in labour or birthing or had planned to birth rurally or remotely or not at WCH. On occasion, if supported by an Aboriginal Community Controlled Health Service the mother may have avoided referral.

3.2.3. *Psychosocial assessment*

The Departmental Policy Directive requires a risk assessment be undertaken: ‘all decisions will be based upon high quality, holistic risk assessment that takes into consideration the child, their family and the social context’ (SA Health, 2019, p. 4). Just over a third of mothers (26, 37 %) had a psycho-social assessment undertaken, not a formal risk assessment. These varied in quality and thoroughness and were primarily undertaken by either hospital social work or Perinatal and Infant Mental Health Service (PIMHS). Of those assessments conducted, 4 (15 %) were conducted by PIMHS. Except for a PIMHS assessment, it was often difficult for the researchers to discern what was considered the psycho-social assessment as there was no consistent format or document labelled ‘psychosocial assessment’. The content contained within the identified psychosocial assessments were inconsistent. Of the 26 assessments conducted the mother was involved in 20 (77 %) and only 4 (15 %) were deemed culturally safe by the reviewers (Table 3). There was limited evidence of the conduct of culturally safe psychosocial assessments. Only 2 (3 %) involved extended family members (Table 4) and Child Protection (HRI and CPO) was involved in 15 (21 %). There was no evidence that formal culturally safe assessment tools were used by social workers to undertake the psychosocial assessment. A social work assessment was documented using the following headings: accommodation and finances, relationships, supports, mental health, drug use and summary of concerns. However, in general social work assessment notes in the casefiles were inconsistent in content and structure. There was a lack of transparency in

Table 4

Frequency distribution of who was reported to be involved in healthcare.

	Psycho-social assessment n (%)	Case discussion n (%)	Discussion of perinatal care plan n (%)	Development perinatal care plan (PCP) n (%)	Planned removal post birth n (%)
Mother	20 (28)	4 (6)	3 (4)	2 (3)	10 (14)
Father of Baby	3 (4)	4 (6)	2 (3)	2 (3)	3 (4)
Partner	n/a	2 (3)	0	n/a	n/a
Aunties	n/a	n/a	n/a	n/a	0
Grandmother	n/a	n/a	n/a	n/a	2 (3)
Sisters	n/a	n/a	n/a	n/a	0
Trusted Aboriginal Person	n/a	n/a	n/a	n/a	1 (1)
Extended Family	2 (3)	4 (6)	3 (4)	0	n/a
Aboriginal Health Practitioner	n/a	1 (1)	1 (1)	n/a	n/a
AMIC Worker/Practitioner	0	7 (10)	8 (11)	2 (3)	n/a
Hospital Aboriginal Liaison Officer	1 (1)	2 (3)	3 (4)	2 (3)	n/a
Aboriginal SEW	n/a	1 (1)	2 (3)	n/a	n/a
Aboriginal Worker NGO	0	4 (6)	2 (3)	2 (3)	n/a
Aboriginal Family Cultural Consultant	1 (1)	5 (7)	2 (3)	2 (3)	n/a
Aboriginal Practitioners	3 (4)	3 (4)	n/a	n/a	n/a
Manager AFBP	n/a	17 (24)	3 (4)	6 (8)	n/a
AFBP Worker	4 (6)	n/a	n/a	n/a	n/a
Aboriginal FST Social Worker	n/a	n/a	5 (7)	n/a	n/a
Non-Aboriginal practitioners	2 (3)	2 (3)	0	2 (3)	n/a
WCHN Social Worker	n/a	n/a	18 (25)	n/a	n/a
Nursing Staff	0	1 (1)	0	1 (1)	n/a
High Risk Infant Midwife Consultant	4 (6)	10 (14)	8 (11)	9 (13)	n/a
Midwifery Staff	1 (1)	7 (10)	1 (1)	4 (6)	n/a
Child Protection Officer	9 (13)	15 (21)	37 (52)	19 (27)	n/a
High Risk Infant Worker Child Protection	6 (8)	15 (21)	12 (17)	23 (32)	n/a
Other trusted person	n/a	0	1 (1)	n/a	n/a
Other services	0	2 (3)	1 (1)	n/a	n/a
Support Worker	n/a	5 (7)	4 (6)	n/a	n/a
Other	9 (13)	25 (35)	15 (21)	23 (32)	9 (13)
No other person identified	n/a	12 (17)	17 (24)	n/a	n/a
Not applicable	32 (45)	25 (35)	33 (46)	13 (18)	32 (45)
None of the above	n/a	17 (24)	19 (27)	9 (13)	n/a

PCP - Perinatal Care Plan; AMIC – Aboriginal Maternal Infant Care; SEW – social and emotional wellbeing; NGO – non-government organisation; AFBP – Aboriginal Family Birthing Program; FST – Family Social Therapeutic; WCHN - Women’s and Children’s Health Network; n/a – not applicable.

who was involved in the assessment and no clear presence of the voice of the mother. While fewer assessments were conducted by PIMHS; they were described as comprehensive, involved the mother, acknowledged and recognised trauma, chaos and impacts on the mother's mental health history. These assessments explained and contextualised the mother's potential behaviours when under stress, such as swearing when under pressure.

3.2.4. Assessment of risk and protective factors

Many risk and limited protective factors were identified within the assessment and across the casefiles (Table 5). There was no identified tool (or culturally safe tool) to undertake the risk assessment. The most frequent risks identified were maternal substance use (37, 52 %), domestic and family violence (34, 48 %), maternal mental health (28, 39 %) and a previous infant removed (26, 37 %). One case had 17 risk factors, and no strengths identified. The contemporaneous nature of the reporting of risks in the case notes and reports made to CARL were questioned by the data collectors as HCP did not distinguish between historical and current risk factors. For example, in one case the mother had a previous removal as the father of the baby was a DFV perpetrator. However, in the current pregnancy the mother advised the HCP that the father of the baby was a new paternity and not a DFV perpetrator, and yet the HCP made a report to CARL noting the woman had a history of DFV without noting the paternity had changed and so the risk reduced. Given only 19 (27 %) of all cases reviewed involved the mother in the assessment of risk and protective factors (Table 4), other sources were used to guide the assessment of risk and parenting capacity. Through email evidence, these other sources were primarily child protection officers rather than extended family or people who knew the mother. There was no documented evidence of attempts to seek

Table 5
Frequency distribution of strength and risk factors (n = 71).

	Factors identified in assessment/casefile[a] (%)	Basis for reporting UCC[a] (%)
Previous removal of infant/s	37	44
History of Child Protection involvement as a child	16	28
Maternal substance abuse issues	52	72
Paternal substance abuse issues	18	21
Domestic/family violence	48	61
Maternal mental health issues	39	52
Paternal mental health issues	7	7
No or minimal prenatal care	23	7
Previous history of harming other children	8	3
Parent guilty of qualifying offence	14	31
Maternal childhood trauma/abuse	31	8
Paternal childhood trauma/abuse	4	15
Intergenerational trauma	3	34
Poor parenting capacity	n/a	7
Other children in kinship care	30	1
Children in alternative care or GoCE	21	n/a
History of being in care or GoCE	14	25
Financial issues	6	20
Housing issues	14	20
Homelessness	20	7
Social isolation	3	15
Lack of engagement with services	27	42
Parental age between 15 and 25	11	3
Cultural status	n/a	0
Maternal intellectual disability	6	7
Paternal intellectual disability	0	3
Other	7	24
N/A	13	n/a
Psychosocial assessment not conducted	38	n/a
Connection to culture	1	n/a
Connection to country	0	n/a
Connection to community	1	n/a
Relationship with family	10	n/a
Family support	11	n/a
Social support	6	n/a
Engagement with services	7	n/a
Finances	0	n/a
Housing secured	6	n/a
Identified trusting relationships	1	n/a
History of managing adversity and making change	3	n/a
Parent focused on needs of infant	6	n/a
High level of motivation	3	n/a
Prepare for infant	1	n/a
Other strengths	3	n/a
No strengths identified	35	n/a

GoCE – Under Guardianship of the Chief Executive; n/a – not applicable.

[a] More than one response per person.

out kin or extended family.

3.2.5. Perinatal care plan

The Policy Directive included the requirement for the social worker to have completed a perinatal care plan by 34 weeks gestation. The care plan is to document the response of child protection, the birthing hospitals and other agencies for the remainder of the pregnancy and at the time of birth (SA Health, 2019). The guideline outlines: 'the plan will include, but not be limited to, the details about the level and type of risk facing the unborn infant, when a notification will be made post birth and the likely response of DCP' (SA Health, 2019, p. 5). There was insufficient information recorded in the Care Plan to determine if it was completed by 34 weeks gestation. Most perinatal care plans were undated and the stage of the pregnancy at the time of completion was not recorded. Hence our review was unable to examine if the care plan was completed within this timeframe. The lack of dating care plans also made it difficult to determine the currency of the birth plan and for which pregnancy/birth the care plan applied. Overall, 54 (76 %) cases had a perinatal care plan (Table 3). The primary reasons for no plan were either no antenatal care or the mother presented in labour.

Perinatal care plans were developed from the assessment, case discussions and documentation in the case file. The 'basis for the development of the care plan' was reported (Table 7) with 49 (69 %) reporting an identified risk to the unborn child, 41 (58 %) reporting the planned removal of infant post birth, 25 (35 %) referral to a monitoring and information provision program and 9 (13 %) reported as a complex case. The primary items documented in the care plan were details regarding the mother's background (50, 70 %), who in child protection to notify when mother was birthing (49, 69 %), need for toxicology screen (45, 63 %), risk factors (42, 59 %) and child protection risk factors (40, 56 %). Followed by details of planned removal (37, 52 %) and security concerns (35, 49 %). The security concerns included notes about the capacity of the mother to leave the hospital, hence avoiding the removal. This was documented as risk of 'free birth' or 'flight risk'.

3.3. Post birth contact

Mothers were supported to have time with their infant post birth in 33 (46 %) cases (Table 3). A quarter (19, 25 %) of mothers breastfed their infants and 7 (10 %) mothers had skin-to-skin contact with their infant before removal. This post birth contact was influenced by requests from Child Protection. For example, notes included requests from Child Protection for toxicology screening preventing mothers from being able to breastfeed following birth. In one case, the relevancy of the toxicology screen request was challenged by the Doctor who noted that the toxicology report would be positive as the mother was administered the drugs during their medical treatment. Breastfeeding Medicine Clinical protocols suggests, given the complexity and number of factors considered with breastfeeding mothers and substance use, within hospitals: 'individualized care plans for breastfeeding should be created in partnership with the patient' (Harris et al., 2023, p. 715). These requests may have compromised the quality of Midwifery healthcare provided to both the infant and the mother.

Culturally safe post removal support was identified to have been provided in 3 (4 %) cases. Usual practice was for the provision of Midwifery follow-up over the phone. There was evidence of a text message response from a mother who reported distress and anger at the hospital staff for the infant removal. There were notes in the Perinatal Care Plans for a referral to be made to PIMHS if the mother became distressed. There was limited evidence as to whether this was offered and taken-up by the mother. There was no evidence of follow-up post-removal by social work, which may be a capacity issue or related to job role and responsibility. While not documented there were indications that if a removal occurred it was considered 'too risky' for staff to follow-up and there was no 'baby' to follow-up on. There were no case notes regarding informing of the legal rights of either the mother or family post removal.

3.4. Involvement throughout perinatal care journey

There was a lack of consistency in reporting who was involved in decision-making and evidence of patient voice within the case files. There was a case where the mother had identified the hospital as an unsafe location, resulting from previous removals, and yet this was not considered in the provision of healthcare. Across all areas of the perinatal care journey in relation to social care, data collectors were unable to locate evidence in the case files demonstrating mothers were routinely actively involved in planning and decision-making about their care (Table 4). While 20 (28 %) mothers were reported to be involved in their psychosocial assessment; 4 (6 %) were involved in their case discussion, 3 (4 %) in the discussion of the perinatal care plan and 2 (3 %) in the development of their perinatal care plan. Similarly, partners, father of the baby, Aunts, Grandmothers and extended family had limited involvement at all stages of the mother's perinatal care (Table 4). There was evidence of meetings in casefiles, however no notes detailing the presence of the mother or kinship/extended family members. Correspondence (emails) in the casefiles between child protection demonstrated engagement between hospital and child protection social workers, not mothers or kinship/extended family. As reported in the casefiles, Aboriginal HCPs whether as part of the hospital/healthcare roles or NGOs were more likely to be involved in perinatal social care than extended family. While availability of Aboriginal HCPs may have varied over time, there were no reports in the casefiles of access issues in relation to Aboriginal HCPs. Child Protection Officers were most frequently involved across the perinatal care journey. There were occasions when hospital social work contacted Child Protection for information about a mother prior to an unborn child concern being raised by HCPs. This suggested the HCP relationship with Child Protection was stronger than their relationship with their Aboriginal HCPs.

3.4.1. Communications regarding possible infant removal

There were several opportunities throughout the perinatal care journey where the mother could be advised of child protection concerns (Table 6). For example, before or after Unborn Child Concern report or High Risk Infant notification or any report to Child Abuse Report Line (CARL), after the psychosocial assessment when risks were identified, during the perinatal care planning process (prior to 34 weeks gestation).

An unborn child concern report (Table 6) was made in 53 (75 %) cases, yet only 4 (6 %) mothers were advised of the notification made by the hospital. While there is no legal mandate to advise the mother of the notification, it could be considered an expectation of patient-centred care. Of the 26 (37 %) psychosocial assessments conducted, only 7 (10 %) mothers were advised of the outcomes of the assessment and risks identified (Table 6). Of 54 (76 %) perinatal care plans developed only 10 (14 %) mothers were involved in open and transparent discussions following their development. In support of this pattern of not involving the mother, data collectors reported the presence of a sticker on the perinatal care plan in the casefile correspondence stating: 'Do not discuss with patient'. The only explanations for sticker usage were accompanying descriptions of the mother as 'flight risk' or 'free birther'. Otherwise, no documented rationale was identified. In summary, throughout the perinatal journey, there was evidence of limited transparency in advising the mother of a child protection (CARL) report being made and imminent risk of removal of the infant.

4. Discussion

In reviewing the 71 mother's case files, complexity in the mother's socio-psychological and medical history was evident with high levels of domestic and family violence, maternal mental health issues and/or maternal substance use. This complexity was in tandem with high levels of maternal childhood trauma, their own experiences of being in care or previous engagement with child protection. Compounding this was intersectional disadvantage based on culture, remoteness, ability and experiences of systemic racism. Given this complexity, coupled with trauma backgrounds and resultant vulnerability (Broadhurst & Mason, 2013, 2020), it is critical that the pregnant patient be treated with respect and dignity and provided with assurance of their patient rights including the extent and content of information sharing across agencies. We found over half of the mothers presented in the first two trimesters of their pregnancy and concomitantly there were frequent opportunities for the mother to be made aware of the concerns regarding their capacity to parent and risk of infant removal. There was an organisational culture of a lack of transparency and non-disclosure, further evidenced by the sticker stating: 'Do not discuss with patient', evidencing systemic racism and further supporting claims the 'removal of infants shortly after birth occurs without acceptable and effective support being provided to parents' (Chamberlain et al., 2022, p. 7). Organisational policies for collaborative case management of high risk infants include set service targets (SA Health, 2019); we found gaps in meeting and monitoring these targets such as conduct of the psycho-social assessments and perinatal care plans. Further there was a lack of involvement of the mother (and kin networks) in her own healthcare resulting in reduced patient-centered cultural and social care for the mother.

4.1. Cultural care

In Aboriginal communities' pregnancy care is women's business and women of kinship can be vital sources of knowledge and support during and after pregnancy, highlighting the strengths of cultural connection (Hine et al., 2023). HCPs are expected to 'understand the cultural influences on family and parenting practices and respond in a culturally sensitive way including the use of the Aboriginal Child Placement Principle for Aboriginal children' (SA Health, 2019). We identified low levels of the following signifiers of provision of cultural care: mother, father, grandmother, aunties and extended family involved in care; mother supported by an Aboriginal HCP or support person; acknowledgement and identification of culture as a strength; healthcare occurred at time and place of relative safety; culturally safe tools used; engagement with family. Overall, there was evidence of systemic racism through a combination of a lack of culturally sensitive practice and respect. For example: lack of inclusion of Aboriginal HCPs in meetings, lack of culturally safe tools used, little and inconsistent engagement between non-Aboriginal HCPs with Aboriginal HCPs and Aboriginal family members, and lack of use of a trauma-responsive approach.

At the case level we uncovered a systematic pattern of exclusion of Aboriginal HCPs from the provision of cultural care. Culturally safe healthcare requires the involvement of the Aboriginal person, family and/or Aboriginal Health HCPs (Wilson et al., 2020; Withall et al., 2021) in the provision of cultural care in health environment. At this hospital 2.5 % of workforce are Aboriginal (SA Health, 2023a) and there is Aboriginal representation on governance systems (SA Health, 2023b). Even though these organisational level measures attempt to ensure Aboriginal cultural safety are in place, this study has uncovered the operations of power at the case-level.

Table 6
Mother's involvement (n = 71).

	n	%
CARL contacted to make UCC	53	75
Mother was notified of UCC report at some stage during healthcare	4	6
Contact the Aboriginal worker before CARL	9	13
UCC made before assessment	13	18
UCC made after assessment	12	17
Psychosocial assessment not conducted	31	44
Discussion held with mother re assessment outcome	7	10
Open and transparent discussion with mother post perinatal care plan	10	14

CARL – Child Abuse Report Line; UCC – Unborn Child Concerns.

Table 7
Perinatal care plan.

	n	%
Basis for development of perinatal care plan		
Identified risk unborn child	49	69
Involved with monitoring and information provision program	25	35
Mental Health Specific Plan	2	3
Complex Case	9	13
Planned removal of infant post birth	41	58
Support of woman post birth including cultural support	4	6
Key aspects of perinatal care plan		
Referral to Aboriginal service	5	7
Involvement of extended family	2	3
Referral to WCHN/external services	12	17
Discussion with mother re risk of removal	10	14
Birthing Plan	27	38
Support to access resources	7	10
Assertive engagement	1	1
Protective factors for mother	2	3
Content of perinatal care plan		
Personal and family strengths	0	0
Important relationships (e.g. kinship, cultural supports)	7	10
Cultural background, practice and issues	8	11
Past parenting practices	16	23
Type of stay	15	21
General functioning of woman	19	27
Parenting capacity	19	27
Care arrangements of other children	28	39
Referral to services for postnatal care	27	38
Relationship of woman to unborn infant	16	23
Engagement with support services during pregnancy	27	38
Security concerns	35	49
Details planned removals	37	52
Child protection risk factors	40	56
Need for toxicology screen	45	63
Who to notify when birthing	49	69
Risk factors	42	59
Details of the woman	50	70

WCHN - Women's and Children's Health Network.

Where case by case, mothers of Aboriginal infants are not receiving culturally safe care as they, their family nor Aboriginal HCPs are being invited into the mother or infant's healthcare or involved in decision-making. There was evidence of a lack of engagement between sections of the hospital workforce such as social work and Aboriginal Health.

Systemic racism and oppression are operating through the exclusion of mothers, fathers, family and Aboriginal HCPs from being able to provide cultural care. Cultural care would, even in cases of infant removal, increase the opportunity for the provision of a culturally safe environment. Micro-practices of power, for example, decisions regarding who is sitting at the table and involved in case discussions, have led to a lack of cultural care. It is evident that it is not sufficient to have policies and guidelines in place in isolation from monitoring their implementation to ensure a cultural voice is at the table and an equal voice with the power to influence the outcomes for the mother and infant. To inform future directions there are models of culturally safe maternal and infant care including 'Birthing on Country' services (Kildea et al., 2021) and the need for trauma-informed care and practice in the provision of maternity services (Kildea et al., 2016).

4.2. Social care

Psychosocial assessments in Social Work are based on a conversation between the social worker and the patient, seeking a shared understanding (with the patient), where the voice of the patient is documented, and preferences for their social care are recorded (Milner et al., 2020). As part of their usual practice Social Workers undertake an assessment of people's biological, psychological, social, emotional, cultural and spiritual contexts and needs which should include an assessment of both the risk and protective factors (Sutherland et al., 2024). A non-Indigenous social worker will be limited in their ability to undertake an assessment of the Aboriginal mother and infants cultural and spiritual needs without input from the mother, their family or an Aboriginal HCP. We identified psycho-social risk assessments were not routinely conducted, and there were occasions when mothers had previous infant removals and subsequent 'fresh' assessments were not undertaken. In these cases, the relevancy of the decision to notify was questioned by the researchers due to potential lack of currency of the assessment. In their study examining the characteristics of parents who use substances and do and do not maltreat their children Scannapieco and Connell-Carrick (2007) found specific assessment techniques are needed to discriminate between the two groups. This recognises the importance of the psychosocial risk assessment process and skill particularly in cases of infant removals. While standardised assessment tools are not routinely used in hospital social work, the inclusion of structured template for social work psychosocial assessments and case formulations would enhance consistency; and the inclusion and documentation of the 'patient voice' (Sutherland et al., 2024) in their social care. Earlier psycho-social risk assessments could also provide early intervention referral pathways and opportunities to engage kinship systems and work to prevent removal or secure kinship care for the infant. There were too few case examples where this occurred. Where assessments were conducted they needed a more balanced focus on both strengths and risks. As identified by Hine et al. (2023, p. 138) there are 'inherent risks of seeing only risks' in perinatal healthcare. There is a need for culturally responsive psychosocial risk assessment tools and practices.

Decision making regarding infant removals firmly rested with Child Protection Services. Sharing information and a working relationship is required between HCPs and child protection officers to ensure the safety and wellbeing of the infant. However, high levels of collaboration were identified between HCPs and child protection officers, accompanied with a lack of inclusion of Aboriginal HCPs, as well as the Aboriginal mother and family, which may have been detrimental to the mother's rights and health. As identified in studies at the intersection of DFV and child protection collaboration must ensure the safety of the child as well as the safety of the mother, nurturing the relationship between the mother and child (Bastian & Wendt, 2023). It is important to recognise outcomes that are best for the health of the infant (child-centred) are not mutually exclusive from those that are best for the health and wellbeing of the mother (patient-centred). For example, there is a role for HCPs to advocate for opportunity for the development of secure attachments between Aboriginal infants and their mothers, as secure attachments support the development of health and wellbeing outcomes for the infant (Lima et al., 2024; Yeo, 2003). This includes advocating for opportunities for breastfeeding (even in cases of substance abuse), skin-to-skin contact, and time with the infant in the first critical days of life (Karakas & Dagli, 2019).

4.3. *Both social and cultural care*

We recognise removals are required for the safety of the infant in some circumstances however we question the necessity for removals to occur within health services where the infant is safe. If removals are required in health services, then we want to ensure the mother's dignity and rights are respected and the Aboriginal child placement principle is applied. In addition, we want to ensure that infant removal is the last option and all other least restrictive options have been exhausted prior to infant removal. There was a low tolerance for risk by HCPs in notifying child protection which is possibly explained by higher vulnerability of the infant. This is not unusual, in their study in Israel examining the rates of substantiations following reports by hospital child protection teams, Jedwab et al. (2015) found cases involving newborns and infants were less likely to be substantiated than cases involving older children. Explanations included the hypervigilance of HCPs when reporting this vulnerable population group (Jedwab et al., 2015; Williams et al., 2011). Ideally this may be reduced by having more service options to mitigate or lower the risk, coupled with early intervention.

The provision of post-removal social care to the mother was limited. As soon as the infant was born and removed the mother was left, often by themselves, with their grief and loss and little else except possibly a referral to PIMHS and the child protection legal process. This lack of social and cultural care for the mother is evidence of systemic racism and may set-up the mother for ongoing trauma, social and emotional wellbeing and health issues (Burrow et al., 2024; Keddell et al., 2023). This research contributes to the evidence that Stolen Generations (Australian Human Rights and Equal Opportunities Commission, 1997) are not in our past, but continue into our futures (O'Donnell et al., 2019). This casefile review demonstrates the insidious nature of systemic racism as perpetuated through professional decision-making and micro-practices of power.

4.4. *Strengths and limitations*

This study provides an objective snapshot into the care received by mothers of Aboriginal infants at a Statewide birthing hospital, it does not shed light on the subjective experiences of the care received and whether or not the patients themselves would deem the care they received as culturally safe. This study has several limitations. Due to the inadequacies of the data systems in place, we are unsure if we have captured the full population of mother's whose Aboriginal infants were removed at birth. The data collected also relied on the quality of the content in the case files. A retrospective casefile review may include partial and incomplete data e.g. reporting who attended meetings, which potentially biases the findings and conclusions. We are however reporting on the casefiles as they stand, official records of the care received by the mothers and infants as reported by the HCPs. While led by a non-Aboriginal researcher, Aboriginal governance, data collection and reporting ensured a cultural lens was applied.

5. Conclusion

This study explored the contributions of HCPs decision-making and reporting to the disproportionate rate of removal of Aboriginal infants across a four-year period in a statewide metropolitan hospital. We found when psycho-social assessments were undertaken, they were routinely deficit-focused and not culturally safe. While presenting in the early stages of their pregnancy for healthcare, mothers were not supported to build their parenting capacity nor advised about the risk of imminent removal. While important to providing cultural support and care to mothers, Aboriginal kin and/or Aboriginal HCPs were not routinely involved in decision-making about their healthcare excluding the opportunities for transparent, culturally-safe, patient-centred care. Building trusting working relationships between non-Aboriginal HCPs and Aboriginal HCPs needs to be a future focus. Mothers, once their Aboriginal infant/s were removed, were not routinely provided with culturally safe post-removal grief counselling, support and information about their rights. These findings suggest systemic racism continues and mothers of Aboriginal infants are not afforded basic patient-centred care.

6. Implications for practice

Building the Aboriginal workforce is imperative as is the provision of a culturally safe workplace. Substantial effort will be required to change systemically embedded policy and practices and build trust and collaboration between the Aboriginal and non-Aboriginal workforce.

Through casefile review this research identified HCPs micro-practices of power within the hospital operate to reduce the provision of holistic care. This research has clinical significance for improving social and cultural care to mothers and infants within the hospital. Improved data systems are required to monitor implementation of policy directives such as completion of culturally safe psycho-social risk assessments and peri-natal care plans. This will hold HCPs to account for their practices and decisions.

Early intervention, transparency, culturally safe assessments, involvement of mothers, kin and Aboriginal HCPs are strategies that may serve to improve social and cultural healthcare for mothers and address unborn child concerns. This research aimed to enhance culturally responsive decision-making processes of institutions to alter the trajectory for Aboriginal infants, mothers, and families.

7. Postscript

After the research was completed but before its publication, the following impacts have been observed: From January 2025 there have been reduced numbers of Aboriginal infant removals within the hospital; facilitated by the Aboriginal Health Division, social work staff have been involved in a yarning circle to better understand racism and bias in their practice; Aboriginal Health Division has advocated for greater transparency and patient-rights pathways, when child protection concerns are raised; Mothers within Ngangkita Ngartu (Aboriginal Family Birthing) have been receiving greater post-removal support. Continued and future actions are planned including early intervention programs such as employing an Aboriginal Family Support Worker and Aboriginal Social Worker, to work with families in the antenatal period.

CRediT authorship contribution statement

Michelle Jones: Writing – original draft, Supervision, Methodology, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Cathy Leane:** Writing – review & editing, Supervision, Methodology, Investigation, Conceptualization. **Jackie Ah Kit:** Writing – review & editing, Supervision, Project administration, Methodology, Funding acquisition, Conceptualization. **Natalie Hood:** Writing – review & editing, Supervision, Project administration.

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References

Ackroyd, S., & Karlsson, J. C. (2014). Critical realism, research techniques and research designs. In P. K. Edwards, J. O'Mahoney, & S. Vincent (Eds.), *Studying organizations using critical realism: A practical guide* (pp. 21–45). OUP Oxford.

AHPRA & National Boards. (2020). The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025 Australian Health Practitioner Regulation Agency. https://www.ahpra.gov.au/About-Ahpra/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx.

AIATSIS. (2020). AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research. http://aiatsis.gov.au/ethics.

Australian Human Rights and Equal Opportunities Commission. (1997). Bringing them home: National inquiry into the separation of Aboriginal and Torrres Strait Islander children from their families. https://humanrights.gov.au.

Bastian, C., & Wendt, S. (2023). Collaboration between chld protection and domestic and family violence: A case file review. *Australian Social Work, 76*(2), 186–202. https://doi.org/10.1080/0312407.2021.2000627

Bennett, B. (2014). How do light-skinned Aboriginal Australians experience racism? Implications for social work. *AlterNative: An International Journal of Indigenous Peoples, 10*(2). https://doi.org/10.1177/117718011401000207

Breen v Williams. (1996). *CLR, 186*, 71.

Broadhurst, K., & Mason, C. (2013). Maternal outcasts: Raising the profile of women who are vulnerable to successive, compulsory removals of their children – A plea for preventative action. *Journal of Social Welfare and Family Law, 35*(3), 291–304. https://doi.org/10.1080/09649069.2013.805061

Broadhurst, K., & Mason, C. (2020). Child removal as the gateway to further adversity: Birth mother accounts of the immediate and enduring collateral consequences of child removal. *Qualitative Social Work, 19*(1), 15–37. https://doi.org/10.1177/1473325019893412

Burrow, S., Wood, L., Fisher, C., Usher, R., Gayde, R., & O'Donnell, M. (2024). Parents' experiences of perinatal child protection processes: A systematic review and thematic analysis informed by a socio-ecological approach. *Children and Youth Services Review, 166*(107960). https://doi.org/10.1016/j.childyouth.2024.107960

Chamberlain, C., Gray, P., Bennet, D., Elliott, A., Jackomos, M., Krakouer, J., … Langton, M. (2022). Supporting Aboriginal and Torres Strait Islander families to stay together from the start (SAFeST start): Urgent call to action to address crisis in infant removals. *Australian Journal of Social Issues*, (2), 252–273. https://doi.org/10.1002/ajs4.200

Chambon, A. (1999). Foucault's approach: Making the familiar visible. In A. S. Chambon, A. Irving, & L. Epstein (Eds.), *Reading Foucault for social work* (pp. 51–81). Columbia University Press.

Commission Child Protection Systems Royal. (2016). *The life they deserve*. Child Protection Systems Royal Commission Report, Government of South Australia.

Commissioner for Aboriginal Children and Young People SA. (2020). Family and culture is everything: South Australia's Commissioner for Aboriginal Children and Young People report 2020 (ISBN: 978-0-646-84395-7). https://cacyp.com.au/wp-content/uploads/2021/09/CACYP04-2020-Report-opt.pdf.

Commonwealth of Australia. (2024). Framework for governance of Indigenous data. https://www.niaa.gov.au/resource-centre/framework-governance-indigenous-data.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative and mixed methods approaches* (3 ed.). Sage Publications.

Davis, M. (2019). *Family is culture. Independent review into Aboriginal out-of-home care in NSW*. NSW Government. https://bettercarenetwork.org/sites/default/files/2019-11/Family-Is-Culture-Review-Report.pdf.

Dudgeon, P., Wright, M., Paradie, Y., Garvey, D., & Walker, I. (2014). Chapter 1 Aboriginal social, cultural and historical contexts. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander mental Health and wellbeing principles and practice*. Australian Government. https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf.

Elvidge, E., Parides, Y., Aldrich, R., & Holder, C. (2020). Cultural safety in hospitals: validating an empirical measurement tool to capture the Aboriginal patient experience. *Australian Health Review, 44*, 205–211. https://doi.org/10.1071/AH19227

Font, S. A., & Maguire-Jack, K. (2015). Decision-making in child protective services: Influences at multiple level of the social ecology. *Child Abuse and Neglect, 47*, 70–82.

Freedom of Information Act (SA).(1991).

Funston, L., & Herring, S. (2016). When will the Stolen Generations end? A qualitative critical exploration of contemporary 'child protection' practices in Aboriginal and Torres Strait Islander communities. *Sexual Abuse in Australia and New Zealand, 7*(1), 51–58.

Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). "They treated me like crap and I know it was because I was native": The healthcare experiences of Aboriginal Peoples living in Vancouver's inner city. *Social Science and Medicine, 178*, 87–94. https://doi.org/10.1016/j.socscimed.2017.01.053

Harnett, P. H., & Featherstone, G. (2020). The role of decision making in the over-representation of Aboriginal and Torres Strait Islander children in the Australian child protection system. *Children and Youth Services Review, 113*, Article 105019. https://doi.org/10.1016/j.childyouth.2020.105019

Harris, M., Schiff, D. M., Saia, K., Muftu, S., Standish, K. R., & Wachman, E. M. (2023). Academy of breastfeeding medicine clinical protocol #21: Breastfeeding in the setting of substance use and substance use disorder (revised 2023). *Breastfeeding Medicine, 18*(10), 715–733. https://doi.org/10.1089/bfm.2023.29256.abm

Hine, R., Krakouer, J., Elston, J., Fredericks, B., Hunter, S. A., Taylor, K., … Skouteris, H. (2023). Identifying and dismantling racism in Australian perinatal settings: Reframing the narrative from a risk lens to intentionally prioritise connectedness and strengths in providing care to First Nations families. *Women and Birth, 36*(1), 136–140. https://doi.org/10.1016/j.wombi.2022.04.007

HPC. (2019). Measuring and reporting on institutional racism. https://www.hpcsa.com.au/reports/institutional-racism accessed 20/8/20.

Jedwab, M., Benbenishty, R., Chen, W., Glasser, S., Siegal, G., & Lerner-Geva, L. (2015). Child protection decisions to substantiate hospital child protection teams' reports of suspected maltreatment. *Child Abuse & Neglect, 40*, 132–141. https://doi.org/10.1016/j.chiabu.2014.11.006

Karakas, N. M., & Dagli, F. S. (2019). The importance of attachment in infant and influencing factors. *Turkish Archives of Pediatrics, 54*(2), 76–81. https://doi.org/10.14744/TurkPediatriArs.2018.80269

Kaufman, H. (1981). *The administrative behavior of federal bureau chiefs*. Washington, DC: Brookings Institution.

Keddell, E. (2013). *Beyond care versus control: decision-making discourses and their functions in child protection social work*. PhD thesis. New Zealand: University of Otago – Dunedin https://ourarchive.otago.ac.nz/handle/10523/3886.

Keddell, E., Cleaver, K., & Fitzmaurice, L. (2023). Experiences of baby removal prevention: A collective case study of mothers and community-based workers. *Qualitative Social Work, 22*(2), 266–285. https://doi.org/10.1177/14733250211058178

Kildea, S., Gao, Y., Hickey, S., Nelson, C., Kruske, S., Carson, A., … Roe, Y. (2021). Effect of a Birthing on Country service redesign on maternal and neonatal health outcomes for First Nations Australians: A prospective, non-randomised, interventional trial. *The Lancet Global Health, 9*, Article e651-59. https://doi.org/10.1016/S2214-109X(21)00061-9

Kildea, S., Tracy, S., Sherwood, J., Magick-Dennis, F., & Barclay, L. (2016). Improving maternity services for Indigenous women in Australia: Moving from policy to practice. *MJA, 205*(8), 375–379. https://doi.org/10.5694/mja16.00854

Lima, F., Taplin, S., Maclean, M., & O'Donnell, M. (2024). Infants entering out-of-home care: Health, developmental needs and service provision. *Child Abuse & Neglect, 149*(106577). https://doi.org/10.1016/j.chiabu.2023.106577

Long, M., & Sephton, R. (2011). Rethinking the "best interests" of the child: Voices from Aboriginal child and family welfare practitioners. *Australian Social Work, 64*(1), 96–112. https://doi.org/10.1080/0312407X.2010.535544

Milner, J., Myers, S., & O'Byrne, P. (2020). Chapter 1 assessment in the twenty-first century. In (5th ed.)*, Vols. 1–18. Assessment in social work*. Red Globe Press.

National Health and Medical Research Council. (2018). Ethical conduct in research with Aboriginal and Torres Strait Islander Peoples and communities: Guidelines for research and stakeholders. www.nhmrc.gov.au/guidelines-publications/ind2.

NICE. (2022). Social work with adults experiencing complex needs. https://www.ncbi.nlm.nih.gov/books/NBK588598/pdf/Bookshelf_NBK588598.pdf.

O'Donnell, M., Taplin, S., Marriott, R., & Lima, F. (2019). Infant removals: The need to address the over-representation of Aboriginal infants and community concerns of another 'stolen generation'. *Child Abuse and Neglect., 90*, 88–98.

Priest, N. C., Paradies, Y. C., Gunthorpe, W., Cairney, S. J., & Sayers, S. M. (2011). Racism as a determinant of social and emotional wellbeing for Aboriginal Australian youth. *Medical Journal of Australia, 194*(10).

Radford, D. C., & Radford, J. P. (1998). From the case files: Reconstructing a history of involuntary sterilisation. *Disability and Society, 13*(3), 317–342. https://doi.org/10.1080/09687599826669

SA Health. (2019). *Collaborative case management of high risk infants in hospitals policy directive*. Adelaide, SA: Government of South Australia.

SA Health. (2023a). New WCH aboriginal engagement strategy. https://cdn.wchn.sa.gov.au/downloads/nWCH/New-WCH-Aboriginal-Engagement-Strategy_Final.pdf.

SA Health. (2023b). *Women's and children's Health network 2022–2023 annual report ISSN: 2201-102X*.

Scannapieco, M., & Connell-Carrick, K. (2007). Assessment of families who have substance abuse issues: Those who maltreat their infants and toddlers and those who do not. *Substance Use & Misuse, 42*(10), 1545–1553. https://doi.org/10.1080/10826080701212576

SNAICC. (2023). Family matters report 2023. https://www.snaicc.org.au/our-work/child-and-family-wellbeing/family-matters/.

Stanley, N., & Manthorpe, J. (2004). Introduction: The inquiry of Janus. In N. Stanley, & J. Manthorpe (Eds.), *The age of inquiry: Learning and blaming in health and social care* (pp. 1–16). Routledge.

Sutherland, K., Cumming, S., McCawley, A.-L., Rossini, G., Wishart, L., & Finnigan, S. (2024). A structured template for social work psychosocial assessments and formulations in healthcare. *Australian Social Work*. https://doi.org/10.1080/0312407X.2024.2322741

Taplin, S. (2017). Prenatal reporting to child protection: Characteristics and service responses in one Australian jurisdiction. *Child Abuse & Neglect, 65*, 68–76. https://doi.org/10.1016/j.chiabu.2017.01.007

Tilbury, C. (2013). *The Aboriginal and Torres Strait Islander Child Placement Principle: aims and core elements*. SNAICC. Retrieved 5 August from https://www.snaicc.org.au/wp-content/uploads/2013/06/130601_8_ATSICPP-Aims-Core-Elements.pdf.

Titscher, S., Meyer, M., Wodak, R., & Vetter, E. (2000). *Methods of text and discourse analysis*. Sage.

Tuhiwai Smith, L. (1999). *Decolonizing methodologies: Research and Indigenous Peoples*. Zed Books Ltd.

Walter, M., Lovett, R., Maher, B., Williamson, B., Prehn, J., Bodkin-Andrews, G., & Lee, V. (2021). Indiegnous data sovereignty in the era of big data and open data. *Australian Journal of Social Issues, 56*, 143–156. https://doi.org/10.1002/ajs4.141

Williams, G., Tonmyr, L., Jack, S. M., Fallon, B., & MacMillan, H. L. (2011). Determinants of maltreatment substantiation in a sample of infants involved with the child welfare system. *Children and Youth Services Review, 33*(8), 1345–1353. https://doi.org/10.1016/j.childyouth.2011.04.015Wilson

Wilson, A., Kelly, J., Jones, M., O'Donnell, K., Wilson, S., Tonkin, E., & Magarey, A. (2020). Working together in Aboriginal health: A framework to guide health professional practice. *BMC Health Services Research, 20*, 601. https://doi.org/10.1186/s12913-020-05462-5

Withall, L., Ryder, C., Mackean, T., Edmondson, W., Sjoberg, D., McDermott, D., & Wilson, A. (2021). Assessing cultural safety in Aboriginal and Torres Strait Islander Health. *Australian Journal of Rural Health, 29*(2), 201–210. https://doi.org/10.1111/ajr.12708

Yeo, S. S. (2003). Bonding and attachment of Australian Aboriginal children. *Child Abuse and Review, 12*, 292–304. https://doi.org/10.1002/car.817

Yin, R. (2018). *Case study research and applications: Design and methods* (6th ed.). Sage.