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DISCUSSION

Guilty until proven innocent? – The Assumption of Care of a baby at birth

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ABSTRACT

Background: This paper provides an overview of the history of child protection, the associated law and the 2008 amendments to the Child and Young Persons (Care and Protection) Act 1998 in relation to the Assumption of Care at birth Practice.
Objective: To explore the current practice of an Assumption of Care (AOC) where a newborn baby is removed from his/her mother at the time of birth, particularly focussing on the impact of the AOC on midwives.
Discussion: Assumption of Care practices in NSW raise significant issues for midwives in relation to the midwifery codes of ethics and conduct and importantly, to their ability to work in ways that honour a "woman-centred care" philosophy. When midwives are exposed to conflict between workplace and personal or professional values such as the practice of AOC cognitive dissonance can occur.
Conclusions: Further research is required to understand the impact of current Assumption of Care. Broader research to not only look at effect on the midwife but also on other health professionals involved and the women who personally experience the removal of their baby at the time of birth. Consideration must also be given to ways of working with vulnerable families to enhance the acceptability and efficacy of maternity services and with associated agencies will decrease the need for Assumption of Care at birth.

1. Vignette

Amanda a 35 year old mother of 2, presented for her antenatal booking visit at 16 weeks gestation. Her psychosocial screening revealed a past history of Domestic Violence (DV) and dealings with the Department of Community Service (DoCS). Amanda's previous contact with DoCS was for assistance with out of home care for her children while she left her violent partner. She was now in a new stable relationship and the pregnancy was planned. Because of her history with DoCS the midwife was mandated to submit a Prenatal Report to DoCS. With regular antenatal care no further action was taken.

Amanda attended all her antenatal visits and at 39 weeks gestation presented in labour. She developed a trusting relationship with her midwife and her baby was born at 5 pm. As a Prenatal Report had been made the obligatory birth notification to DoCS was completed. A follow up call from DoCS indicated that within an hour Amanda would be served with a Court Order signifying an assumption of care (AoC). No indication was given as to the reason for the AoC however security back up was requested. Owing to the risk of "flight" Amanda was not to be informed. Although Amanda's antenatal history indicated past DV and DoCS involvement the midwife had no child protection concerns.

Two security officers cordoned off the area prior to the AoC. When the DoCS case manager arrived introduced herself and explained the purpose of her visit the family were distraught. After being told to say good bye to their baby the case manager took him away. Although Amanda pleaded with the midwife to help stop her baby being taken there was nothing the midwife could do. All Amanda could do was to pack up and leave the unit without her baby.

2. Introduction

This is a fictitious vignette but it highlights some of the issues that arise due to assumption of care practices. Over the past four years there has been a significant increase in the number of babies being removed from their mothers in the birthing environment because of child protection concerns.[1] In NSW

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the Department of Community Services (DoCS) is involved and the process is known as 'assumption of care'. This paper does not enter into the debate around individual child protection cases but focuses instead on the actual practice and effects of AoC at birth. The effect of AoC is devastating for the woman. It also raises complex issues for all professionals involved. For midwives charged with the responsibility to provide "woman centred care", AoC of a baby following birth can present particular clinical, moral and ethical challenges. This paper provides background information on the practice of AoC, an overview of the history of child protection and the associated laws that govern child protection (specifically in New South Wales), discusses the issues that the practice raises for midwives and the implications on antenatal care.

3. Background

Child protection is everybody's business[2] and is as much a concern for midwives as it is for others in our community. Child abuse and neglect are not new problems but concerns are perhaps elevated now more often due to routine psychosocial and domestic violence screening that increasingly form part of antenatal care in Australia and internationally. In Australia formal antenatal psychosocial screening was first introduced in Sydney. The initial 2001 version consisting of 31 questions and in conjunction with the Edinburgh Depression Scale (EDS) was used to identify women with psychosocial risk factors. The number of questions has been reduced and with the EDS is used routinely to identify and refer women to appropriate support and early intervention services.[3]

In NSW health policy mandates psychosocial assessment and depression screening for all women at the antenatal booking visit and at six to eight weeks after birth.[4] The combined screening occurs at the woman's first midwifery antenatal booking visit and identifies women with psychosocial vulnerabilities such as adverse childhood experiences, domestic violence, drug and alcohol or mental health issues or a history with the DoCS, as seen in the above vignette. NSW health policy directives clearly outline health care worker's responsibilities for mandatory reporting of any child at risk of harm.

Despite policy and mandatory child protection and training aiming to equip health and related workers with the necessary knowledge and skills, Woods suggests there remains a lack of understanding of the principles of child protection.[5] Additionally the practice of health care professionals varies depending on the maternity facility's location, service capabilities, and the associated support systems/services in place.

Midwives play a role in the AoC of babies who are deemed to be at-risk from birth. Participating in the removal of babies from their mothers during this time can conflict with the fundamental role of midwives and can be a source of great distress. Little is known about how best to conduct the process of AoC in order to protect the emotional, professional and social safety of all of those involved.

4. History of child protection

In 1796 Thomas Spence published 'The Rights of Infants', which is among the earliest English-language assertions of the rights of children.[6] Australia's history of child protection begins in the United Kingdom where in 1889 the parliament passed the "children's charter" which was designed to prevent cruelty to children. Following this, police had the power to enter a home to arrest anyone found physically ill-treating a child. The Child Protection Act of 1908 specified that foster parents had to be registered and changed the accountability of sexual abuse within families from the clergy to that of the State.

In Australia, with increasing public awareness of child protection issues, the first child protection society, the National Society for Prevention of Cruelty to Children (NSPCC), was established in NSW in the late 19th century.[7] The Victorian and Western Australian NPSCC followed in 1984 and 1906 respectively. These groups were responsible for investigating and reporting child abuse and neglect; a mandate that continued well into the 20th century.[8,9] By the end of the 19th century each Australian State and Territory had Children's Courts and legislation to protect children from recognisable forms of maltreatment. This included physical abuse and denying medical treatment to a sick child.

Up until the 1950s neglected or abused children were placed in institutionalised children's care facilities but concerns about the standard of living led to children being placed in smaller group care.[10] Although legislation and Children's Courts had been established, it wasn't until the early 1960s that governments and the general public became interested and involved in child protection.[11] The catalyst for this was research by Kempe, Silverman, Steele, Droegemueller, and Silver in 1962 that identified the "battered-child syndrome".[12] The research described untreated physical injuries in children that were caused by physical abuse by caregivers resulting in a significant cause of childhood disability and death for children under the age of 3 years.[13] Subsequent pressure placed by medical staff and media led state governments to establish and enhance systems for investigating and dealing with child abuse and neglect in Australia.

Legislation defining child abuse and neglect were expanded to include emotional abuse, neglect, sexual abuse and physical abuse with the age increased to include young people up to the age of 18.[13] Tasmania first introduced legislation for mandatory reporting of child abuse and neglect (1974) followed by South Australia, New South Wales and Queensland. It is now in place Australia wide. Since the late 1990s Australian state and territory governments have acknowledged the importance of a collaborative child protection model to support families and have subsequently adopted 'new' models of child protection and family support services.[14,15] Despite Australia being established as a Commonwealth in 1901 child protection services remain state based, governed by differing legislation and practices.

Australian state and territory governments agree that statutory child protection services in isolation are unable to provide support to all families in need. Child protection approaches now encompass the belief that protecting children is everyone's business and that parent's, communities, governments, non-government organisations and businesses all have a role to play. The contemporary public health model provides a framework where preventative interventions are categorised as primary, secondary or tertiary. Secondary prevention interventions are provided to families who are deemed to be at risk of child maltreatment, while tertiary child protection services are deemed to be a last resort for families where child abuse and neglect has occurred.[16]

5. The legislative framework

5.1. National perspective

The *National Framework Working for Protecting Australia's Children 2009–2020* was released by the Australian Government in April 2009.[17] The National Framework represents for the first time cooperation and collaboration between Australian state and territory governments and non-government organisations in order to protect children. The emphasis in the plan is on early intervention programmes, better support for children in care and their families, and improved information-sharing between

Table 1
Relevant Australian state and territory departments and legislation.

State	Relevant department	Legislation
New South Wales (NSW)	Department of Community Service (DoCS) Commission for Children and Young People	Children and Young Person (Care and Protection) Act 1998
Victoria (Vic)	Department of Human Services Child Safety Commission	Children Youth and Families Act 2005 Child Wellbeing and Safety Act 2005
Queensland (QLD)	Department of Child Safety	Child Protection Act 1999
Western Australia (WA)	Department of Child Protection	Children and Community Services Act 2004
South Australia (SA)	Department for Families and Communities	Child Protection Act 1993 – amended 2006
Tasmania (TAS)	Commissioner for Children	Child and Young Person and Their Families Act 1997
Australian Capital Territory (ACT)	Department of Disability, Housing and Community Service – Office for Children Youth and Families Support	Children and Young People Act 2008
Northern Territory (NT)	Department of Health and Families	Care and Protection of Children Act 2007

the states and territories. Although the states and territories retain responsibility for statutory child protection under the National Framework they each have responsibility to report their progress and outcomes in relation to the National Framework.[18]

Table 1 describes the state and territory departments responsible for child protection in each jurisdiction along with relevant legislation in Australia.

5.2. New South Wales

In 2007 two young children who were well known to DoCS died tragically from child abuse and neglect. These two cases became the focal point of public concern and media attention. The parents of Shelley Ebony Ward aged seven years, were convicted of starving her to death in October 2007. Her mother was found guilty of murder and her father guilty of manslaughter. One month later in November 2007, Dean Shillingsworth, aged two years and seven months old, was found in a suitcase floating in a duck pond in a Sydney reserve. His mother was charged with murder. Shelley, Dean and his siblings were known to DoCS. DoCS had lost contact with Shelley when she was two years old. Dean and his siblings were subjects of 34 at risk of harm notifications from 2002 till Dean's death. Both deaths were reviewable under section 35 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*.[19]

The Special Commission of Inquiry into Child Protection Services in New South Wales, headed by Justice James Wood AOQC was established on 14 November 2007 to investigate the safety and welfare of all children and became known as the "Wood's enquiry".[5] At the time of Shelley and Dean's death people who work with children were mandated to notify DoCS if they suspected any child at risk of harm. Justice Wood noted that DoCS were overflowing with reports of "at risk" children and children with genuine risks were overlooked, undermanaged and not supported effectively. Justice Wood's report, handed down on November 24, 2008 recommended changes within the child protection system to cope with future levels of demand and included a change to the mandatory reporting from a child at risk of any harm to a child at risk of "significant harm". Following the Woods enquiry The Child and Young Persons (Care and Protection) Act 1998 was amended in 2009. As a result the NSW Government developed a five year (2009–2014) comprehensive plan, known as 'Keeping Them Safe: A shared approach to child wellbeing' was introduced to reform the child protection system in NSW.[20] The implementation was staged to ensure training and supports were in place.

The amendments to the Child and Young Persons (Care and Protection) Act 1998 that influences an AoC at birth are sections 23, 44, 45 and 106A.[21] This paper focuses on these particular sections. The relevant changes are summarised as follows.

5.3. Section 23

The expanded Section 23 (f) establishes that a child or young person is at risk of significant harm if

> ....(f) the child was subject of a pre-natal report under section 25 and the birth mother did not engage successfully with support services to eliminate, or minimise to the lowest level reasonably practical, the risk factors that gave rise to the report...

Prenatal reports are fundamentally designed to enable agencies to organise services that can potentially be of benefit to the mother and the unborn child or to prepare appropriate statutory/protective intervention following the birth of the child (section 25 Child and Young Persons Care and Protection Act[22]). As in the vignette the woman is informed that a prenatal report has been submitted to DoCS and contacting DoCS will establish what requirements are essential to consider her suitable to parent this baby, e.g. parenting courses. In the majority of cases prenatal reports are not seen as a priority until the baby is born.[1] Besides identifying children at risk of serious harm the NSW Mandatory Reporting Guide suggests that inadequate preparation for birth is a risk factor that indicates a prenatal report. This includes a woman not engaging or effectively engaging or obtaining adequate antenatal care, and who has not made necessary arrangements for the child's birth and the birth is imminent.[23] Once a prenatal report is made, under section 25 of the Act a notification to DoCS is obligatory at the time of the birth. This information is entered onto DoCS client information system – the Key Information and Directory System (KiDS). Subsequently this birth notification can lead to an unplanned AoC at birth, as occurred in Amanda's story.

5.4. Section 44

> If the Director-General
>
> ...(a) suspects on reasonable grounds that a child or young person is at risk of serious harm, and
> (b) is satisfied that it is not in the best interests of the child or young person that the child or young person be removed from the premises in which he or she is currently located signed by the Director-General and served on the person (whether or not a parent of the child or young person) who appears to the Director-General to be in charge of the premises...

This amendment gives the Director-General the ability to remove the newborn from the mother in hospital if DoCS are concerned that the newborn is at "serious risk of harm" or has an unsubstantiated prenatal report. In order for a report to be substantiated the child protection agency needs to have investigated and evaluated the case to determine if there are safety issues.

If the allegations of abuse or neglect are validated, the child protection agency and/or courts will evaluate the case and determine what level of intervention is necessary. An unsubstantiated prenatal report can either be that:

- DoCS have investigated and evaluated the case and no safety concerns have been identified or
- a prenatal report has been made and at the time of the baby's birth the case has not been investigated or evaluated.

5.5. Section 45

If a child or young person is removed or assumed by an order under section 44, the Director-General must explain to the Children's Court within 3 working days after the day on which the removal or assumption of care occurs why the removal of the child or young person without a warrant was considered to be necessary as well as making a care application to the Children's Court for

a. an emergency care and protection order
b. an assessment order
c. any other care order

If at the first session the magistrate is satisfied, on reasonable grounds that the baby is at risk of serious harm an interim care order is made and a hearing date set, usually 2–4 weeks later. The amendment to Section 45 means that a woman, whose baby is removed at birth, can have limited or no access to her baby for weeks until the court process is resolved. Babies held skin-to-skin with their mothers cry less often, have less breathing difficulties, and stay warmer than babies who are separated from their mothers. Mother–infant interaction and breast feeding is enhanced with close contact.[24] Women who experience an AOC at birth, usually request immediate discharged from hospital, have limited postnatal care and therefore do not have adequate support or access to the baby to breast feed.[39]

5.6. Section 106A

. . .The Children's Court must admit in proceedings before it any evidence adduced that a parent or primary care-giver of a child or young person who is the subject of a care application:

(i) from whose care and protection a child or young person was previously removed by a court under this Act or the Children (Care and Protection) Act 1987, and
(ii) to whose care and protection the child or young person has not been restored. . .

- Evidence adduced under subsection (1) is prima facie evidence that the child or young person the subject of the care application is in need of care and protection.
- A parent or primary care-giver in respect of whom evidence referred to in subsection (1) has been adduced may rebut the prima facie evidence referred to in subsection (2) by satisfying the Children's Court that, on the balance of probabilities: the circumstances that gave rise to the previous removal of the child or young person concerned no longer exist. . .

If a woman has had a previous history identified with DoCS as was the case with Amanda in the vignette, or if a prenatal report has not been substantiated, an emergency care and protection order leading to an AoC at birth can be initiated without quantifiable evidence as per section 106A. The mother or parents in the Children's Court have to assert that the circumstances that gave rise to the previous removal of the child or young person concerned no longer exist. Instead of the Principle of Fundamental Rights that one is considered innocent until proven guilty, this legislation allows for one to be guilty until proven innocent[25] (Human Rights Act 2004). The burden of proof is thus on the woman or her family to collect and present enough compelling evidence to convince the Court by evidence and testimony that is legally admissible that the accused is innocent beyond reasonable doubt and the newborn is not at risk of "significant harm". If reasonable doubt remains the Court can continue with a care and protection order with arrangements for contact in place.

6. Impact of the changes to the act

Prior to these amendments at risk families were identified and engaged in the antenatal period. Using a multidisciplinary approach an extended hospital postnatal stay assessment process allowed parents to participate in planning and developing strategies to lower the risk to the newborn. DoCS case managers, midwifery and allied health professionals jointly evaluated and assessed each individual case over a 7–10 day period. If the indications warranted a Care and Protection Order DoCS then submitted a report to the Children's Court and an AoC occurred,[1] usually in the second week of the baby's life.

Although multi-disciplinary antenatal case planning meetings occur when a woman is identified with psychosocial vulnerabilities the impact of the 2009 amendment to the Children and Young Persons (Care and Protection) Act 1998 has influenced the planning and the AoC process. Although the actual statistical information of AOC at births are not reported by AIHW in Child Protection Australia annual reports babies in Out-Of-Home Care <1 year of age are reported and these statistics would include babies who have been removed by AOC at birth. Although unreported anecdotal evidence suggests a higher number of babies undergo an AoC by DoCS, this is now occurring immediately after birth and is directly linked to Amendment 106A. DoCS does not have to build or submit evidence to create a "at risk of serious harm" case as 106A automatically establishes the baby is at risk of harm and therefore removed from his or her mother at birth and placed in foster care.[26] The onus of proof now lies with the mother, as seen in the vignette with Amanda or parents to prove, at court, that the child is not at significant risk of harm.

7. Discussion

AoC is a highly emotive and traumatic event for all concerned, especially the parents. It also raises significant issues both for maternity services and for the profession of midwifery. Midwives have always played a vital role in caring for women and their families and our roles have evolved and advanced, not only with contemporary evidenced based practice but also with society's changing needs. However the practice of AoC at birth particularly in NSW brings us into conflict with several of the standards/values of our professional Codes.

7.1. Assumption of care and the midwife

The midwifery philosophy is based on the word 'mid-wife' which literally means "with woman", therefore the midwifery philosophy aligns midwives with women first and foremost. Midwifery practice in Australia is guided by the Australian College of Midwives (ACM) philosophy and professional and regulatory documents that include the Midwifery Code of Conduct and Code of Ethics.[27] Read in conjunction these documents provide midwives with a framework to guide practice both professionally and ethically.

The Code of Ethics informs women receiving midwifery care, of the human rights standards and ethical values they can expect midwives to uphold.[28] This includes recognising, respecting, actively promoting and safeguarding the right of each woman and her infant(s) to the highest attainable standard of midwifery care as a fundamental human right. The Code acknowledges that violations or lack of attention to human rights can have serious health consequences.

The Midwifery Code of Conduct has ten standards underpinned by three principles[29];

1. Midwives practise competently in accordance with legislation, standards and professional practice.
2. Midwives practise within a woman-centred framework.
3. Midwives practise midwifery reflectively and ethically.

There are times when practices associated with Assumption of Care (enabled by Child Protection legislation in NSW) bring midwives into conflict with principles two and three above. We contend that at times, practices associated with Assumption of Care are not woman centred and in colluding with these practices, midwives are not practicing ethically.

Ethical practice is based on human engagement in relationship, not merely abstract principles. Midwives take a holistic approach which allows the woman to define her social, emotional, physical, spiritual and cultural needs and expectations while upholding the trust and privilege inherent in the relationship between midwives and each woman. This trust also extends to the community and their faith and confidence in the midwifery profession.

The risk of "flight" as seen in the vignette is used as a reason not to inform a woman of an impending AoC. This creates an environment of deception and it is here that midwives are brought into conflict most notably with the midwifery philosophy and standards for ethical and professional practice. Withholding information related to child protection concerns or a planned Assumption of Care denies women the opportunity to make fully informed decisions that will impact profoundly on their future including engaging with services that might assist them to work towards agreed goals and make the necessary changes to their situation or lifestyle. What is more, in withholding this information from women, midwives are colluding in this deception and this practice challenges any notion of "woman-centred" care and profoundly impacts on the relationship of trust and respect that underpins midwifery practice.

7.2. Cognitive dissonance

Cognitive dissonance occurs when an individual must accommodate two contradictory beliefs, ideas or values at the same time or when their actions do not align with their beliefs or values.[30] This can occur when there is conflict between workplace and personal or professional values or as in the example of Assumption of Care, when the practice contradicts midwifery values of; respect for women, informed choice and consent and a desire to provide woman centred care and develop a trusting relationship with women. Feininger's cognitive dissonance theory suggests that we inherently attempt to hold all our attitudes and beliefs in harmony and avoid disharmony (or dissonance).[31] Dissonance occurs when we are unable to reconcile opposing values and or practices and this produces discomfort and stress, often manifesting in anger, sadness and anxiety.

The experience of dissonance is unpleasant and once identified, we are motivated to reduce or eliminate it, and achieve consonance by one of three actions:

1. Focus on more supportive beliefs that outweigh the dissonant belief or behaviour.
2. Reduce the importance of the conflicting belief.
3. Change the conflicting belief so that it is consistent with other beliefs or behaviours.[30]

The more elements that are personally valued, the greater the dissonance. The pressure to reduce cognitive dissonance is a function of the degree of this dissonance.

Midwives identify their relationships with women and their families as a crucial component of job satisfaction.[32] However the context in which care is provided during AoC can hamper the formation of meaningful relationships. When midwives experience dissonance this impedes not only the quality of relationships with women but also the emotional aspects of midwifery, midwives' job satisfaction and ultimately workforce retention.[33]

7.3. Implications for antenatal care

There is a real risk that the amendments to the Act as outlined above, will mean that some of our most vulnerable women (those with prior involvement with DoCS) will avoid antenatal care.

These women are sometimes reluctant to engage with services because of the lack of continuity of service providers, time constraints on service providers and the fear of having their children removed. These factors also create a major barrier to disclosure, particularly so for Aboriginal women.[34]

Studies clearly demonstrate that antenatal care prevents health problems for both the woman and her baby.[35] There are a number of social and environmental factors that impact on this groups' engagement with maternity services including; fear that disclosure will worsen the situation, worry about the healthcare professionals' reaction and social services' involvement.

All women have the right to participate in decisions about their care but this is not possible without full disclosure. Vulnerable families may need different levels and intensities of intervention or support at different times as their circumstances change. Their needs are likely to increase at differing stages and therefore warrant flexible multi agency networks and partnerships models across the continuum. A nonthreatening, non-judgemental antenatal service run by culturally sensitive staff may increase uptake and access to antenatal care for marginalised women.[36] The ultimate aim is always to reduce the number of births where child removal is necessary. This necessitates finding a balance between child and family preservation and child protection. Vulnerable and marginalised women require good quality antenatal care that is collaborative, flexible in terms of the woman's needs, have open disclosure, honesty and provide information that will allow the woman a choice. Antenatal care that provides support to pregnant women and maximises preventative and early intervention strategies to promote the health of the woman as to enable vulnerable women to take action to improve their social circumstances and so potentially avoid AoC.[37] Trusted relationships are crucial to successful engagement with the most vulnerable families. Relationships built on rules, such as confidentiality, honesty, respect for differences; parental empowerment and a collaborative approach are crucial.[38]

8. Conclusion

This paper provides an overview of the history of child protection in Australia and an analysis of the recent changes to legislation impacting on child protection in NSW. Assumption of Care practices in NSW raise significant issues for midwives in relation to the midwifery codes of ethics and conduct and importantly, to their ability to work in ways that honour a "woman-centred care" philosophy.

Further research is required to understand the impact of current Assumption of Care on midwives and other health professionals involved. Consideration must also be given to ways of working with these vulnerable families to enhance the acceptability and efficacy of maternity services and empower them to work with agencies to improve their health and social circumstances which in turn will decrease the need for Assumption of Care at birth.

References

1. Wickham M. Who's left holding the woman: practice issues facing social workers working with women who have infants removed at birth by NSW DoCS. *Child Aust* 2009;**34**(4):29–35.
2. Commonwealth of Australia. In: Council of Australian Governments, editor. *Protecting children is everyone's business: National Framework for Protecting Australia's Children 2009-2020*. 2009.
3. Matthey S, Phillips J, White T, Glossop P, Hopper U, Panasetis P, et al. Routine psychosocial assessment of women in the antenatal period: frequency of risk factors and implication for clinical services. *Arch Womans Mental Health* 2004;**7**:223–9.
4. NSW Department of Health. *NSW Health/Families NSW Supporting Families Early Package - SAFE START Strategic Policy. North Sydney*. 2009.
5. Woods J. In: Government N, editor. *Special Commission of Inquiry into Child Protection Services in NSW, 2008*. 2008, November.
6. Bonnett A. The other rights of man: the revolutionary plan of Thomas Spence. *History Today* 2007;**57**(9):42–8.
7. National Society for the Prevention of Cruelty to Children. *A history of the NSPCC: protecting children from cruelty since 1884*. London: NSPCC; 2000.
8. Jeffreys H, Stevenson M. *Statutory social work in a child protection agency: a guide for practice*. Whyalla, S.A.: Department of Family and Community Services and the University of South Australia; 1996.
9. Scott D, Swain S. *Confronting cruelty: historical perspectives on child protection in Australia*. Carlton, Vic.: Melbourne University Press; 2002.
10. Liddell M. Child welfare and care in Australia: understanding the past to influence the future. In: Goddard CR, Carew R, editors. *Responding to children: child welfare practice*. Melbourne: Longman Cheshire; 1993. p. 28–62.
11. Fogarty J. Some aspects of the early history of child protection in Australia. *Family Matters* 2008;**78**:52–9.
12. Kempe H, Silverman FN, Steele BF, Droegemueller W, Silver HK. The Battered-Child Syndrome. *JAMA* 1962;**181**(1):17–24.
13. Lonne B, Parton N, Thompson J, Harries M. *Reforming child protection*. London & New York: Routledge; 2009.
14. Higgins DJ, Bromfield LM, Richardson N, Holzer P, Berlyn C. *Mandatory reporting of child abuse (NCPC Resource Sheet)*. 2009.
15. Bromfield L, Irenyi M. In: House NCPC, editor. *Child abuse and neglect statistics Australia*. Canberra: Australian Institute of Family Studies; 2009.
16. Holzer P. Australian statutory child protection data: 2007–08 update. *Aust Inst Family Stud* 2009;**17**(1):3–7.
17. Australian Government. In: Australian Government, editor. *National Framework for Protecting Australia's Children 2009-2020*. 2009.
18. Council of Australian Governments. *Protecting children is everyone's business: National Framework for Protecting Australia's Children 2009-2020*. 2009.
19. NSW Ombudsman. In: NSW Ombudsman, editor. *The death of Dean Shillingsworth: critical challenges in the context of reforms to the child protection system*. 2009, December. ISBN 978-1-921132-50-6.
20. Special Commission of Inquiry into Child Protection Services in NSW. In: DOCS, editor. *Keeping Them Safe: A shared approach to child wellbeing 2009-2014. NSW*. 2009.
21. Minister for Community Services. In: NSW Government Legislation, editor. *Children and Young Persons (Care and Protection). Act 157*. 1998.
22. Expert Group Models for a NSW Health Children and Young People's Health Authority (NSW Kids). *Future Governance arrangements for children and young people's health services in NSW*. 2012.
23. NSW Department of Health. In: Children's Research Center, editor. *New South Wales Mandatory Reporter Guide*. 2009.
24. Moore ER, Anderson GC, Bergman NTD. Early skin-to-skin contact for mothers and their healthy newborn infants. *Cochrane Database Syst Rev* 2012;**5**.
25. Human Rights Act. 2004.
26. Ainsworth F, Hansen P. Babies for the deserving: developments in foster care and adoption in one Australian state – others to follow? *Just Policy* 2009;**50**:23–9.
27. ANMC. *Standards and Criteria for the Accreditation of Nursing and Midwifery Courses Leading to Registration, Enrolment, Endorsement and Authorisation in Australia - with Evidence Guide*. 2009.
28. The Nursing and Midwifery Board of Australia. Code of ethics for midwives. *Professional conduct for midwives*. 2008.
29. ANMC. *A midwife's guide to professional boundaries*. 2010.
30. Festinger L, Carlsmith JM. Cognitive consequences of forces compliance. *J Abnormal Social Psychol* 1959;**58**(2):203–10.
31. Festinger LA. *Theory of cognitive dissonance*. California: Stanford University Press; 1962.
32. Hunter B. Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery* 2005;**21**:253–66.
33. Hunter B, Berg M, Lundgren I, Ólafsdóttir Ó.Á.. Kirkham M. Relationships: the hidden threads in the tapestry of maternity care. *Midwifery* 2008;**24**(2):132–7.
34. Laing L. Domestic violence and woman's health. *Routine screening for domestic violence in health services*. Australian Domestic and Family Violence Clearinghouse 2003; 2003.
35. Banta D. *What is the efficacy/effectiveness of antenatal care and the financial and organizational implications?*Copenhagen: WHO Regional Office for Europe Health Evidence Network (HEN); 2003.
36. Shepphard V, Zambranab R, O'Malley A. Providing health care to low-income women: a matter of trust. *Family Pract* 2004;**21**(5).
37. AIHW. *Child Protection Australia 2010-2011. Canberra*. 2012.
38. Downe S, Finlayson K, Fleming A. Creating a collaborative culture in maternity care. *J Midwifery Women's Health* 2010;**55**(3):250–4.
39. Crenshaw J, Klaus JPH, Klaus MH. No Separation of Mother and Baby with Unlimited Opportunity for Breastfeeding. *J Perinat Educ* 2004;**13**(2):35–41.