Child Protection

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1. Overview

Purpose

This policy provides Waitemata District Health board community and hospital based staff with a framework to identify and manage actual and/or suspected child abuse and neglect.

It recognises the important role and responsibility staff has in the accurate detection of suspected child abuse and/or neglect, and the early recognition of children at risk of abuse and provides guiding kaupapa/principles.

It provides guidelines for the development of services/unit specific procedures and policies relating to child abuse and neglect.

Scope

This policy applies to all cases of actual and/or suspected abuse and neglect encountered by employees, students and people working at WDHB under a contract for service.

Staff Responsibility

It is the responsibility of WDHB staff to be alert to the signs and symptoms of neglect or abuse and to take appropriate action to protect the well being and safety of children and young people, whether the child/young person is directly or indirectly our client/patient.

Mandatory Reporting

Although, from a legal viewpoint, it is not mandatory to report, WDHB has a policy that staff must report actual or suspected child abuse or neglect to CYF. This includes situations where child abuse is disclosed but the child may not be present.

Accessing Forms

WDHB wide Child Protection forms can be located on the intranet under:

- Policy and Controlled Document – Clinical Forms – Organisational Wide
- Family Violence Intervention Programme site

Forms include:

- CYF Referral Form / Notification to Child Protection Coordinator
- Child's Body Diagram
- Child Protection Initial Risk Assessment
- Child Protection: Discharge Safety Checklist

2. Kaupapa / Principles

The tamariki/child and rangatahi/young person's safety, welfare and rights are our first and paramount consideration.

"The welfare and interests of the child or young person shall be the first and paramount consideration…" (CYP&F Act 1989)

The protection and nurturing of children and young people is the responsibility of adults. Children are not responsible for abuse/neglect inflicted on them by others.

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Health services must contribute to the nurturing and protection of children/young people and advocate for them as part of their role to promote, protect and preserve health.

Health services for the care and protection of children/young people must be built on a partnership that aligns with the Treaty of Waitangi.

The whanau/family's primary role in providing for the care, welfare and safety of children and young people must be valued, maintained strengthened and supported by health services. However, at all times the child's health and safety has priority.

WDHB provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection.

DO NOT WORK ALONE. In all matters of child protection concerns (known or suspected) staff must follow consultation processes.

3. Terms and Definitions

All terms and definitions related to this document have been defined. S*ee Appendix 1.*

3.1 Child Abuse and Neglect – Definitions of Terms

Child Abuse	Child abuse means the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect or deprivation of any child or young person (Children, Young Persons & Their Families Act 1989). *See Appendix 2 for specific forms of abuse.* A child is defined as a boy or girl under 14 years and a young person of or over 14 but under 17 years.
Physical Abuse	Child physical abuse is any act or acts that result in inflicted injury to a child or young person. It includes injuries which are caused by excessive punishment**.** Such injuries may be deliberately inflicted or the unintentional result of rage, regardless of motivation, the result for the child is physical abuse.
Sexual Abuse	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It includes sexual involvement of children/adolescents with an adult or older child, and also includes children being exposed to pornography.
Child Neglect	Child neglect is the failure to provide basic necessities of life (food, shelter, clothing), as well as emotional security, medical care, supervision, education. It is any act that can result in impaired physical functioning, injury, and/or development of a child or a young person.
Emotional Abuse	Emotional abuse is any act or omission which results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
Family Violence	The exposure of children and young people to any form of family violence is abusive. It concerns behaviours perpetrated by household members (i.e. by parents/caregivers/siblings/extended family/step-parents) and within other close personal relationships.

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4. Child Protection Concerns for the Unborn Child

4.1 Vulnerable Families

As a consequence of providing care to a pregnant woman clinicians may become concerned about a woman's ability to prioritise the needs of her infant. This may be as a result of emotional immaturity; substance abuse; mental health problems; family violence; previous involvement with CYF services either as a child or with her current children.

Behaviours of concern include:

- Failure to engage or avoidance of antenatal care
- Failure to discuss or disclose information about the location of her children
- Failure to modify or attempt to modify behaviours likely to be harmful to the unborn child
- Expressing persistent negative views about the pregnancy and unborn child
- Expressing unrealistic beliefs about infant behaviour and the demands of childcare, to a degree where there are concerns for the child's safety or well-being.

4.2 Intervention

Staff MUST share their concerns with appropriate staff/ management within their service *(See service protocols*). Referral to CYF services MUST be made where there is a child protection concern for the unborn or the child following birth. WDHB and CYF have agreed to work together where appropriate in the care planning around the pregnancy, birth and discharge. *See MOU August 2011 on Family Violence Intranet Site).*

CYF acknowledge the need to work collaboratively with parents, whanau, professional and lead maternity carers as early on in pregnancy as possible. A family group conference may be called to plan care following birth. http://www.paracticecentre.cyf.govt.nz

4.3 Te Aka Ora Advisory Forum

Te Aka Ora provides multi-disciplinary advice and support to clinicians providing care for vulnerable pregnant or postpartum wahine/women up to six weeks post delivery.

Referral to Te Aka Ora Advisory Forum

Any pregnant or postpartum wahine/woman (up to 6 weeks) who is currently a client of WDHB or resides in the WDHB geographical area or has an LMC who is a WDHB Maternity Access Holder can be referred (*See Te Aka Ora Advisory Forum Terms of Reference Classification: 0125-20-003 May 2012).*

The below criteria should trigger consideration for referral however other concerns may be relevant and clinicians are advised to seek advice if they are unsure. Criteria below includes current and/or past concerns:

- CYF involvement of either parent or partner
- Family violence concerns
- Drug and alcohol concerns
- Criminality or offending behaviour concerns
- Mental health concerns
- Self-harm
- Cognitive or developmental impairment
- Concerns parenting ability or life skills
- Concealed/unwanted pregnancy

- Attachment concerns
- Transient lifestyle
- Teenage parents
- Poor engagement with maternity care

5. Organisational Responsibilities

Executive Responsibilities

The Waitemata District Health Board (WDHB) is responsible for ensuring it has an organisation-wide policy for the management of child abuse and neglect, regular training for staff, processes to ensure the policy is adhered to, such as clinical audit, and adequate support and supervision for staff. These activities need to be properly resourced and evaluated.

Unit Responsibilities

All units who provide care for women, children and youth will have unit level child protection policies/procedures based on this policy.

Employee Responsibilities

All employees of WDHB have responsibility for the management of suspected family violence and child abuse and neglect. Responsibilities are:

- To be conversant with WDHB policy.
- To understand the processes for referral and management of suspected abuse and neglect.
- To take action when child abuse is suspected or identified.
- To attend WDHB child protection training and regular updates appropriate to their area of work. It is a requirement that clinical staff (including allied health) in children's services and emergency care to attend WDHB child protection training. Training will take place in a variety of settings e.g. WDHB Learning and Development, staff meetings, study days/workshops. Leadership training is provided to key nominated staff in some services, with an emphasis on staff support.
- To provide or access WDHB Specialist Health Services that may include:
  - Cultural assessments.
  - Mental Health assessments.
  - Diagnostic medical assessments.
  - Social work services, counselling and therapy resources.
  - Paediatric assessment.

Human Resource Responsibilities

WDHB recruitment policies will reflect a commitment to child protection by including comprehensive vetting and screening procedures. Where suspicion exists of child abuse perpetrated by an employee or volunteer in the organisation, the matter will be investigated and if upheld, the matter dealt with in accordance with the Discipline and Dismissal policy. If a student is involved, this matter would be referred back to the tertiary institute where the student is studying. Police action may follow as appropriate.

Child Protection Coordinator Responsibilities

- To ensure that there are effective and clear policies and procedures across WDHB services in identifying and managing child protection concerns.
- To develop training plans and ensure provision of training in child abuse and neglect is available.
- To facilitate effective communication between WDHB internal services and external agencies, including with Child Youth and Family Services (CYF), in regards to child protection issues.

- To be available to staff for consultation regarding child protection concerns.
- To ensure staff are supported to achieve a high standard of assessment, documentation and communication in child protection.
- To coordinate the National Child Protection Alert System within WDHB.
- To ensure that the Child Protection programme is evaluated regularly (including training of staff, case management processes, community and client satisfaction, documentation, and staff confidence and attitudes), and that evaluation recommendations are acted on**.** The programme will be audited and reported on as required by the Ministry of Health. Feedback will be provided to managers and relevant staff and an analysis of results reported annually to the Executive Leadership Team (ELT).

6. Legal Framework

6.1 Amendment to the Crimes Act

Legal duties to protect children and vulnerable adults from ill treatment or neglect.
Under the Crimes Act WDHB staff may, in some circumstances, be under a legal duty to take steps to protect children from ill treatment or neglect. The duty applies to children up to the age of 18. A vulnerable adult is a person who is unable to withdraw himself or herself from the care of another, by reason of:

- Detention
- Age
- Sickness
- Mental impairment
- Any other cause.

Section 151 provides that anyone who has actual care or charge of a child or vulnerable adult is under a duty to provide them with necessaries *and* to take reasonable steps to protect them from injury.

Section 152 provides that a parent, or anyone acting in the place of a parent, who has actual care or charge of a child is under a duty to provide the child with necessaries *and* to take reasonable steps to protect them from injury.

Under Section 195 anyone who has care or charge of a child or vulnerable adult or is a staff member of a hospital, institution or residence where a child or vulnerable adult resides may be criminally liable if their conduct is likely to cause suffering, injury, adverse effect to health or any mental disorder or disability to the child or vulnerable adult.

Section 195A specifies that a person who is a member of the same household as a child or vulnerable adult or a staff member of a hospital, institution or residence where a child or vulnerable adult resides *and*

- has frequent contact with the child or vulnerable adult *and*
- knows the child or vulnerable adult is at risk of death, grievous bodily harm or sexual assault as the result of an unlawful act by another person or an omission by that person to perform a legal *and*
- fails to take reasonable steps to protect the child or vulnerable adult from that risk may be criminally liable.

Criminal liability will only arise if the failure to protect is a major departure from the standard of care expected of a reasonable person to whom the duties under section 151, 195 and 195A apply.

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7. Procedure for the Management of Child Protection Concerns

All situations where recent or ongoing child abuse and/or neglect is disclosed, detected or suspected must be acted on and reported using the following procedure. Unit level procedures will detail specific actions. *Also refer to Child Protection Flow Chart p21.*

7.1 STEP ONE: IDENTIFY

Child abuse and neglect may be identified a number of ways:

- Disclosure (by a child, young person or adult)
- Recognition of signs and symptoms.
- * Recognition of risk indicators. *Refer to Child Protection Concerns for the Unborn' p4 and 'Risk Assessment' p9*.

* The presences of risk factors does not mean abuse/neglect has occurred, but it increases the likelihood of abuse/neglect occurring. The identification of risk is therefore an important aspect of identifying child protection concerns.

There are times where the type of abuse (physical, sexual, emotional/psychological, neglect) can be ascertained, however, often child protection concerns are identified through physical, behavioural or emotional signs, body language and interaction, or disclosure. The signs, symptoms, and history described below are not diagnostic of abuse/neglect. However, in certain situations, contexts and combinations they will raise suspicion of abuse/neglect. It is better to refer/consult on suspicion. If you wait for proof, serious harm could occur.

History

• History inconsistent with the injury presented • Past history of family violence or child abuse • Exposure to family violence, pornography, alcohol or drug abuse. • Isolation and lack of support • Mental illness, including post-natal depression. • Inappropriate or inconsistent discipline (especially thrashings or any physical punishment of babies). • Disclosure by the caregiver of excessive physical force, including shaking a baby/child.	• Delay in seeking help. • Disclosure by the child. • Severe social stress. • Parent/s abused as child/children. • Unrealistic expectations of child. • Terrorising, humiliating, or oppressing. • Promoting excessive dependency in the child. • Actively avoiding seeking care or shopping around for care. • Frequent changes of address (transience). • Neglecting the child.

Physical signs

• Multiple injuries, especially of different ages: bruises, welts, cuts, abrasions. • Scalds and burns, especially in unusual distributions such as glove and sock patterns. • Pregnancy. • Genital injuries. • Sexually transmitted diseases. • Patterned bruising.	• Unexplained failure to thrive (FTT). • Poor hygiene. • Dehydration or malnutrition. • Fractures, especially in infants or in specific patterns. • Poisoning, especially if recurrent. • Apnoeic spells. Especially if recurrent. • Intoxication

Behavioural, emotional and developmental signs

• Aggression. • Anxiety and regression. • Depressive symptoms. • Obsessions. • Overly responsible behaviour. • Frozen watchfulness. • Sexualised behaviour. • Fear. • Sadness. • Changes in mood, behaviour, eating patterns. • Cruelty to animals.	• Defiance. • Self-harm • Suicidal thoughts/plans. • Withdrawal from family. • Substance abuse. • Overall developmental delay, especially if also failure to thrive. • Patchy or specific delay: Motor, emotional, speech and language, social, cognitive, vision and hearing. • Family Violence

From: 'Family Violence Intervention Guidelines. Child and Partner Abuse', Ministry of Health, 2002, p56.

Alcohol consumption

If a child or young person presents to WDHB intoxicated to the degree that hospital treatment is required, consider a referral to CYF, particularly for minors who present to the Emergency Department repeatedly for alcohol related issues.

Consider if the police also need to be contacted. The Sale and Supply of Alcohol Act 2012 makes it an offence to supply alcohol to minors (under 18 years) unless the person supplying:

- Is the parent/guardian of the minor and supplies the alcohol in a responsible manner
- Believes on reasonable grounds the minor is not a minor
- Believes on reasonable grounds that s/he has the express consent of the parent/guardian and supplies the alcohol in a responsible manner.

7.2 STEP TWO: SUPPORT AND EMPOWER VICTIMS OF ABUSE

- Offer cultural support where possible. To access support for Maori contact He Kamaka Waiora (WDHB and ADHB Maori Health) **x2324**. Support is also available through WDHB Asian Health and Pacific Health Services, as appropriate. Ensure the cultural support offered is safe and appropriate for the client. (NB. Ensure the client does not have a personal/family connection with the support being offered which may place the client in an unsafe situation).
- For mental health concerns consult with appropriate child adolescent and/or adult mental health services.
- Enlist WDHB Social Work Support in services where applicable.
- Always use interpreter services through WATIS Interpreting and Translation Service (through Asian Health) when required. **Do not** use a family member for interpretation. Translation services will provide gender and age appropriate translators as required.
- After hours support is service specific – *refer to service level protocols.*

Handling Disclosure of Abuse

Disclosures of abuse may be made by the victim or another person, such as a sibling, parent/caregiver.

- If a child/young person discloses abuse, listen. Tell them that no one deserves to be hurt and that is was not their fault.
- Do not over-react. Let them know you're glad they told you.
- **Ensure the child's immediate safety.** Try not to alert the alleged abuser. Seek advice and support.

- **Do not** ask investigative or leading questions (as this can contaminate evidence), but **assess safety** by asking open ended questions, such as "Who did this?", "When did this happen?", "Where did this happen?"
- Discuss confidentiality and its exclusions and that you will need to seek help for them and their family/caregivers.

Communication with victim's parents/caregivers

Communicate with victim's parents/caregivers only when safe to do so. If the decision is to discuss concerns or child protective actions with a victim's parents or caregiver, the delegated staff person must understand and acknowledge the sensitivity of the situation. Consult first with senior staff or social worker within your service, or with the duty social worker at Child, Youth, and Family (CYF). ***Do Not*** discuss concerns or child protective actions to be taken with a victims' parents or caregivers under the following conditions:

- It will place either the child or you, the health care provider, in danger
- Where the family may close ranks and reduce the possibility of being able to help a child
- If the family may seek to avoid child protection agency staff.

Consultation

Consultation must occur at least once and in a timely manner, with the safety of the child, and any other person, as the paramount consideration. If urgent action is required, and senior staff in your service are not available to consult with, phone CYF immediately for advice. There must be consultation in regards to any physical examination that may be required. *(Repeated questioning and examination can further traumatise the child and contaminate evidence and needs careful consideration).*

The following staff are available within WDHB for consultation:

- An experienced/senior colleague /Paediatricians
- Social workers (Hospital and Community)
- Team Leaders/Charge Nurses/Professional Advisors
- Child Protection Coordinator

The following external services are available for consultation:

- Te **Puaruruhau (Starship Specialist Unit).** The team offers a 24-hour urgent medical service for acute abuse cases, and carries out medical, nursing and social work assessments for alleged physical or sexual abuse or neglect. *Contact Details:* Phone (09)3072860 / (09)3074949 x6584 / 021 492365. *Out of hours:* Auckland Hospital Operator (64 9) 3074949, ask for the child abuse Paediatrician on call.
- **Child**, **Youth and Family:** 0508 FAMILY (326 459**): 24 hour support** *(after hours for emergency only).***CYF/WDHB Hospital Liaison Social Worker:** (x7635 / 029 650 1337)

7.3 STEP THREE: ASSESS RISK

National Medical Warnings and Local Child Protection Alerts

WDHB has signed up to the National Child Protection Alert System (CPAS). This will be implemented in WDHB in May 2014. *(See Child Protection Alert Management Policy March 2014)*

As part of completing a thorough assessment of the presenting child/patient National Medical Warnings and local PiMs alerts should be viewed at each presentation. An alert may be present antenally (on the pregnant women's NHI) or on the child's NHI.

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These alerts sit on the front page of Concerto. For services who do not use Concerto (i.e. Mental Health and CADS who use HCC and Maternity who use Healthware), alerts will need to be checked in Concerto. Where a Child Protection Alert exists, if there is a phone number provided from the DHB who placed the alert, this number must be phoned and the child protection information accessed.

The alert is there to inform you that care and protection concerns have previously existed for the child, so that when assessing the child at this presentation, you can be alert to indicators of current abuse. It prompts a thorough assessment and social history.

A Child Protection Alert is a reminder to take a thorough assessment. It is important to note that:

- No alert *does not* mean no abuse
- An alert *does not* mean the child is currently unsafe / at risk

Risk Indicators

What is happening in the environment around the child?

- Any history of previous abuse or suspected abuse
- Family violence
- Parent indifferent/intolerant/overly views the child as troublesome
- Severe social stress
- Severe isolation and lack of support
- Parents abused as children
- Alcohol or drug abuse
- Mental illness including post natal depression
- Parent very young
- Frequent changes of address, more than 2 over last year
- At risk family actively avoids contact with health care providers or family support agencies

What is happening to the child?

- Screen all episodes of care. Identify current or previous contact with WDHB services.
- Nature of abuse neglect or risk.
- Details of: how, what, where, when, who saw it happen.
- What is the trend? (Increasing, decreasing, static).
- Assess safety of siblings within the household.
- Are adequate protectors available (e.g. an adult who will keep the child safe; family and/or other support people involved with child?)
- What is the child's ability to protect him/herself?
- What access does the perpetrator have to child?
- Identify other agencies involved with the family.

Red Flags

- Uncorroborated history / A discrepancy between the history and injury
- Varying/changing history
- History of repeated trauma
- Delay in seeking medical advice
- Inappropriate parental response
- Sudden change in child's behaviour
- Unusual child/parent interaction
- Physical injuries on both sides of the body

Consider:

- Risk of self-harm or suicide.
- Co-occurrence of partner abuse. If child abuse is suspected assess the parent/caregiver for partner abuse. Do not ask about partner abuse if another adult or child aged over two years is present. *(Refer to Family Violence/Partner Abuse Screening Policy (Jan 2014). This includes asking appropriate questions, risk assessment and referral pathways*
- Developmental age of the child.

Search for episodes of care/Review medical records.

Where there are any concerns regarding actual or suspected abuse/neglect all available information should be accessed. Track health records for location of relevant information. Request notes from Clinical Records Department for inpatient files and from relevant community or mental health services.

Injury Assessment

All child injuries must be appropriately assessed. A child who presents with an injury must be referred to their GP, WDHB Emergency Department (ED) or direct to Te Puaruruhau (Starship Children's Hospital). *Refer to Appendix 6 for guidelines for assessing injury. If the child is referred to WDHB ED an injury assessment will be carried out by medical staff and further referrals will be made where required.*

Guideline for referral

For minor injuries refer to GP or WDHB ED
For significant injuries refer to WDHB ED in the first instance.
For immediate and serious injuries refer direct to Starship (which can also be carried out via WDHB ED if appropriate to do so). Ensure safe transportation (e.g. use an ambulance)

Minor Injuries	Injuries which have caused minimal harm/trauma **(Do not affect function.)**
Significant Injuries	Injuries which have cause harm/trauma and medical assessment is required, but not urgently. **(Function is affected such as not being able to walk or play.)**
Immediate/Serious Injuries	Injuries which require urgent medical assessment or the harm-trauma is at a high level**. (Function is severely affected, or potentially life threatening.)**

Emergency Department responsibility

Emergency Department will complete a paediatric injury assessment and follow consultation and referral processes.

Non Accidental-Injuries

For known or suspected non-accidental injuries (NAIs) all appropriate referrals must be made (e.g. to Te Puaruruhau/Starship, Police and CYF). *Refer to detailed section "Safety Planning/Intervention", p12).* **The CYF/WDHB Hospital Liaison Social Worker must also be informed (x7635 / 029 650 1337).**

7.4 STEP FOUR: SAFETY PLANNING / INTERVENTION

Refer detailed section 'Supervision of Child at Risk - Inpatient' p23

When a child presents to WDHB with known or suspected abuse

- Staff must instigate care and protection processes if there are high concerns about child's safety.

- Continue assessment and multidisciplinary consultation.
- Ensure safety planning includes collaboration with relevant primary health care providers, including the child's General Practitioner or Well-Child Provider.
- Ensure collaborative practice is carried out according to the Memorandum of Understanding (MOU) (August 2011) with WDHB, New Zealand Police and CYF (*See Family Violence Intranet Site).*
- MOU Parties (WDHB, CYF and Police where relevant) must ensure that timely medical examinations are carried out where injuries to a child have been identified, by appropriate medical services/staff. Referrals to Starship Children's Hospital and/ or DSAC (Doctors for Sexual Abuse Care) must be made for all cases where the injury and/or how it occurred raises concern.
- Social admissions must be in agreement with service management and in liaison with CYF and Police where relevant. It is to be a temporary plan only while a safety plan is devised.

CYF, Police and Trespass orders

- CYF or the Police can obtain a warrant to keep a child safe if required. This means the child must remain in a named safe location and only persons named by the CYF Key Worker or police may visit the child.
  - A 'Section 39 Place of Safety Warrant' (which is a CYF application), can take anything up to 4hrs and CYF will require supporting documentation from hospital staff. *(NB. So while it is urgent it is not immediate).*
  - CYF social workers can also make an application for a 'Section 78 Interim Custody Order' which can take longer. Therefore, risk assessment carried out with hospital staff is critical.
  - The police can uplift a child/young person under 'Section 42' which does not require permission from the Court. However, the police are required within 3 days to furnish a report to the Commissioner of Police on the exercise of that power and the circumstances in which it came to be exercised.
- Trespass Orders may be issued if high concerns regarding child safety exist. These are instigated by contacting security.

Referring to the Police/CYF/Te Puaruruhau

Keep child safe and report to Police if:

- The child has been severely abused or neglected (e.g. abuse which has caused significant or serious harm or trauma / Function is severely affected, or potentially life threatening.)
- Known or suspected non-accidental injury.
- The child has been sexually abused.
- There is immediate danger of death or harm.
- Abuse has occurred and is likely to escalate or recur.
- The child/ren is/are home alone, and there are safety concerns (i.e. because of the age of the child, the ability of the child to protect him/herself, or parent cannot be located).
  ***Action**: Stay with the child/ren, call the Police and stay until the Police arrive.*
- There is immediate risk to the child, or the environment to which the child is returning is unsafe.
- Your safety is compromised

Report to CYF if the child has:

- Injuries which seems suspicious, or are clearly the result of abuse.
- There has been a disclosure of abuse by the child or another person about the child (i.e. older sibling, parent, and caregiver).
- Interaction between the child and parent or caregiver seems threatening or aggressive.

- Child states that they are fearful of parent/s, caregiver/s, or have been hurt by parent/s or caregiver/s.
- If multiple risk indicators exist (e.g. Partner abuse in the relationship, alcohol abuse or drug use by caregivers, or caregiver's avoidance of health agency contact).

See 'Procedures for Management of Child Protection Concerns: Referral' p 17 for CYF referral processes.

A child must be referred to **Te Puaruruhau: Starship Specialist Unit** in cases of serious physical/sexual abuse or neglect, or known or suspected non accidental injury. See *'Consultation, p9 for contact details. Also see appendix 5 for procedures on 'Guidelines for Responding to Child Sexual Abuse'.*

7.5 STEP FIVE: REFERRAL

Police referral

Orewa 09 42 6 4555 / North Shore 477 5000 / Waitakere 839 0600

CYF referral

1. The Report of Concern (ROC) to CYF must be by phone *and* a faxed written report, using the WDHB/CYF ROC Form. Notify CYF call centre **(0508 FAMILY / 0508 326 459)** and fax to **(09) 914 1211.** Urgent referrals must be made by a phone call in the first instance. **State to the operator that the referral is urgent.**

2. If the client is an adult or another person (e.g. a sibling), a file for the child must be opened by the referral service. All documentation regarding the referral is to be placed on the child's file.

3. Information for data collection and Child Protection Alert processes needs to be provided to the Child Protection Coordinator. Fax a copy of the ROC to **WDHB Child Protection Coordinator** on DDI: (**09) 838 1720 (external) / ext 7720 (internal)**. Ensure details of all children are provided where possible.
(See Appendix 7 for data collection and reporting protocols).

4. All referrals to CYF should be followed up by the staff member who made the referral or another appropriate person, e.g. service social worker. *(See service specific protocols for follow up and referral processes).*

There is no issue of breach of confidentiality where staff report child protection concerns 'in good faith' to police or CYF. (See Appendix 4 for legal and privacy issues).

Note: From May 2014 all children referred to CYF by WDHB will be assessed as to whether or not a national and local child protection alert will be placed. This will be through a multi-disciplinary team process and is underpinned by a WDHB Child Protection Alert Management Policy, Terms of Reference and a Memorandum of Agreement with WDHB, the Ministry of Health and Paediatric Society of New Zealand. **The completed CYF ROC will form the basis for the alert decision and will apply to all children, whether a client or non-client.**

Referral to Te Puaruruhau (Starship Specialist Unit)

Contact Details: Phone (09)3072860 / (09)3074949 x6584 / 021 492365
Out of hours: Auckland Hospital Operator (64 9) 3074949, ask for the child abuse Paediatrician on call.

Support services/agencies, including /Family Violence agencies

For family violence disclosures, ensure appropriate safety planning and referral, e.g. with the woman's consent liaise with Women's Refuge to ensure safety for the mother and children. When you are

concerned about a child's care, but not to the extent requiring a notification to CYF, refer to a WDHB Social Worker or appropriate community agency to enlist support. Where a parent/caregiver declines community or refuge support, and there are risks identified to the children, consider a referral to CYF.

Sexual Abuse Referral

In cases of known or suspected sexual abuse, the child should be referred directly to Te Puaruruhau (Specialist Unit at Starship Children's Hospital) by the department to which they initially present. The paediatrician on call should be contacted in cases that present after hours where the alleged sexual abuse has NOT occurred in the past 7 days for adolescents or past 3 days for pre-pubertal children. The department to which the patient presents must ensure that a referral to CYF, and police where necessary, is completed.

There must be consultation (e.g. with senior colleague / WDHB Paediatrician / Te Puaruruhau clinician) in regards to any physical examination that may be required following the identification or disclosure of sexual abuse. Medical/ DSAC examinations will occur at Starship Hospital at a time arranged by Te Puaruruhau staff. S*ee appendix 5 for procedure on 'Guidelines for Responding to Child Sexual Abuse'.*

Discharge Planning

Discharge planning with key internal and external people is vital in ensuring the safety of the child. Where appropriate, involve the following key people:

- CYF & police
- Clinical staff/service social worker
- Child's General Practitioner (GP) / Well-Child Provider
- Discharge agency e.g. women's refuge

A letter or report must be provided to the child's GP outlining the child protection concerns and actions taken. *See service specific protocols.*

Note: For all cases where a CYF referral is required or CYF are involved, use the 'Child Protection: Discharge Safety Checklist' prior to discharge.

7.6 STEP SIX: DOCUMENTATION

Document all observations, process and assessment thoroughly.

In all cases accurate informative documentation is essential and must be recorded in the Health Record with time, date, legible signature and designation. Document facts and observations as soon as possible after the event or discussion.

- Record only facts and/or observations.
- Clearly differentiate between what was seen and heard and what was reported or suspected and by whom.
- Detail who was present at the time.
- Record date and time.
- Where there has been a disclosure, write what was said in quotation marks (verbatim).
- A 'Child's Body Diagram'can be used to record bruises, cuts and other injuries.
- Use the 'Child Protection: Discharge Safety Checklist' prior to discharge *(see above – 'Discharge Planning' p14).*
- When a referral has been made to CYF, the Report of Concern (ROC) must be placed in the child's clinical record. Where the patient/client is an adult or another person (e.g. a parent or sibling), a file for the child must be opened by the referral service where possible *(see service level protocols).*

- If the referral is for an unborn child the ROC remains on the patient/client's file. Once the baby is born the ROC will be cross-referenced to a file for the baby where applicable.

Child Protection Alert

Service level: Activate Service Child Protection Alert if Police and/or CYF notification has been made**.** *Refer to service specific protocols.*

National level: Ensure the process for consideration of a National Medical Warning and local PiMs alert has been actioned (as of May 2014), according to section 7.5 as follows:

Ensure the completed CYF Report of Concern has been provided to the WDHB Child Protection Coordinator. NB. This also includes referrals for the unborn child.

7.7 STAFF SUPPORT AND SAFETY

Child protection is a sensitive area of work. Therefore, staff need to be aware of the supports available (e.g. EAP, supervision). Managers and clinical leaders should be particularly alert to the needs of their staff.

In any case where staff have been involved in the reporting and/or management of abuse or neglect they should seek debriefing, supervision or counselling from an appropriate person. Staff may access Employee Assistance Programme (EAP), which provides a confidential counselling service for all WDHB staff (ph 09 358 2110). Staff can self refer, which does not require management approval. At the staff member's request, a referral can also be made via service management. WDHB provides this service to staff for an initial three sessions. After this, extra sessions need to be accessed via EAP Services to the manager of Occupational Health & Safety.

This also relates to staff experiencing abuse personally (e.g. at home or in the workplace), are affected by past abuse, or are perpetrators of abuse.

Refer to service specific protocols for supervision and debriefing processes.

8. Supervision of a Child at Risk – In-patient

- If the child is an inpatient WDHB is responsible for keeping the child safe. Under the general law if we are aware that a child is at risk of abuse, we are under a duty of care to take reasonable steps to ensure that the child is protected from that risk.
- Once CYF is notified then responsibility for the child's safety is shared between WDHB and CYF. There must be a clear and written agreement between WDHB and CYF as to who is responsible for what in terms of ensuring the child's safety. This agreement must be placed in the child's file.
- The level of supervision required to keep the child safe will be decided following a comprehensive risk assessment which should be completed at the earliest opportunity. *(It is recommended that this is carried out with or by the service social worker if applicable– See service specific protocols).*
- The final decision about the level of supervision required will be decided in consultation between Clinical Charge Nurse (out of hours- Duty Manager), the Paediatrician on call and CYF.
- If a watch is the only/best way of ensuring a child's safety, and CYF has not agreed to pay for a watch, then we are obliged to continue paying for the watch for as long as it is needed (and for continuing to work with CYF to share the responsibility with us).

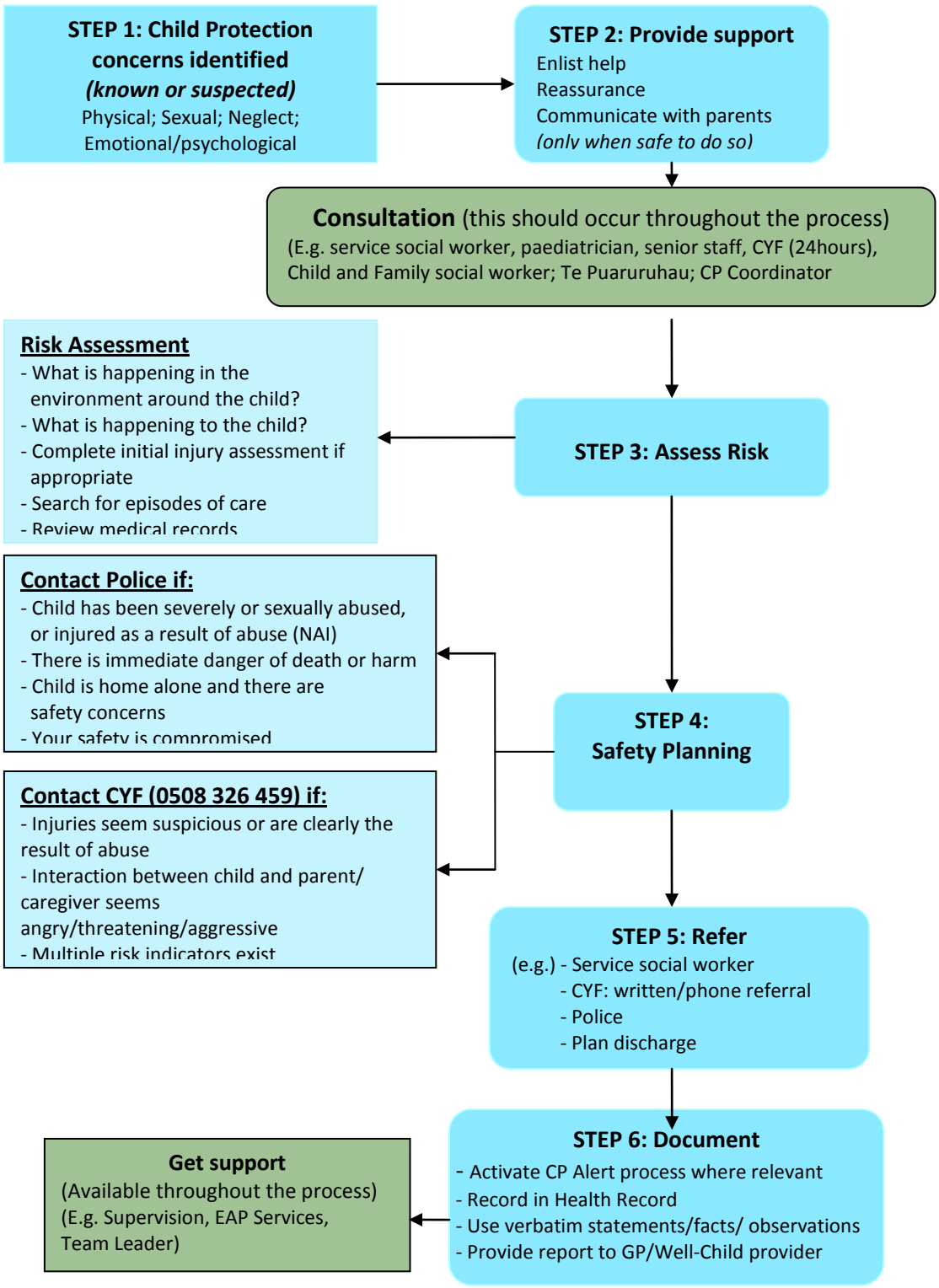
Child Protection

- Security can be called to assist as required when concerns regarding child safety are identified. **For emergency response from Security ring extn: 777. If potentially violent or violent situation call CODE ORANGE extn: 777.**
- Access to the inpatient units Rangatira / SCBU / Wilson Centre is limited at all times through locked doors except during visiting hours. Following the risk assessment staff may further limit access throughout the visiting period if required. *Refer to service protocols.*
- Supervision options for a child with care and protection concerns:
  - Place the child in a site visible to staff.
  - Designated visitors only.
  - Ban all visitors (consider the impact on the child when making this decision).

Refer to Appendix 3 for 'Table 1: Supervision options for a child admitted with actual or suspected child abuse'.

Child Protection

9. Child Protection Flow Chart



Child Protection

10. Death of a Child and Sibling Assessment

In the event that a child is brought into WDHB and is deceased on arrival or the child dies while in WDHB and the cause of death is suspicious, then an assessment of the safety of any siblings should be urgently undertaken. A referral to Police and/or CYF should be made for siblings assessed as being at risk.

See p 12 'Safety Planning/ Intervention' for CYF referral processes.

11. Family Safety and Security Processes

In high risk cases it may be necessary to suppress patient details and or provide secure processes at the time of discharge. Security processes and name suppression must be in consultation with service management.

<u>The following are guidelines for safety and security processes:</u>

- It is important to ensure that anyone making public enquiries about the victim is given **no** details. **Do not** confirm that the client has been admitted / discharged or has had contact with WDHB. State clearly that under the Privacy Act you cannot provide information.
- If a notification has been made to the police or CYF, discharge plans should be arranged in consultation with the agency/case worker concerned and the parent/guardian (if appropriate), e.g. ensure the guardian speaks to the agency concerned and that all parties are in agreement with the discharge plan.
- Do not discuss with other members of the family/whanau unless they are part of discharge planning and security processes.
- The discharge plan may include leaving ED/hospital ward/or other department by a safe route, in consultation with security staff.
- Ensure safe transportation for victims and family members if needed (e.g. Use an ambulance to transfer a child to Te Puaruruhau/Starship Children's Hospital, and for transportation to a women's refuge provide a taxi chit, if no other safe option is available).
- Document the discharge plan.
- Complete an Incident Report if any unexpected outcomes occurred.
- Advise the Duty Manager / Team Leader / Manager of the discharge outcome.

Ensure security processes account for the needs of Maori.

- Consult with He Kamaka Waiora (WDHB and ADHB Maori Health) x 3553 where applicable, e.g. in regards to an appropriate and safe discharge plan.
- If referring to a Maori violence intervention service, family support agency or health service, i.e. a Maori refuge for women and children, ensure this is in consultation with the child's parent/guardian.
- Do not discuss any details with other members of the whanau unless they are part of discharge planning and security processes.

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12. Associated Documents

Type	Title/Description
Legislation	Children, Young Persons and their Families Act 1989 (CYPFS) Crimes Act 1961 Domestic Violence Act 1995 Health Act 1956 Health & Disability Sector Standards Regulations 2001 Privacy Act 1993, Health Information Privacy Code (1994)
National protocol	CYPFS & Crown Health Enterprises (1996). National Interagency Protocol, July.
WDHB Policies	Health Information/privacy – 3rd party requests. Discipline and Dismissal Policy. Corporate Emergency Procedures – general. Family Violence/Partner Abuse Screening Jan 2014. Child Protection Alert Management Policy (March 2014). Recruitment Policy (Sept 2013) – Classification No. 015-001-02-022.
National DHB Policies	Hawkes Bay District Health Board (2006). Child Abuse and Neglect Policy - Management of. Auckland District Health Board (2002) Child Abuse and Neglect, Care & Protection Policy Document. Starship Children's Health Clinical Guideline (2005). Abuse and Neglect. Hutt Valley District Health Board (2001). Child Abuse Management: Suspicion of Abuse, Non-accidental injury, or neglect.
Publication	Family Violence Intervention Guidelines: Child & Partner Abuse (MOH, 2002) CYF (2001). An Interagency Guide to Breaking the Cycle: Let's Stop Child Abuse Together.
Agreement	Memorandum of Understanding between Waitemata District Health Board, New Zealand Police and Child, Youth and Family (August 2011). National Child Protection Alert System. Memorandum of Agreement. Paediatric Society of New Zealand, Ministry of Health and Waitemata District Health Board (2012).
Other	Violence Intervention Programme (VIP) (2009) Quality Toolkit for VIP Coordinators. Violence Intervention Programme (VIP) National Training Resources 2014. Te Aka Ora Advisory Forum Terms of Reference Classification: 0125-20-003 March 2014

Child Protection

13. Appendix 1 - Terms and Definitions

Child	In this document the word child refers to child/tamariki and young person/rangatahi ages under 17 (unless married or in a civil union).
Child Protection	Means the activities carried out to ensure the safety of the child/tamariki, young person/rangatahi in cases where there is abuse or risk of abuse.
Child Abuse	Refers to the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect, or serious deprivation of any child/tamariki, young person/rangatahi (Section 14b Children, Young Persons and their Families Act 1989). This includes actual, potential and suspected abuse.
DSAC	Doctors for Sexual Abuse Care. National organisation advancing knowledge and improving medical care for those affected by sexual abuse. Only DSAC trained practitioners should perform medical examinations for child sexual assault.
Child Youth and Family (CYF)	Government agency that carries out the legislative requirements of the Children, Young Persons, and their Families Act 1989. Responsibilities are: • To investigate cases of actual and suspected child abuse and/or neglect • To complete diagnostic interviews • To complete evidential interviews in cooperation with NZ Police • To provide care and protection for children found to be in need.
NZ Police	Government agency responsible for: • Working cooperatively with Child, Youth and Family in child abuse and/or neglect protection work • Investigating cases of abuse and/or neglect where an offence has or may have been committed • Prosecuting offenders where an offence has been committed • Accepting reports of suspected abuse and or neglect and referring these to Child, Youth and Family.

Child Protection

14. Appendix 2 - Four Recognised Categories of Child Abuse

These frequently overlap in individual cases. Refer to the "Recognition of Child Abuse and Neglect" published by the Risk Management Project, Children, Young Persons and Their Families Agency 1997.

1. Physical Abuse

Child physical abuse is any act or acts that may result in inflicted injury to a child or young person. It may include, but is not restricted to:

- Bruises and welts
- Cuts and abrasions
- Fractures or sprains
- Abdominal injuries
- Head injuries
- Injuries to internal organs
- Strangulation or suffocation
- Poisoning (including intoxicating with drugs and alcohol)
- Burns or scalds
- Non organic failure to thrive
- Fabricated Or Induced Illness By Carers (formerly Munchausen Syndrome by Proxy)
- Shaking a baby or young child

2. Sexual Abuse

Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It may include, but is not restricted to:

Non-contact abuse

- Exhibitionism
- Voyeurism
- Suggestive behaviours or comments
- Exposure to pornographic material
- Inappropriate photography

Contact abuse

- Touching breasts
- Genital/anal fondling
- Masturbation
- Oral sex
- Object or finger penetration of the anus or genitalia
- Penile penetration of the anus or genitalia
- Encouraging the child or young person to perform such acts on the perpetrator
- Involvement of the child or young person in activities for the purposes of pornography or prostitution.

Child Protection

3. Emotional/Psychological Abuse

Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It may include, but is not restricted to:

- Rejection, isolation or oppression.
- Deprivation of affection or cognitive stimulation.
- Inappropriate and continued - criticism, threats, humiliation, accusations, expectations of, or towards, the child or young person.
- Exposure to family violence.
- Corruption of the child or young person through exposure to, or involvement in, illegal or anti-social activities.
- The negative impact of the mental or emotional condition of the parent or caregiver.
- The negative impact of substance abuse by anyone living in the same residence as the child or young person.

4. Neglect

Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It may include, but is not restricted to:

- **Physical neglect** - failure to provide the necessities to sustain the life or health of the child or young person.

- **Neglectful supervision** - failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm.

- **Medical neglect** - failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development.

- **Abandonment** - leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning.

- **Refusal to assume parental responsibility** - unwillingness or inability to provide appropriate care or control for a child or young person.

Child Protection

15. Appendix 3 - Supervision Options for a Child Admitted with Actual or Suspected Child Abuse

Table 1: Supervision options for a child admitted with actual or suspected child abuse

	Visits	Supervision
Child admitted to ward, with suspected Non-accidental injury (NAI): ▪ Assessment ongoing ▪ Notification to CYF ▪ Perpetrator identified/not identified.	Options include: • Place child in a site visible to staff • Designated visitors only • Visits supervised & restricted	<u>If supervision is required:</u> • By arrangement with ward staff in consultation with Clinical Charge Nurse/shift co-ordinator • Responsibility of WDHB until CYF notified, and for the first 24 hours. • Once CYF notified then responsibility for the child's safety is shared between WDHB and CYF.
Child admitted to ward, under care of CYF	The Child Protection Plan (CPP) is communicated to the inpatient Team Leader/Clinical Charge Nurse/Clinical Coordinator. Visits are in accordance with the plan.	<u>If supervision is required:</u> • By arrangement with ward staff • Responsibility of WDHB to ensure visits are supervised • Responsibility of CYF to provide supervision in accordance with CPP. • WDHB should provide supervision in the event that CYF are unable to provide supervision, or the visit should not occur.

Child Protection

16. Appendix 4 - Legal and Privacy Issues

Particularly, since the introduction of the Privacy Act 1993 and the Health Information Privacy Code (1994), agencies and individuals have become concerned about how much information can be given to statutory social workers or the Police. Both the Act and Code authorise disclosure of information necessary to prevent or lessen serious harm to any individual (but only to the extent necessary).

As well, all privacy considerations give way to certain provisions of the Children, Young Persons and their Families Act 1989. These deal with the reporting of child abuse (s15) and protection of an individual from proceedings (disciplinary, civil and criminal) when disclosing child abuse to either a CYF social worker or the Police (s16).

WDHB encourages good communication between DHB staff and CYF/police to keep children safe. Requests for information should be referred directly to unit managers, who are responsible for ensuring such requests are dealt with promptly and appropriately. Upon their request, information must be released to a CYF social worker, police officer or care and protection coordinator (s66 CYF Act) and may be released under s22C Health Act - see below). Health workers therefore, are able to (and in some instances are required to) give information to the Child, Youth and Family or the Police, both by reporting abuse or when requested by either agency.

Release of information to others, outside of these categories, does not attract the same protection. Therefore, great care is needed when dealing with requests for information from third parties (refer to privacy policies) and any such request should always be discussed with a senior colleague.

CHILDREN, YOUNG PERSONS AND THEIR FAMILIES ACT

S15 Reporting of ill treatment or neglect of child or young person

Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally, or sexually), ill-treated, abused, neglected, or deprived may report the matter to a social worker or a member of the police.

S16 Protection of person reporting ill treatment or neglect of child or young person

No civil, criminal, or disciplinary proceedings shall lie against any person in respect of the disclosure or supply, or the manner of the disclosure or supply, by that person pursuant to section 15 of this Act of information concerning a child or young person (whether or not that information also concerns any other person), unless the information was disclosed or supplied in bad faith.

S66 Government Departments may be required to supply information

(1) Every Government Department, agent, or instrument of the Crown and every statutory body shall, when required, supply to every Care and Protection Co-ordinator, CYF social worker, or member of the police such information as it has in its possession relating to any child or young person where that information is required -

(a) For the purposes of determining whether that child or young person is in need of care or protection (other than on the ground specified in section 14 (1)(e) of this Act): or

(b) For the purposes of proceedings under this part of this Act.

Child Protection

Section 66 means that where a care and protection coordinator, CYF social worker or police officer requires information about a child/young person for the purposes of determining whether the child/young person is in need of care and protection, or for proceedings under the CYF Act, WDHB staff must provide that information. A staff member may be asked to provide this information in an affidavit. WDHB recommends that the staff member seeks the support and advice of the service/unit manager, child protection coordinator and/or WDHB legal adviser.

PRIVACY ACT

Principle 11 (f) (ii)

An agency may disclose personal information if that agency believes, on reasonable grounds that the disclosure of the information is necessary to prevent or lessen a serious threat to the life or health of the individual concerned or another individual.

HEALTH INFORMATION PRIVACY CODE

Rule 11 subsection 2 (d) (ii)

An agency that holds health information must not disclose the information to a person or body or agency unless – the disclosure of that information is necessary to prevent or lessen a serious threat to the life or health of the individual concerned or another individual.

HEALTH ACT 1956

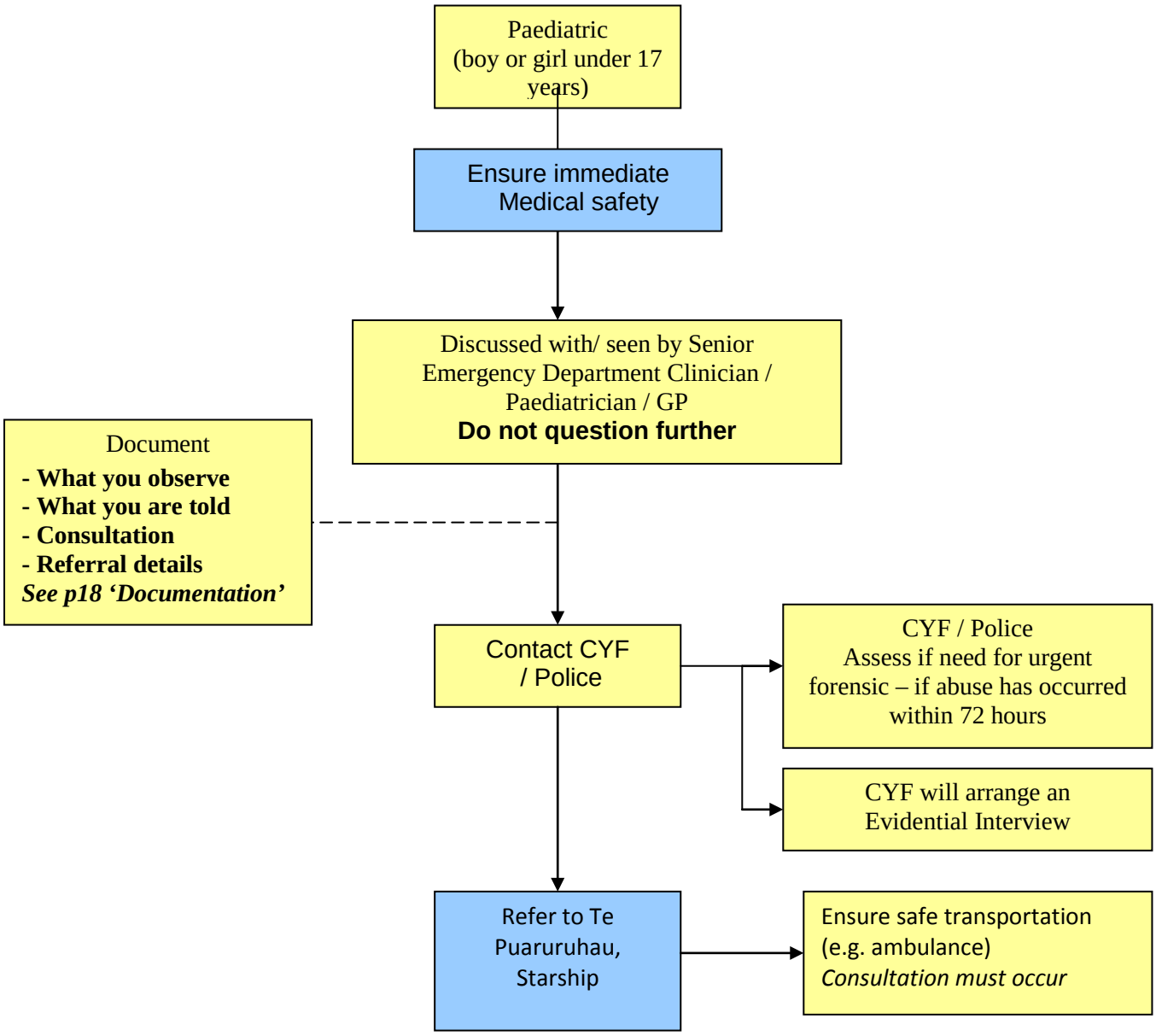
Section 22 (2) (c) Disclosure of health Information

Any person being an agency, that provides health services or disability services…may disclose health information… to a social worker or a Care and Protection Co-ordinator within the meaning of the Children Young Persons and their Families Act (1989), for the purposes of exercising or performing any of that person's powers under that Act.

See s66 above of the Children's, Young Person's and Their Families Act 1989.

Child Protection

17. Appendix 5 - Guideline for Responding to Child Sexual Abuse

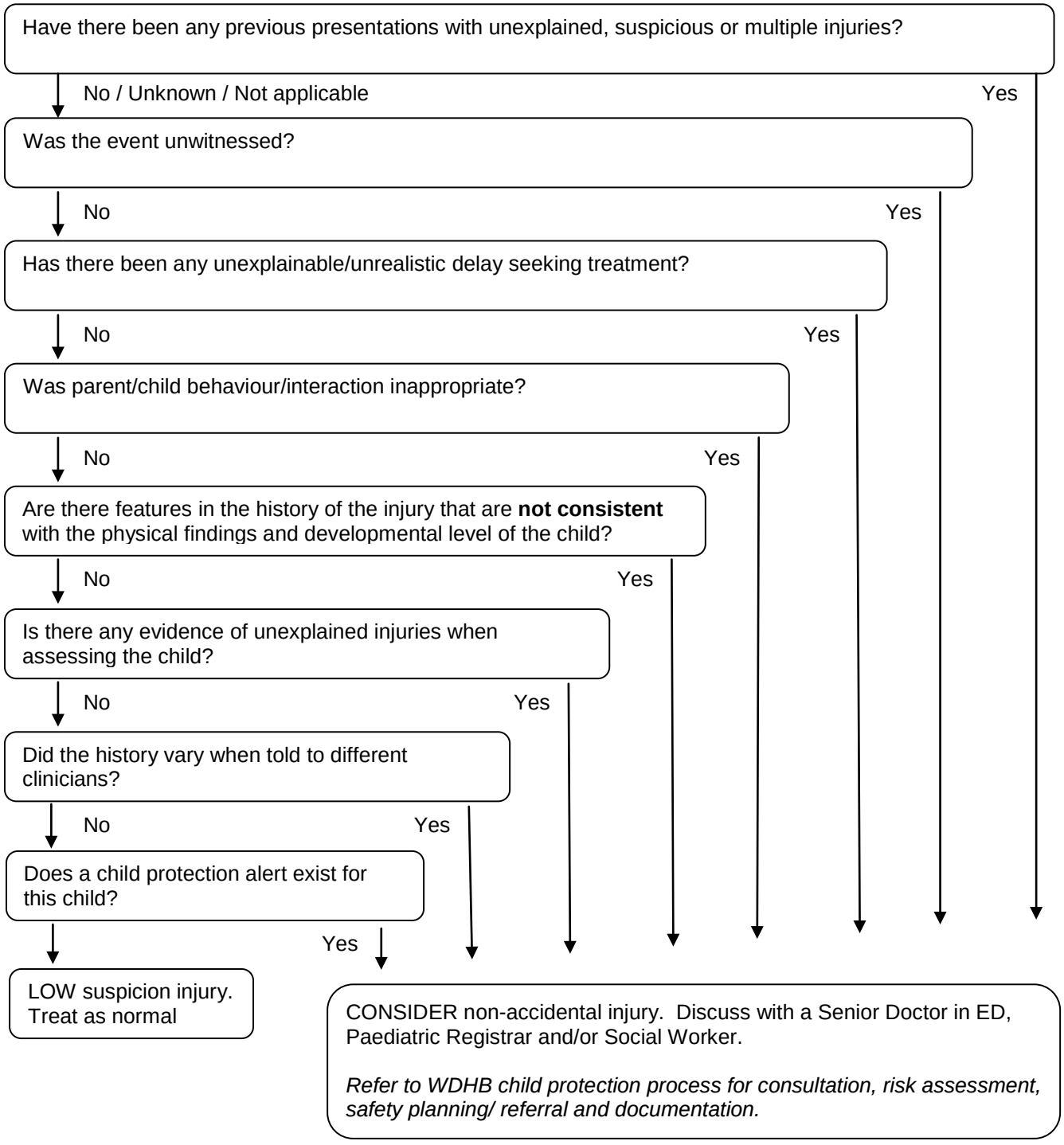


One specialist examination is enough

Assessment and examination may be required by the forensic service, and repeated questioning and examination can further traumatise the child and contaminate evidence

Child Protection

18. Appendix 6 - Paediatric Injury Assessment Flow Chart



Child Protection

19. Appendix 7 - Protocols for the Collection of CYF Referral Information

Informing the Child Protection Coordinator of referrals to CYF

- When a referral is made to CYF, the referrer must complete the last page of the CYF notification form: 'Notification to Child Protection Coordinator' and fax to the appropriate number (x4209 internal / 09 427 3509 external).
- A separate form must be completed for each child being referred, including siblings.
- Each form is to have the child's NHI number and relevant details.
- The WDHB Child Protection Coordinator will enter the referral onto PiMS using the assessment function. Date of referral; referring service (not the referrer's name); police notified (Yes/No); abuse categories and whether the referral was a result of family violence screening will be entered. There will also be limited space for comments.

Placing CYF referral information on a child's NHI

- Only authorised persons, one of which will be the Child Protection Coordinator, can place information from the 'Notification to Child Protection Coordinator' form into the PiMs assessment.

The information collected is for the purposes of:

- Identifying the number and types of CYF and police referrals that are being made from WDHB.
- Identifying child abuse and neglect trends over time, within WDHB and how this compares to the national picture.
- Identifying specific training needs (e.g. by identifying services referring to CYF, so that support and training can be put in place if necessary).
- Evaluating the effectiveness of Family Violence screening in regards to identifying child protection issues and referrals to CYF.
- Reporting to the Ministry of Health and audit requirements

The process for reporting data from the PiMS assessment

- Reports will be developed using COGNOS.

Documentation

- The form faxed to the WDHB Child Protection Coordinator will be kept in a locked file in the coordinator's office. Once this has been entered into PiMs the form will be placed in the appropriate confidential bin for shredding. The original will remain on the child's/client's file in the service the referral was made.