HUTT VALLEY DHB	**CHILD ABUSE AND NEGLECT POLICY**		Written by: Violence Intervention and Advocacy Programme Clinical Nurse Specialists	
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PURPOSE

This policy provides Hutt Valley District Health Board (DHB) community and hospital -based staff with a framework to identify and respond to actual and/or suspected child abuse and neglect. It recognises the important role and responsibility staff have in the accurate identification of suspected child abuse and/or neglect, and the early recognition of children at risk of abuse, and adults at risk of abusing children.

POLICY

Scope:

- This policy applies to all cases of actual and/or suspected abuse and neglect encountered by employees, students and people working at Hutt Valley DHB under a contract for service.
- This policy is to be read in conjunction with the Hutt Valley DHB Partner Abuse Policy
- This policy is the overarching Hutt Valley DHB Child Abuse and Neglect policy. Any additional unit level child protection procedures will be based on this policy. This policy applies to all services within Hutt Valley DHB including inpatient and outpatient services.

CYF Statutory Responsibility; CYF has statutory responsibility for the investigation of suspected or actual child abuse and/or neglect.

Principles: The rights, welfare and safety of the child/tamariki, young person/rangatahi are our first and paramount consideration.

All people have a fundamental right to be safe and free from violence.

Hutt Valley DHB should contribute to the nurturing and protection of children and advocate for them as part of their role to promote and preserve health.

Hutt Valley DHB recognizes that there is a substantial overlap between the occurrences of child abuse and partner abuse in families. Consideration will be given to the identification, support, safety and referral of adults connected with the child or young person who may be experiencing partner abuse.

Hutt Valley DHB services for the care and protection of children are built on a bicultural partnership in accordance with the Treaty of Waitangi. Māori children/tamariki, young persons/rangatahi are assessed and supported within a culturally safe environment.

Hutt Valley DHB recognises and is oriented to the specific cultural and communication needs of children, young people and families from minority cultural groups such as Pacific and other refugee and migrant populations. Children from these groups are assessed and supported within a culturally safe environment.

Hutt Valley DHB services recognise and are oriented to children and young people with specific developmental and communication needs. Children and young people from these groups are assessed and supported appropriately.

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

Hutt Valley DHB employees who work with children and young people are confident and competent to recognise and manage actual or suspected child abuse.

TERMS AND DEFINITIONS

All terms and definitions related to this document have been defined *(see Appendix 1: Terms and Definitions).*

ORGANISATIONAL RESPONSIBILITIES

Executive Responsibilities

The Hutt Valley DHB is responsible for: ensuring it has an organisational wide policy for the management of child abuse and neglect, processes to ensure the policy is followed such as clinical audit, appropriate support, supervision and mandated training for responding to child and partner abuse. This training will be initially implemented in a staged approach based on priority in the following designated departments: Emergency, Maternity, Paediatric, Neonatal and Mental Health Services. A training plan is being developed.
For departments receiving mandatory training later in the roll-out there will be learning opportunities about the Violence Intervention Programme and family violence will be profiled as a legitimate health issue.
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Unit Responsibilities

All units including outpatient departments, where children and young people are cared for will adhere to this policy. Any additional unit level child protection procedures will be based on this overarching policy.

Employee Responsibilities

All employees of Hutt Valley DHB have responsibility for the management of actual, and/or suspected child abuse and neglect. Responsibilities include:

- To be conversant with Hutt Valley DHB Child Abuse and Neglect Policy.
- To take action to protect a child or young person when abuse and/or neglect is suspected or identified.
- To attend mandatory Family Violence: Child and Partner Abuse training and regular updates appropriate to their area of work.
- To routinely screen all women over 16 years old for Partner Abuse who attend Hutt Valley DHB as the main care-giver with a child.
- To consult and seek expert advice when responding to actual or suspected child abuse. Advice required may include:

    - Cultural assessments.
    - Mental Health assessments.
    - Diagnostic medical assessments.
    - Social work services, counseling and therapy resources.
    - Paediatric assessment.
    - Plastics assessment.
    - Orthopaedic assessment.
    - Violence Intervention Programme (VIP) Clinical Nurse Specialists

This includes situations where child abuse is disclosed but the child may not be present.

Human Resource Responsibilities

Hutt Valley DHB recruitment policies will reflect a commitment to child protection by including a pre employment police check.

Where suspicion exists of child abuse perpetrated by an employee or volunteer in the organisation, the matter will be dealt with in accordance with the Discipline Procedure and the Protected Disclosures (Whistleblowers) Policy, both found in the Personnel Manual and HR Policies on the intranet.

Hutt Valley DHB provides an Employee Assistance Programme 0800 327 669 (0800 EAP NOW) for staff who may be affected by family violence.

Violence Intervention Programme (VIP) Clinical Nurse Specialist (CNS) Responsibilities

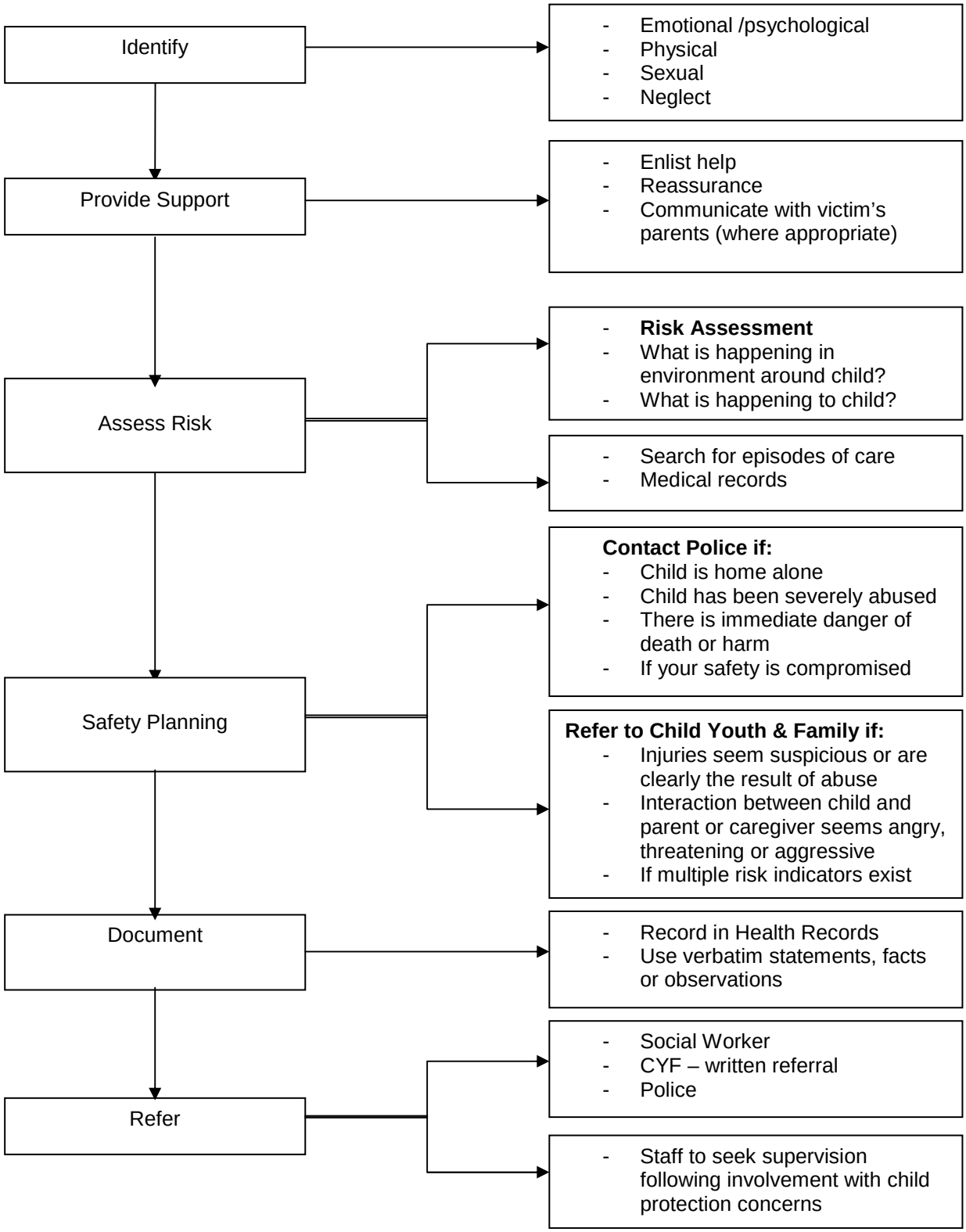
The responsibilities of the VIP CNS include but are not limited to:

- To implement the Child Abuse and Neglect Policy and review compliance to this policy.
- To undertake regular clinical audits to review clinical practice and review outcomes for families experiencing violence.
- Facilitate training in Family Violence: Child and Partner Abuse.
- To be available to staff for consultation and support regarding child protection concerns.
- To facilitate regular communication with child protective services, such as Child Youth and Family (CYF), NZ Police, Women's Refuge and Family Violence Intervention Service and social support services for families.
- To implement the Hutt Valley DHB routine partner abuse screening programme for all women aged 16 years and older.

PROCEDURE FOR RESPONDING TO ACTUAL OR SUSPECTED ABUSE

All situations where child abuse and/or neglect is disclosed, identified or suspected must be acted on and reported using the following procedure (flowchart). This flowchart outlines the standard six step process for assessment and response. (Developed by the Family Violence Intervention Guidelines: Child and Partner Abuse, Ministry of Health 2002)

Procedure for Responding to Actual or Suspected Abuse



CONSULTATION

Should occur at **least** once during this process

Seek expert advice early.

Consultation should occur at <u>least</u> once with one or more of the following staff:

- An experienced colleague
- Paediatrician
- Violence Intervention Programme Clinical Nurse Specialists
- CYF Hospital Liaison
- Hutt Valley DHB Social Worker

Procedure for Responding to Actual or Suspected Abuse (as per flowchart above):

1. Identify

Either by disclosure or recognition of signs and symptoms of abuse and/or neglect. Always consult if the possibility exists. (*Refer to Appendix 2 "Four Recognised Categories of Child Abuse")* Review previous episodes of care including outpatient visits.

2. Support

- Provide emotional support for identified or suspected victim/s.
- Enlist Social Work support in areas where a Social Worker is employed.
- For Māori children/tamariki, young persons/rangatahi and whanau, offer support from the Māori Health Unit during office hours. Referrals should always be made to the Maori Health Unit at the earliest opportunity.
- For Pacific children, young persons and family, offer support from the Pacific Health Unit during office hours. Referrals should always be made to the Pacific Health Unit at the earliest opportunity.
- It is important that this does not delay any referral to Child, Youth and Family (CYF).
- An interpreter should be used whenever a lack of ability in the English language could restrict understanding of a person's rights, needs and obligations. Refer to Interpreting Service Policy under General Policy Manual or the intranet.

3. Assess Risk

Risk assessment ascertains the level of risk to the health and safety of the child, young person and family. If child abuse is identified or suspected it is necessary to conduct a risk assessment. Seek information about the child/young person's current injuries, medical history, social, family and home situation as appropriate.

For information on **High Risk Indicators associated with child abuse**, *see appendix 3.*

For information on **Signs and symptoms associated with child abuse and neglect,** *see appendix 4*

Immediate protection of the child or young person is required if:

- Child or young person has been severely abused.
- There is immediate danger or risk of harm for the child or young person.
- Abuse has occurred and is likely to recur or escalate. For example - Has the physical violence increased in severity? Threats of homicide? Threats of suicide? Alcohol or substance abuse?
- There is immediate risk to the child or young person, or the environment to which the child or young person is returning is unsafe. For example - Is there a gun in the house? Is the client afraid to go home?

Refer to Child, Youth and Family if:

- Suspected or actual child abuse and neglect
- Interaction between the child or young person and parent or caregiver seems threatening or aggressive
- The child or young person states that they are fearful of parent/s, caregiver/s, or have been hurt by parent/s or caregiver/s
- Multiple risk indicators exist, e.g. partner abuse in the relationship, alcohol/drug use by caregivers and caregiver's avoidance of health agency contact.

Identify abuse by asking open ended questions. An example could be: "tell me more about the incident" Listen and document as appropriate what the child or young person has to say.
Avoid using closed questions when assessing the child or young person. CYF and NZ Police have a statutory responsibility for the investigation of suspected or actual child abuse and/or neglect.

The child or young person may be feeling intense emotions such as anger, guilt or distress. Conduct a risk assessment for self harm or suicide. Involve the Mental Health Service as indicated. If the child or young person is under the care of Infant Child and Family Service (ICAFS), consult with ICAFS at the earliest opportunity.

Seek expert advice early.

4. Safety Planning/Intervention

A: When a child presents to the DHB with suspected abuse or confirmed abuse and the perpetrator is unknown

When abuse is suspected or identified, a CYF Report of Concern must be made to CYF at the earliest opportunity (See 4.C below for process).

- The Hutt Valley DHB is responsible for keeping the child/ young person safe in hospital. Once CYF is notified then responsibility for the child's safety is shared between HVDHB and CYF (*See: Schedule 1, MOU between NZ Police, CYF and DHB's, 2011).*
- The level of supervision required to keep the child safe in hospital will be decided following a comprehensive risk assessment by the Paediatric team, which will address the child's/young person's immediate safety needs. This may include the risk of suicide or self harm.
- The final decision about the level of supervision required in hospital will be decided in consultation between Clinical Nurse Manager or After Hours Duty Nurse Manager, the Paediatrician on call and the CYF Key Social Worker (and the local Police Child Protection Team, as necessary). Each party will identify the staff member who will be the key contact person for the other parties.
- Continuing assessment and multidisciplinary consultation is essential.
- All children admitted to hospital with suspected or confirmed abuse or neglect will have a "Multi Agency Safety Plan (MASP)" in place prior to discharge from hospital. CYF has a key responsibility for the development and implementation of this plan. This multi-disciplinary process must commence within 24 hours of the child/young person being admitted to hospital and must lead to the development of a detailed safety plan prior to the child's discharge. The plan, a copy of which should be included in the patient's clinical notes, will include:
  - Who will care for the child
  - How safety will be addressed
  - How health needs will be responded to
  - How support will be provided
  - Roles and responsibilities of professionals
  - How monitoring and review will occur.
- Security can be called to assist as required when concerns regarding safety of the child or staff are identified. **For emergency response from Security page 777.**
- Safety is paramount and supersedes other considerations where there is potential risk to the child/young person, family, staff and/or other patients in the ward. For information regarding visitor's policy see Hutt Valley DHB Visitors/Support Persons Policy on intranet.
- If visitors become verbally abusive, call security and After Hours Duty Manager at the earliest opportunity to assist. Once the situation has resolved, complete an event form to record the incident.
- CYF or the NZ Police can obtain a Place of Safety Warrant. This means the child must remain in a named safe location and only persons named by the CYF Key Social Worker may visit the child.

- Trespass Orders may also need to be issued if high concerns regarding child and young person's safety exist. These are instigated by contacting security or After Hours Duty Nurse Manager.
- Following the risk assessment, staff may limit access to the wards via lockdown arrangements. Ward Lock Down is arranged by the Clinical Nurse Manager and/or After Hours Duty Manager. Hospital Lock Down is arranged by the Service Manager or After Hours Duty Nurse Manager.
- Supervision options for a child with care and protection concerns include:
  - Place the child in a site visible to staff.
  - "Special nursing" 1:1 nursing care for the child or young person.
  - Designated visitors only. (This will be decided in conjunction with CYF). Some visits may require supervision.
  - Restrict all visitors (consider the impact on the child when making this decision).

B: Keep child safe and report to Police if:

- Child or young person has been severely abused.
- There is immediate danger of death or harm for the child or young person.
- Abuse has occurred and is likely to recur or escalate.
- The child/ren is/are home alone, 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.
- Staff safety is compromised

C: Report to Child, Youth and Family

- Phone CYF call centre first on 0508 FAMILY (0508 326 459) followed by a written report via fax or email, using the CYF Report of Concern template.
- Note that there is **no** issue of breach of confidentiality where staff report valid child protection concerns to police or CYF.
- The CYP&F Act provides specific protection from legal action to anyone reporting to CYF in good faith *(see Appendix 5: Privacy and Legal Issues)*
- In cases of sexual abuse, referral must also be made to the Paediatrician on call who will liaise with the DSAC trained doctor, who will undertake the medical internal examination as required. (*See Appendix 6: Guidelines for responding to child sexual abuse).*

D: Communicate with victim's parents/caregivers.

There must be an agreed and documented decision on who will be responsible for any communication with the family/whanau. This may vary between services and cases (see unit specific protocols). Ideally communication with family/whanau should not take place before consulting with senior staff within your practice setting such as the treating consultant, Paediatrician, hospital Social Worker, CYF Hospital Liaison with the duty Social Worker at Child, Youth and Family. **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.

Concerns or child protection actions DO NOT need to be discussed with a victim's parents or caregivers where it is believed that:

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

5. Document all observations, processes and assessment thoroughly.

In all cases accurate informative documentation is essential and must be recorded in the Clinical Record with time, date, legible signature and designation.

- Document only facts and/or observations not "feelings".

- Clearly differentiate between what was seen and heard and what was reported or suspected and by whom.
- Detail who was present at the time of the interview and examination.
- Include date and time.

- Where there has been a disclosure, write what was said in quotation marks (verbatim)
- Your notes and records could be used as evidence in court at a later date. Ensure the clinical records are kept in a secure place.
- A body diagram can be used to record bruises, cuts and other injuries. See Appendix 7
- Photographs of abuse should be ideally taken by police involved in the case. If police photography is not available and photographs of injuries are required, it is preferred the person assessing the patient takes the photo with another staff member present. Consent to take the photograph must be recorded in the clinical notes. Photos should be stored electronically inclusive of name and NHI number. Photographs can be released to the police for evidential or child protection purposes by written request to the clinician treating the case as per Hutt Valley DHB Release of Information Requested by the Police Policy.

6. Reporting or Referral

- If following a comprehensive risk assessment and appropriate consultation, abuse is identified or suspected then the child/ren should be reported to CYF and /or the Police as identified in Section 4
- Advise the Hutt Valley DHB VIP Clinical Nurse Specialists by phone or email of all Reports of Concern made to CYF
- When you are concerned about the child's care, but not to the extent requiring reporting to CYF then refer to a hospital Social Worker or appropriate community agency to enlist support for the family.

DEATH OF A CHILD/YOUNG PERSON

In the event that a child or young person is brought into the DHB and is deceased on arrival or the child or young person dies in the DHB and the cause of death is suspicious, involve NZ Police, CYF and the Paediatrician on-call who will also investigate care of other siblings. Ensure family/whanau are offered cultural support as appropriate at the earliest possible time.

FAMILY SAFETY AND SECURITY PROCESS

At times it may be necessary to suppress patient details whilst an inpatient and or provide secure processes at the time of discharge. The guidelines for use when staff assesses the safety of a victim of abuse to be high risk are outlined in Appendix 8.

STAFF SUPPORT AND SAFETY

Where a staff member has been involved in the reporting and/or management of abuse or neglect, the situation should be discussed as soon as possible with their manager. It is recommended staff seek debriefing, peer support or clinical supervision from an appropriately trained senior colleague. The Employee Assistance Programme (EAP) is a further source of support.

ATTACHMENTS

Appendix 1 Terms and Definitions
Appendix 2 Four Categories of Child Abuse
Appendix 3 High risk Indicators associated with child abuse
Appendix 4 Signs and symptoms associated with child abuse and neglect
Appendix 5 Legal and Privacy issues
Appendix 6 Guidelines for responding to Child Sexual Abuse
Appendix 7 Body diagrams documentation form for child abuse
Appendix 8 Safety and Security Guidelines
Appendix 9 CYF Report of Concern-Health Practitioners Document

REFERENCES

- *Organisation Documents:*
  - Discipline Policy
  - Event Reporting and Management Policy
  - Hutt Valley DHB Partner Abuse Policy
  - Hutt Valley DHB Elder Abuse Policy
  - Informed Consent Policy
  - Interpreting Service Policy
  - Memorandum of Understanding between NZ Police, Child Youth and Family and District Health Board. June 2011
  - Privacy of Health Information Policy
  - Protected Disclosures (Whistleblowers) Policy
  - Release of Information Requested by the Police
  - Security Policy
  - Visitors/Support Persons Policy

OTHER:

- Breaking the Cycle Interagency Protocols for Child Abuse Management. New Zealand CYPS 1996
- Breaking the Cycle An Interagency guide to Child Abuse New Zealand CYPS 1997
- Children's Commissioner. Safety of Children in Hospital. Wellington: Office of the Commissioner for Children, 2006.
- Family Violence. Guidelines for Health Sector Providers to Develop Practice Protocols. Ministry of Health 1998
- Family Violence Intervention Guidelines .Partner and Child Abuse Ministry of Health 2002

- The Risk Management Project, Children, Young Persons and Their Families Agency 1997. CYF Multi-Agency Safety Plan
- CYF Report of Concern- Health Practitioner's Document

LEGISLATION:

- Health Act (1956) and amendments
- Children's Young Persons and their Families Act (1989) (and Amendments 1994/95)
- Privacy Act (1993)
- Health Information Privacy Code (1994)
- Code of Health and Disability Services Consumers Rights (1996)
- New Zealand Bill of Rights (1990)
- Crimes Act (1961) and amendments
- Domestic Violence Act (1995)
- Guardianship Act (1968)
- Summary Offences Act (1981)
- Vulnerable Children's Act 2014

TERMS AND DEFINITIONS

Child	In this document the word child refers to child/tamariki and young person/rangatahi ages 0-16 inclusive.
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.
Physical Abuse	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
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.
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.
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.
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.
Department of Child Youth and Family Service (Child, Youth and Family)	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.
Section 39 -Place of Safety Warrants	For CYF or the Police to be able to remove, or detain a child, the authority of a Place of Safety Warrant is required in most cases. The warrant gives a social worker the power to remove or detain a child and to place them in the custody of the Chief Executive for no longer than five days. A Place of Safety Warrant can be applied for when a social worker or Police Officer is satisfied that there are reasonable grounds to suspect that a child or young person is suffering or is likely to suffer ill treatment, neglect, abuse or harm (s39.1).
Trespass Order	It is an order that stops a person from coming onto another's property or place of residence such as the hospital grounds. Every person commits an offence against the Trespass Act who trespasses on any place and, after being warned to leave that place by an occupier of that place, neglects or refuses to do so.

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
- Burns or scalds
- Non organic failure to thrive
- Fabricated Or Induced Illness By Carers (formerly Munchausen Syndrome by Proxy)

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.

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. <u>Neglect</u>

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.

HIGH RISK INDICATORS ASSOCIATED WITH CHILD ABUSE

Child characteristics which may predispose them to be at risk.

- Child with a congenital abnormality, either mental or physical.
- Premature infant or ill newborn who is separated during the neo-natal period.
- Colicky or irritable child.
- Child who is rigid or non-cuddly.
- Child who is unwanted.
- Child who is not the gender expected/desired by the parents.
- Foster child, adopted child, or step-child.
- Child who is intellectually impaired, highly intelligent or hyperactive.
- Child is particularly difficult (or is seen as difficult).

Caregiver's perceptions of child that may predispose some children to be at risk.

- 'Bad', 'naughty', or 'manipulative'.
- 'Difficult' and unrewarding to care for.
- Unloving or rejecting of the parents.
- Resembling a disliked person in appearance, behaviour or temperament.
- A rival for attention or affection that parents themselves desire.

Family factors that may place children at higher risk of abuse.

- Partner abuse is present.
- Parent was abused or seriously neglected as a child.
- Parent has serious mental health problems.
- Parent has had frequent trouble with the law.
- Parent has an alcohol or drug problem.
- Parent has rigid or unrealistic expectations of child.
- Previous abuse towards this or another child.
- Parent has violent temper or outburst towards things or people.
- Family socially isolated.
- Parents with low self-esteem.
- Parent is a teenager.
- Family suffers from multiple crises.
- Parent administers harsh or unusual punishment.

From: *Child Abuse Indicators: Information for General Practitioners and Community Workers.* Child and Adolescent Health Service, Taranaki Healthcare (1993, Second Edition).

APPENDIX 4

SIGNS AND SYMPTOMS ASSOCIATED WITH CHILD ABUSE AND NEGLECT

The signs, symptoms, and history described below are not diagnostic of abuse. However in certain situations, contexts and combinations they will raise the practitioner's suspicion of abuse. It is better to refer on suspicion. If you wait for proof, serious harm can occur.

From: *Recommended Referral Processes for GPs: Suspected Child Abuse and Neglect,* Ministry of Health, RNZCGPS, NZMA, CYF, 2000.

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.

Behavioural and developmental signs

- Aggression.
- Anxiety and regression.
- Obsessions.
- Overly responsible behaviour.
- Frozen watchfulness.
- Sexualised behaviour.
- Fear.
- Sadness.
- Defiance.
- Self-mutilation.
- Suicidal thoughts/plans.
- Withdrawal from family.
- Substance abuse.
- Overall developmental delay, especially if also FTT.
- Patchy or specific delay: motor, emotional, speech and language, social, cognitive, vision and hearing.

History

- History inconsistent with the injury presented.
- Past abuse or family violence.
- 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).
- Neglecting the 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).

APPENDIX 5

LEGAL AND PRIVACY ISSUES

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 documents make provision for the disclosure of information necessary to prevent harm to any individual.

As well, all privacy restrictions are over-ridden by certain sections of the Children, Young Persons and their Families Act (1989). These provide for the reporting of child abuse, protection of an individual from proceedings when disclosing child abuse to either a statutory social worker or police, and government agency obligations

DHB encourages good communication between DHB staff and CYF or the 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. Information must only be released to a CYF social worker, police officer or care and protection coordinator (s66 CYF Act: see below).

Health workers therefore are able to give information to Child, Youth and Family or NZ Police
by both reporting abuse or when requested by either agency.

CHILDREN, YOUNG PERSONS AND THEIR FAMILIES ACT 1989

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.

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, DHB staff

must provide that information. A staff member may be asked to provide this information in an affidavit. DHB recommends that the staff member seeks the support and advice of the unit manager, DHB's child protection coordinator and/or DHB's legal adviser.

PRIVACY ACT

Principle 11 (f) (ii)

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

HEALTH ACT 1956

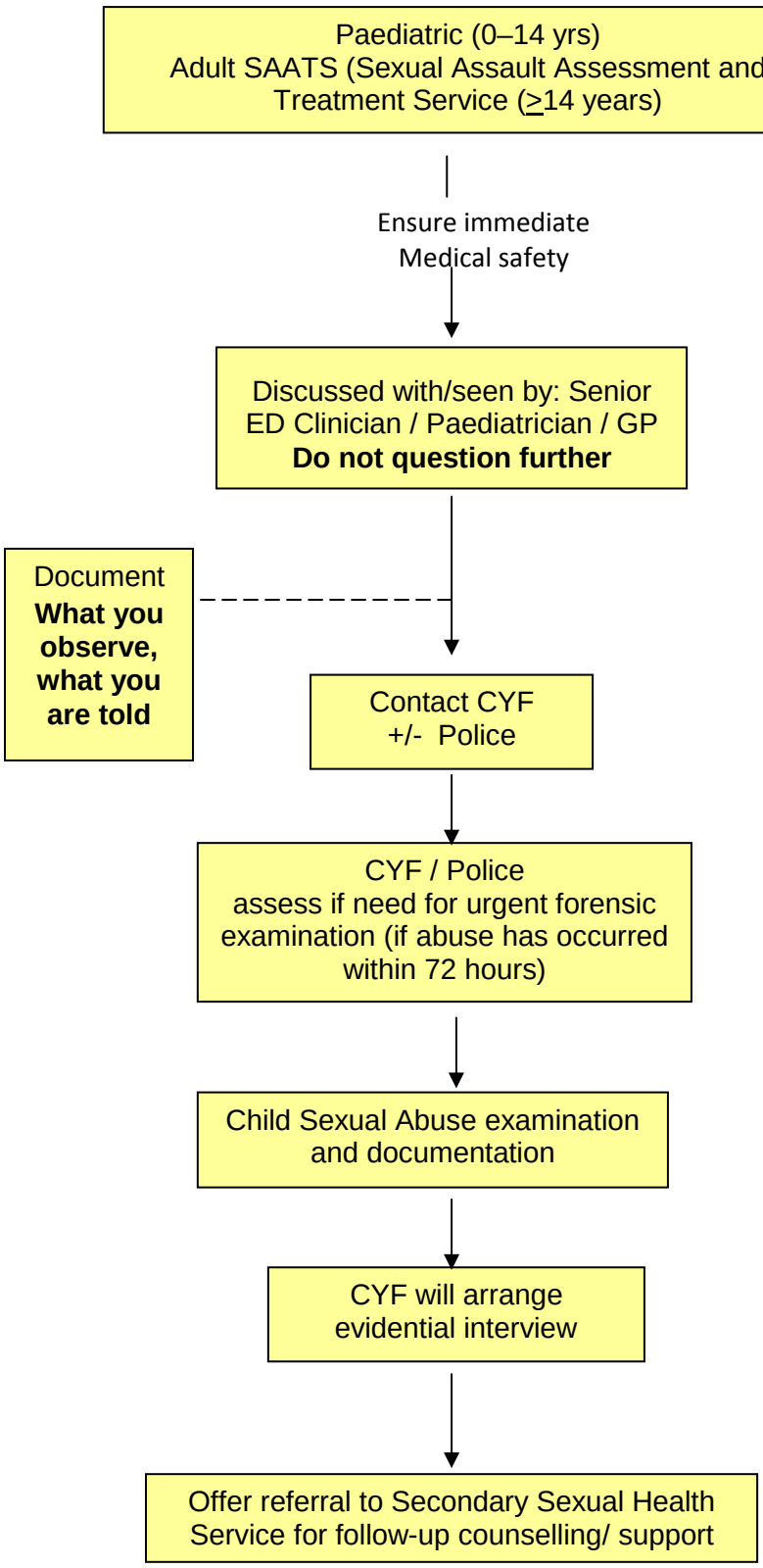
Section 22 (2) (c) Disclosure of health Information

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.

Always seek advice prior to release of information *(refer to Privacy policies in the first instance and/or the Privacy Officer)*.

Guideline for responding to Child Sexual Abuse

To reduce trauma and distress for the child and young person, one specialist examination is enough



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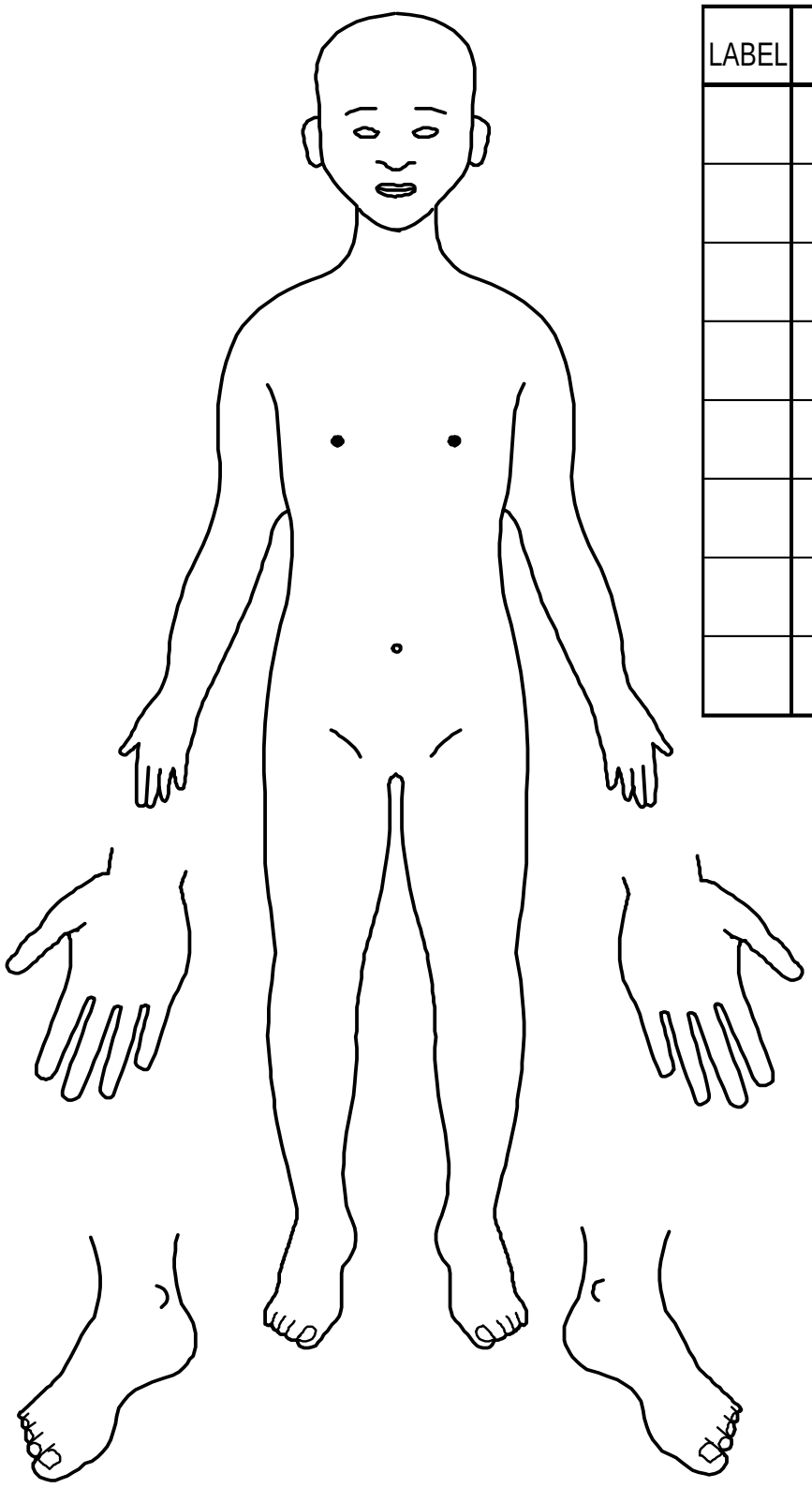

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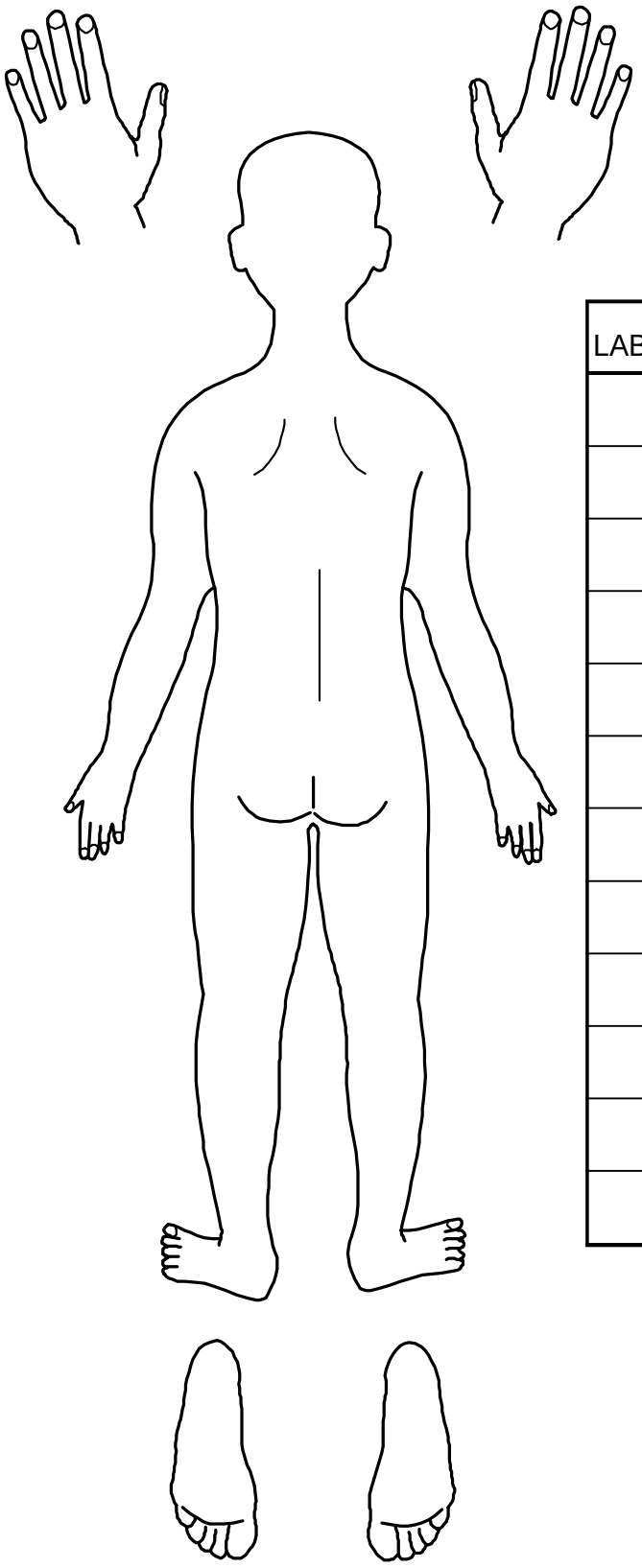

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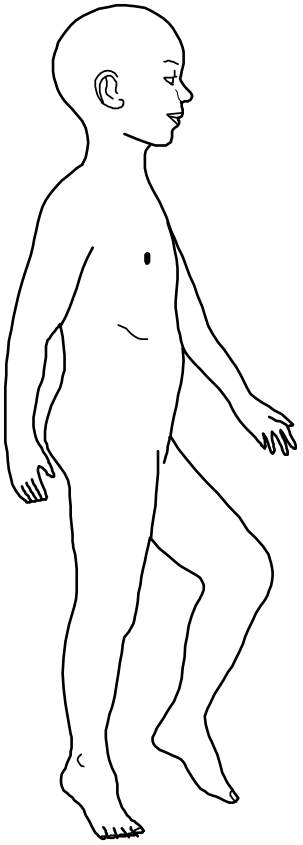

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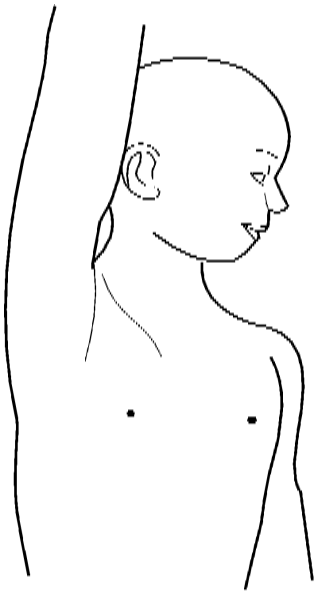

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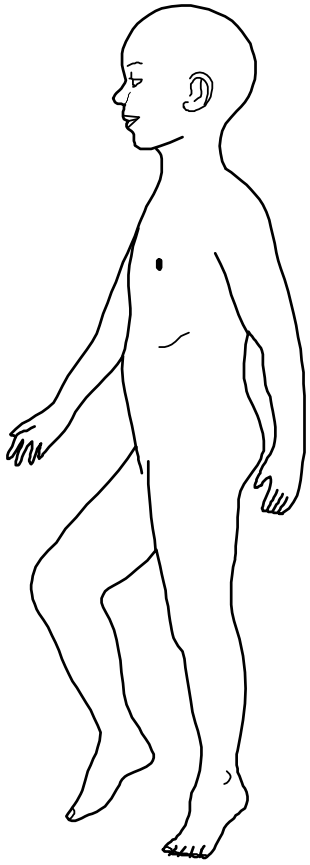

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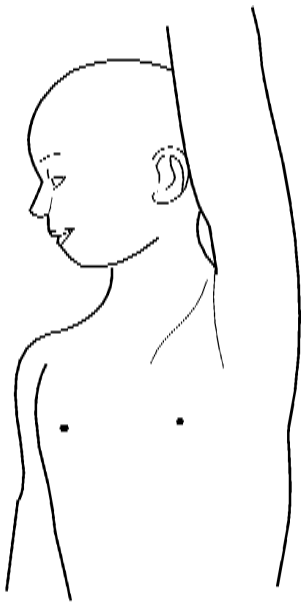

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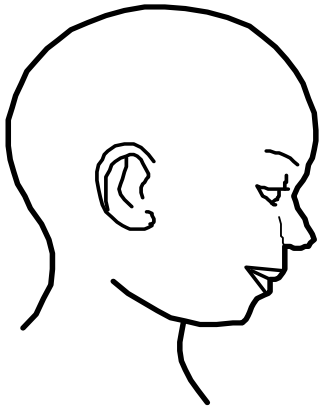

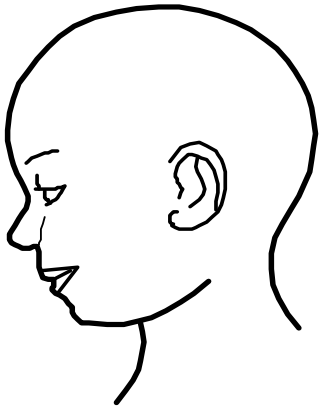

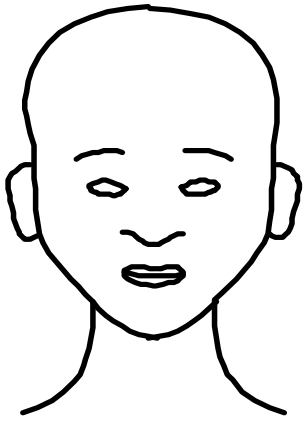

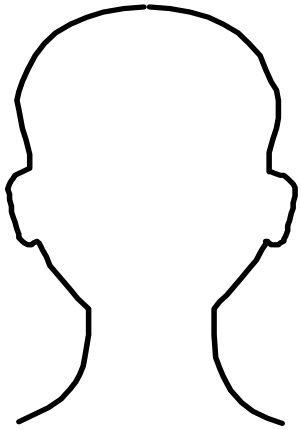

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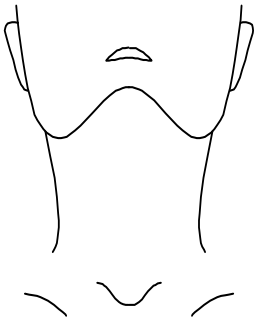
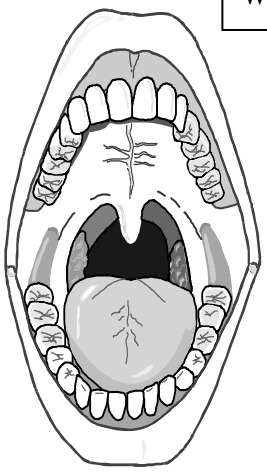
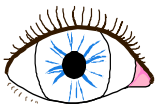
Mouth

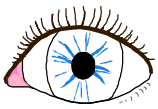


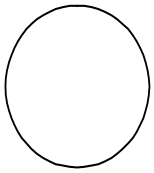
Jaw and Neck

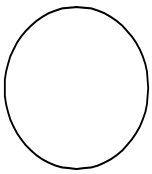


Note: Palate, teeth, gums and frenulum









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APPENDIX 8

SAFETY AND SECURITY GUIDELINES

This guideline sets out the Hutt Valley DHB procedures for staff when there is a need to access support to optimise the safety for victims of family violence when the risk to the victim's safety is assessed as high risk. These guidelines will provide information to support staff to:

- Ensure persons making public enquiries about the victim are given no details by suppressing all details on the hospital computer

At times it may be necessary to suppress patient details during the inpatient stay and or provide secure processes at the time of discharge. Use a safe process to discharge the family to an advocacy agency, e.g. women's refuge. This may include informing an inquirer that the patient has left the hospital before this is so and/or denying knowledge of where the patient has gone.

Name suppression should be discussed with the child or young person and their family/guardian and their consent should be obtained.

The safety of the patient is the paramount consideration. If a patient who is a victim of violence expresses fear of the perpetrator or others s/he is likely to be correct. It is defensible in this case for hospital staff to refuse public access to patient details and to facilitate the patient leaving the hospital for a place of safety.

1. Procedure to establish name suppression for patients in the DHB computer system ensuring persons making public inquires are given no details about the patient

1.1. The patient and/or guardian identifies that s/he is concerned that the perpetrator may trace them to the hospital.

1.2. The staff discusses with the patient/guardian the potential to place name suppression on the patient's details. The patient/guardian consents to name suppression.

1.3. The Clinical Nurse Manager is informed and s/he directs the Unit Receptionist to place the "Anonymous Patient Indicator" padlock in IBA against the patient details on the patient inquiry screen. Only the After Hours Duty Nurse Manager / Team Leader/ Clinical Nurse Manager may direct this action.

1.4. The patient's name is replaced with a pseudonym on all patient details boards in the department/ward.

1.5. The following staff are informed of name suppression
- 1.5.1. After Hours Duty Nurse Manager
- 1.5.2. Switchboard staff
- 1.5.3. Security
- 1.5.4. All relevant staff within the department.

1.6. This information transfers if the patients is admitted to another ward

1.7. Directive against the patient details is valid for the duration of the patient's hospital visit or until appropriate personnel remove the directive.

1.8. Document the name suppression order in the Multi Safety Agency Plan.

2. Procedure for staff to follow when name suppression has been granted.

When any staff member (including switchboard, patient enquiries, clinical staff and volunteers) receives an enquiry about a patient for whom an "Anonymous Patient Indicator" red padlock (instead of the usual yellow) is active s/he will:

2.1 Inform the caller s/he is unable to provide any information.
2.2 Ask for the callers name and write this down if provided.
2.3 Notify the Shift Co-coordinator/Clinical Nurse Manager/Team Leader/After Hours Duty Nurse Manager responsible for the patient's care.
2.4 Notify security (e.g. if the caller is the suspected perpetrator of an assault and police charges are likely).

3. Process used to discharge a victim of abuse in a safe manner from a department or ward setting when there are high-risk safety issues.

3.1. Arrange the discharge plan in consultation with the guardian/ patient and the discharge agency concerned, e.g. ensure the guardian speaks to the agency concerned and that all parties are in agreement with the discharge plan.

3.2. Complete the name suppression process as above if appropriate.

4. When child abuse is identified or suspected a Multi Agency Safety Plan must be completed prior to discharge. This may include provision of safe transportation.

4.1. Ensure that the following people are informed of the discharge plan process:

4.1.1. After Hours Nurse Duty Manager
4.1.2. Security +/- NZ Police (if risk is considered high by department staff and security)

4.2. The discharge plan may include leaving ED / ward or other department by a safe route, in consultation with security staff.

4.3. Document the discharge plan. **N.B.** Complete an Event Reporting Form if any unexpected outcomes occurred.

4.4. Advise the After Hours Duty Nurse Manager of the discharge outcome.

Appendix 9

Child, Youth & Family – Report of Concern Health Practitioners – click here