Procedure: Child Abuse and Neglect Procedure

Background/ Overview

Acts of child abuse or neglect are frequently **NOT** single events. Many children diagnosed with abuse or neglect have previous child protection concerns, evidence of old injury, or a history of being seen by health professionals with vague symptoms that in retrospect could have been indicators of abuse.

Many children who die from abuse in New Zealand are unknown to Oranga Tamariki Ministry for Children but most are known to healthcare providers. Many families at risk are highly mobile. Working collaboratively with other agencies, information sharing about children at risk constitutes better outcomes for children and young people.

Purpose

The purpose of this procedure is to outline the steps to be followed in order that Child Abuse and Neglect is correctly identified, assessed, managed and referred to the appropriate Counties Manukau Health (CM Health) team or Statutory Authority.

Note: This procedure must be read in conjunction with Child Abuse and Neglect Policy.

Objective

This procedure is to be carried out on any occasion when child abuse or neglect is suspected or identified.

Scope of Use

This procedure is applicable to all employees, students and people working at CM Health or under contract for service, who encounter actual, suspected or potential Child Abuse and Neglect.

SIX STEP CHILD PROTECTION INTERVENTION

This procedure outlines the intervention for identifying, assessing, responding to, and referring children who may be victims of violence and/or neglect. Appropriate documentation is also included in the six-step process.

All situations where recent or on-going child abuse and/or neglect is disclosed, detected or suspected must be acted on and reported using the following procedure.

Routine enquiry about child abuse and neglect is not recommended. Health care providers do, however, need to respond to a disclosure or be alert for signs and symptoms that require further assessment or that might be indicative of violence and abuse.

See Appendix 1.

Consultation should occur at least once. The following staff are available:
☐ An experienced colleague.
☐ Paediatrician.
☐ Child Protection Service.
☐ DHB Social Worker.
☐ Oranga Tamariki DHB Liaison Social Worker.

Consultation can occur at any point during the assessment and referral process if concerns exist.

Step 1: Identification of signs and symptoms

The younger and more vulnerable the child (such as a pre-verbal infant), the more important this becomes. For example, a baby caught in the cross-fire of an episode of intimate partner violence (IPV) may need formal physical examination and other investigations for injury, even if they appear physically unharmed.

1.1 *Observing child–caregiver interactions*

- Observe the caregiver–child interactions at any clinical encounter; these observations are not 'diagnostic', but can provide additional information that may be helpful in determining future courses of action (e.g., by providing clues about who the child is comfortable with and seeks support from, or adults whose behaviour towards the child raises some concerns).
- All observations which raise concern should be documented objectively, prospectively and in detail in the clinical records, even if the health care provider is uncertain of their significance at the time. The presence of a documented pattern of concerning behaviours over time may at some stage become very important in enabling the health provider to take effective action on behalf of a child at risk.
- Possible cues/signs and symptoms in parent-child interaction:
  - Lack of emotional warmth, as opposed to strong attachment/bonding.
  - Dismissive/unresponsive behaviours as opposed to sympathetic/comforting responses.
  - Interaction between the child and parent or caregiver seems angry, threatening, aggressive or coercive.
  - Indications that may raise concern are: a parent/caregiver calling the child names, using harsh verbal discipline, telling the child that they will harm something important to the child, threatening to seriously hurt or abandon the child, mocking the child or putting the child down in front of others.

1.2 *Taking a history from parents and caregivers*

- Your ability to interpret signs and symptoms in a child is reliant on the quality of the history taken from the family and (in some circumstances) the child about those signs and symptoms.

- If a child presents with an injury, it is important to understand how that injury occurred. Essential components of the history include the following:
  - Who is giving you the history (what is their name and relationship to the child)?
  - Who saw it happen (the history should be obtained from an eye-witness, if possible)?
  - When exactly did these events occur (time and date)?
  - How exactly did they occur?
  - When exactly did symptoms begin in relation to the accident? How were they noticed, and who noticed them?
- In a young child, it is important to know the developmental capacities of the child. (Can they crawl, pull to stand, climb, run or manage stairs?). It is also important, especially with babies, to know their usual pattern of feeding, sleeping and behaviour, and when that pattern changed.

1.3 *Asking children about possible abuse and/or neglect: an area of specialist practice*

If there is clear evidence of child abuse or neglect, sufficient in your opinion to justify referral to Oranga Tamariki in its own right, then do not interview the child. Record any information that the child volunteers. If you interview the child you may create more problems than you solve.

- If a child has an injury, it is perfectly all right to ask open, non-leading questions e.g. 'how did this happen?' No harm is done by asking the kind of question you would ask of any child you see for treatment of an injury.
- If you have concerns about possible abuse or neglect, but there are other possible explanations for the things causing you concern, then seek advice from the Paediatrician, Child Protection service, a Social Worker with experience in child protection or Oranga Tamariki.
- Privacy is just as important as with adults. Giving an adolescent a chance to talk to you alone should be part of your routine practice. With younger children, you should consider carefully whether or not it is appropriate. A hasty conversation in a gap is unlikely to create the time and space necessary for disclosure by an anxious child.
- Use age-appropriate language; children may not know what to say and use different words to express what is going on. You need to create an atmosphere where the child feels safe to talk to you.
- If you are going to have this kind of conversation, you need to frame it in a way that makes sense in terms of the signs and symptoms for which the child has come to see you, or in terms of your usual practice. For example: 'Sometimes when I see children with pain in their tummy like this, it's because they're worried or anxious about something. Is there anything that's making you worried or unhappy?' Or, 'One of the things I always do with children, who come to see me, when they're old enough like you, is to check how things are at home.'

It is reasonable to ask open and non-threatening questions, such as:

- How are things at home?
- What happens when people disagree with each other in your house?
- What happens when things go wrong at your house?
- What happens when your parents/caregivers are angry with you?
- Who makes the rules? What happens if you break the rules?

There are no evidence-based 'screening' questions for children about sexual abuse; if a presenting symptom has raised this concern for you, then open-ended questions (which do not suggest the answer) are always best.

1.4 *Asking young people about possible abuse,*

- Ask in a place that is private, and confidentiality of information needs to be discussed.
- Use a developmentally appropriate assessment if signs and symptoms of abuse are detected. Assessment of the causes of violence in this age group is best accomplished as part of a thorough psychosocial assessment for adolescents such as the HEeADSss assessment.
- If the young person is sexually active, it is important to consider the possibility of non-consenting sexual activity. This should be a part of routine HEeADSSS assessment in adolescents.

1.5 *Past history*

- Review the child or young person's clinical record (previous presentations or admissions, particularly multiple presentations for illnesses and injuries, may indicate risk).
- Check for the presence of a Child Protection Alert; if an alert exists, follow the CM Health Child Protection Alert Policy to access the health information behind the alert, and take it into consideration when assessing the child.

1.6 *Social history*

- Take a social history; a variety of factors may have an effect on the risk of child abuse and neglect, e.g. IPV, multiple changes of address; alcohol/drug abuse in the household, a family which actively avoids contact with health care providers or family support agencies, a caregiver with a past history of harming and/or neglecting children; severe social stress; social isolation and lack of support; untreated mental illness.
- While these factors are all relevant to the health and welfare of the child, they do not necessarily predict abuse or neglect in any individual case.

1.7 *Physical examination*

- A thorough physical examination is indicated in all cases of identified or suspected child abuse and/or neglect, to identify all current and past injuries.

- Further investigations may be necessary, but this will depend on the exact circumstances, including the age and developmental capacities of the child, and the type of abuse or neglect that is suspected. For example, a suspected head injury from child abuse in a child under one (even if they have no symptoms of concussion) will almost always require a CT scan of the head, and a skeletal survey will be required in most children under two years with suspected physical abuse and in some older children. Full blood count and coagulation studies may be required in the presence of bruising
- CM Health is fully committed to the Power to Protect Programme (formerly known as the Shaken Baby Prevention Programme).

  https://www.kidshealth.org.nz/never-ever-shake-baby
- Cases of sexual abuse, or suspected sexual abuse, should always be discussed with a doctor specifically trained in this field. Always refer to the Paediatrician on call, before you decide whether or not to examine the child.

Acute Sexual Assault (up to seven days).	• Immediate referral to Te Puaruruhau at Starship Hospital, for medical/forensic examination, assessment and follow-up. • Report of Concern (ROC) to Oranga Tamariki. • Notify CM Health Child Protection Service using the Child Protection Alert Form.
Recent Sexual Assault (more than seven days) with current symptoms.	• ROC to Oranga Tamariki. • Refer to CM Health Child Protection Service for an appointment at their regular outpatient clinic or discuss with Te Puaruruhau.
Historical Sexual Abuse.	• ROC to Oranga Tamariki for assessment. • An appointment will be offered at the Child Protection Service weekly clinic for a therapeutic medical assessment after the child/young person has completed a forensic interview with the Police.

- **Emotional Abuse -** Liaise with Child and Adolescent Mental Health Service and Consult Liaison Service.
- **Neglect and Failure to Thrive -** When suspected the following steps should be taken:
  - Where appropriate, request further information gathering and assessment by health professionals such as GP, Public Health Nurse, Maori or Pacific Community Health Worker, Health Social Worker, Community Midwife or Well Child provider.
  - Adequacy of care falls on a continuum from optimal to grossly inadequate. Neglect of Medical Care can place a child at minor risk or at the extreme of high risk of severe disability or even death. An assessment check list/health tool has been developed alongside Oranga Tamariki to assist with early and appropriate intervention. Health professionals should follow this traffic light process when faced with concerns of medical neglect. https://www.starship.org.nz/for-health-professionals/starship-clinical-guidelines/n/neglect-of-medical-care/

- In serious cases, request a medical assessment by the Paediatric Team or appropriate GP in the community.
- In cases of children at home alone Police need to be notified immediately on 111. If at all possible the notifier should remain at or near the home until the police arrive.

The legal age for a child/young person in New Zealand to be left home without adult supervision is 14 years. (Summary Offences Act 1981 sec 10B).

1.8 *Using a child protection check list for ALL children*

- All children presented to the emergency department should have the Child Protection Checklist as below completed; it is only possible to answer the questions it contains, if you have conducted a thorough assessment following the principles outlined above.
- The checklist is only a guide to assist safe process, not a diagnostic algorithm. Never jump to conclusions.

CHILD PROTECTION CHECKLIST-Complete for **ALL** children presenting to ED			
• Concern about the child and/or family's behaviour	☐ yes	☐ no	
• Past history of previous injuries or a child protection alert exist	☐ yes	☐ no	
• Other concerns	☐ yes	☐ no	
Also complete the following for all children under 2 years of age presenting with an injury			
• Delay between the injury and seeking of medical advice for which there is no satisfactory explanation	☐ yes	☐ no	
• History inconsistent with the injury and/or with the child's developmental level	☐ yes	☐ no	
• Child under 12 months of age	☐ yes	☐ no	
☐ **No** answered to all above No suspicion of non-accidental injury (NAI)			
☐ **YES** answered to any above Uncertain or possible NAI. Discuss with senior Doctor and ensure IPV screen done			
Name	Signature	Date	

1.9 *Collection of physical evidence*

- In some circumstances, collection of physical evidence may assist a criminal investigation ('forensic evidence'). If you consider that forensic evidence is required, you should be discussing the matter with the Paediatrician on call and the Police.
- Steps for collection and safe storage of evidence include:
  - Place torn or blood-stained clothing and/or weapons in a sealed envelope or bag (these can be provided by the Police).
  - Mark the envelope with the date and time, the patient's name, and the name of the person who collected the items. Sign across the seal.
  - Keep the envelope in a secure place (e.g. a locked drawer or cupboard) until turned over to the Police. Document in your clinical record the time and date that you handed it over, and to whom the envelope was given.

Step 2: Validation and Support

- If you have concerns about the safety of a child or young person, then you will need to act on these. At some time, someone will need to have a frank conversation with the caregivers and (if old enough to understand) with the child.
- While your actions are intended to support and validate the child or young person, they may not (depending on the circumstances) be seen as supporting or validating their caregiver(s).
- Do not assume that raising care and protection concerns with a family will necessarily result in a hostile reception. Some caregivers may appreciate your honesty and be willing to accept help.
- Do not discuss concerns or child protective actions to be taken with a victim's parents or caregivers under the following conditions.
  - If it will place either the child or you, the health care provider, in danger.
  - If the family may seek to avoid child protective agency staff.
  - Where the family may close ranks and reduce the possibility of being able to help a child. If safe to do so, you should still be transparent about the actions you as a health care provider need to take, and the reasons for them, but do not divulge details of actions planned by the statutory authorities.

2.1 *Talking with the parents/caregivers of the child*

- If you are unsure about how to talk with the parents/caregivers, consult with a Paediatrician/Child Protection Service/senior colleague/Oranga Tamariki.

  Basic principles are:
  - Create time and space for a private conversation.
  - Be professional (be calm, start with the facts before you, explain the reasons for your concern and the reasons for the actions you need to take).
  - Do not accuse anyone. For example, if a child has an injury, you have reached the appropriate point in the consultation and have explained the features of the injury that are unusual; you might use phrasing such as "I am concerned that someone may have injured your child".
  - Access cultural support, e.g. Te Kaahui Ora Maaori Health Unit. It is important that contacting such support does not delay any referral to Oranga Tamariki.
  - Use interpreters (not family members) if there are language barriers.
  - Be transparent about what happens next.
- If circumstances permit discussing concerns with a victim's parents or caregivers, follow these principles:
  - Broach the topic sensitively.
  - Help the parents/caregiver feel supported, able to share any concerns they have with you.
  - Help them understand that you want to help keep the child safe, and support them in their care of the child.

2.2 *Health care provider response to child's disclosure of abuse*

- Listen. Do not put words in a child's mouth. Allow them to tell only as much as they want. Act on the assumption that the child is telling the truth.
- Keep any questions to a minimum. Use open ended questions and use age appropriate language.
- Do not over-react.
- Do not panic.
- Do not criticise.
- Do not make promises you cannot keep.
- Ensure the child's immediate safety. Try not to alert the alleged abuser.

2.3 *Health care provider response to parents/caregivers disclosure of abuse*

- Listen to what the parent or caregiver is saying.
- Thank them for telling you.
- Let them know that you will act to keep the child safe, and them safe, if they need it.

Step 3: Health and Risk Assessment

3.1 *Risk to the child or young person*

- Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans.
- Health care providers are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of Oranga Tamariki or the Police.
- Immediate protection of a child is required if the child has suffered harm which in your view is a result of child abuse, and the environment to which the child is returning is unsafe. Obviously, the more serious the harm and the more vulnerable the child (for example, a baby or a preverbal child), the more critical the risk becomes.
- Safe process means:
  - Never make decisions about risk in isolation.
  - Do not jump to conclusions.
  - Consult with senior staff e.g. a Paediatrician, Child Protection Service, a health Social Worker or youth health service, or with the duty social worker at Oranga Tamariki as you work to determine what level of risk the child might be facing.

- Appreciate that other organisations (e.g. Oranga Tamariki) may hold information that is crucial to determining the safety of the child.

- You do not need proof of abuse or neglect, and do not need to seek permission from a child's family, prior to talking with colleagues or an Oranga Tamariki social worker about a child.
- Early communication with Oranga Tamariki can help identify if there have been other concerns raised about the safety of the child. It can be considered an additional component of reviewing the child's history. This early communication does not need to result in a report of concern to Oranga Tamariki, which is a decision that ideally should only be made after a thorough assessment.

3.2 *Mental health assessment*

The support of Consult Liaison Services or CAMHS should be sought in all cases.

- The health assessment should include an assessment for signs and symptoms of mental health concerns; risk of suicide or self-harm can themselves be symptoms of abuse.
- Signs associated with risk of suicide include:
  - Previous suicide attempts.
  - Stated intent to die/attempt to kill oneself.
  - A well developed, concrete suicide plan.
  - Access to the method to implement their plan.
  - Planning for suicide (for example, putting affairs in order).
- If you are concerned that the child may be at risk of suicidal behaviour, it is appropriate to ask questions such as:
  - "Do you ever think about hurting yourself?"
  - "Do you ever feel sad enough that it makes you want to go away and not come back?"
  - "Do you ever feel like crying a lot?"
- Do **NOT** ask questions using the words "suicide" or "killing oneself". These can suggest behaviours that the child may not have thought of.

- The level of assessed risk (based on the assessment) will inform the referrals required. A referral to the appropriate child or adolescent mental health service may be indicated, but if abuse or neglect issues are also present, referral to Oranga Tamariki is also warranted, particularly if the child or young person cannot be cared for safely within their home. Remember that the most helpful intervention to reduce suicide risk may be to assist the person to obtain safety from the abuse.

3.3 *Risk to other children or young people*

- Consider possible risk to other members of the family because of the high co-occurrence/entanglement of multiple types of violence within families. This includes establishing the whereabouts and safety of other children in the home.

- Oranga Tamariki should be able to determine if previous concerns have been raised about the safety of other children in the family.

3.4 *Co-occurrence of intimate partner violence*

- If child abuse is identified, assess the mother's safety. Follow the procedure outlined in Family Violence policy.
- Victims of family violence are frequently threatened by the perpetrator that if they disclose the violence, s/he will tell Oranga Tamariki that the non-abusive partner is a bad parent/abusive to the children, and that Oranga Tamariki will take the children away. Careful assessment needs to be undertaken to ensure that children's disclosure of violence, or the non-abusive partner's disclosure of violence, leads to further safety for them both, rather than additional trauma through separation or other consequences.
- It is recognised that there are occasions when the only way to ensure the safety of a child in a situation of family violence may be to separate the child from the non-abusive parent, even if only temporarily. In these circumstances, best efforts should be made to mitigate the trauma of the separation to both.

3.5 *Other risk factors*

- If the social history identified other risk factors (see 1.6), then refer to other services e.g. serious untreated mental illness should be referred to the mental health crisis team, alcohol and drug addiction via referral to community alcohol and drug services.

Step 4: Intervention/Safety Planning

- If child abuse and/or neglect is identified or suspected, then a plan is required for ensuring the safety of the child, or for providing help and support to the family.
- Immediate safety - Concerns about immediate safety (including your own), contact the Police 111 (or in-house security if available) and contact Oranga Tamariki 0508 FAMILY (phone followed by written referral).
- How to establish a temporary name change for victims of abuse:

During normal working hours.	The health professional in charge of the patient/caregiver, or the Service Manager should be informed of the potential risk. They will consider whether it is appropriate to initiate the name change.
Out of working hours.	The health professional in charge of the patient/caregiver, or the Service Manager should be informed of the potential risk. They will consider whether it is appropriate to initiate the name change.

N.B. In both situations the Charge Nurse should be informed.

- Information from the health and risk assessment process will help to ensure that acute needs are identified and can be included in the safety plan. Work with a multi-disciplinary team whenever possible or consult with a senior colleague.

- All healthcare providers can undertake basic intervention and safety planning activities if they have received training, and have access to support.
- Note that the purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting. Actual injuries or other evidence of abuse are not required for referral to Oranga Tamariki, particularly if there is risk to children.
- Assessing for positive/protective factors e.g. family's efforts to actively pursue the safety and wellbeing of the child/young person, their willingness and capacity to respond or engage is an important part of identifying resources that may help improve the situation during safety planning.
- The identification of support needs within the family (e.g. health, education or disability) can be strength if meeting these needs assists in establishing connections with other services.
- The tasks at this stage are to:
    - Identify the support and safety procedures that are required e.g. what are the child's needs for; safety, physical and emotional needs, health and rehabilitation, access to caregivers?
    - Specify what are the support or safety procedures that need to be put in place?
    - Allocate responsibilities for action (e.g. who are the key individuals and agencies that need to be engaged?).
- In non-critical situations, multiple referral and follow-up pathways are possible. The key issue is whether the child is 'at risk' or whether the child is actually already coming to harm.

4.1 *Child being harmed*

- A child who, in the opinion of the healthcare provider, is already coming to harm, should be notified to Oranga Tamariki as a ROC. Oranga Tamariki will form their own opinion on the level of risk for the child and triage accordingly.
- Children admitted to hospital with actual or suspected child abuse or neglect should be managed in accordance with the Memorandum of Understanding (2011) between DHBs, Oranga Tamariki and the Police and the associated Schedule 1.

4.2 *Child at Risk*

- Identify the safety, care or behavioural issues that exist. Consider if the risk is likely to be mitigated by the family engaging further with your service, or another health or social agency. Will the family accept this referral? What positive or protective factors exist that could be enhanced?
- If you are unsure, discuss the situation and your concerns with Oranga Tamariki to determine if a formal report of concern should be made.
- If there is a children's team in your area, this may provide another avenue for effective action.

4.3 *Co-occurrence of child abuse and family violence*

Remember, **JOINT** safety planning and referral processes need to be implemented when both family violence and child abuse and or neglect are identified.

- Any concerns about the safety of the children should be discussed with the abused partner, unless you believe that doing so will endanger the child, another person or yourself. If you or your colleagues decide to notify Oranga Tamariki, the abused partner should be informed, unless the same concerns apply.
- Be aware that actions taken to protect the child may place the non-abusive parent at risk. Always refer this parent to specialist family violence support services, and inform Oranga Tamariki about the presence of family violence as well as child abuse.
- Ask the abused partner how they think the abuser will respond (risk that the abuser will retaliate for disclosure of the family secret).
- Ask if a child protection report or report of concern has been made in the past, and what the abuser's reaction was.
- Make sure the abused partner has information on how to contact support agencies (e.g. Police, refuge, Oranga Tamariki).

4.4 *Talking to parents and caregivers about referral to the statutory authorities*

If it is safe to do so, discuss referral to Oranga Tamariki with the child's parents or caregivers:

- Broach the topic sensitively and reasonably, in the light of the concerns you have.
- Help the parents/caregiver feel supported, able to share any concerns they have with you.
- Offer cultural support where appropriate
- Help them understand that you want to help keep the child safe, and support them in their care of the child.
- Keep the parents informed at all stages of the process.
- Where options exist, support the parents/caregivers to make their own decisions.
- Involve extended family/whānau and other people who are important to them.
- Be sensitive to, and discuss the patient or caregiver's fears about Oranga Tamariki.
- However, be clear that your role is to keep the child safe. Do not seek permission to consult with Oranga Tamariki. You may do this at any time.

At times it may be necessary to suppress patient details and/or provide secure processes at the time of discharge. The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in (See Step 4).

Step 5: Referral and Follow-up

- Follow-up and referral plans need to be developed for all children and their families, based on the information obtained during the risk assessment and safety planning, and the collaborative planning undertaken.

- The tasks at this stage are:

  - Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies.

    Oranga Tamariki should be notified of all cases of suspected child abuse and neglect.

    Memorandum of Understanding between DHB, Oranga Tamariki and Police (2011).

  - Ensure there is a plan for review and follow-up, e.g., what is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?

  - A phone referral to Oranga Tamariki should be made whenever possible. A copy of the written referral (ROC) must be sent to Oranga Tamariki and a copy placed in the clinical record of the child/young person (or mother when the concerns reported relate to the antenatal period). A copy must also be sent to the Child Protection Service in accordance with the DHB's policy for the Child Protection Alert System.

    child.protectionservice@middlemore.co.nz

5.1 *Child being harmed*

- To support follow-up, consider if and how the information should be transferred to the GP (e.g. written discharge summary, telephone call, other procedure).

- Continue to provide follow-up to children and families notified to Oranga Tamariki; the DHB remains responsible for the follow-up of the health care needs of the child and family.

5.2 *Child at risk*

- If you have concerns about risk, but there has been no disclosure, and no definitive signs or symptoms, consult with an experienced colleague, Child Protection Service and/or Oranga Tamariki.

- There are opportunities for early intervention (even when a report of concern is not made):

  - Leave the door open for further contact with the child and the child's caregivers.

  - Look for further indicators at the next consultation, or consider if you should raise your concerns with others within the health system (e.g. GP, Well-Child provider) so that additional follow-up and support can be offered, if required.

- Consider if there are other health, social, or community agencies where you can refer the family, to reduce stressors, and/or promote health, e.g. cultural support, the Children's Teams, non-health agencies, such as educational or social support agencies (for the child or the parent/caregiver), or agencies that provide support that may alleviate other risks (e.g., budgeting advice, alcohol and drug addiction services, mental health services).

5.3 *Co-occurrence of child abuse and intimate partner violence*

- Make sure that the abused partner has contact details for local support agencies.
- Provide the abused partner with a private area to make phone contact with a family violence service.

Step 6: Documentation

- Thorough documentation of all steps of the health consultation is necessary.
- Always include the date and time that you saw the child or young person, and when you wrote your notes (if different from the time you saw the patient).
- Always include name, legible signature and practice designation.
- Clearly and thoroughly document the behaviours, signs and symptoms you observed.

6.1 *History*

- Document carefully and in detail the history you took, and who you took it from.
- If you spoke to the child, write down what you asked, and the child's answers to your questions. If you spoke to the parent/caregiver, record what you asked, and how the caregiver responded. Use direct quotes.

6.2 *Examination*

- Note the time and date of examination.
- Use simple body diagrams to improve accurate documentation.
- Document the following features for each injury: site, shape, size (use a tape measure), characteristics (e.g., colour, depth, edges, surroundings, margins, swelling, and tenderness).
- Aging of injuries is a difficult and potentially contentious issue, as many factors influence healing such as site of injury, force applied, age and health of patient and infection.

6.3 *Photographs*

- Many healthcare organisations now regard photography as a routine supplement to the medical records (refer to DHB policies and procedures regarding consent to photograph.
- The taking of photographs should be done by a suitably qualified person in accordance with DHB policy.
- Note that thorough documentation and body maps are always required, and cannot be replaced by photographs.

6.4 *Document the results of your risk assessment*

- Be sure to include suspected or confirmed risk to other family members (e.g., other children in the family, parents or caregivers who may be at risk).

6.5 *Document the consultative process you undertook*

- Who did you speak with? At what points?

6.6 *Document the support agencies, referrals and follow-up plan agreed to*

- Record the actions taken, referral information offered, follow-up care arranged (e.g., report of concern to Oranga Tamariki, discharge summary to GP, or referral information provided to family for other health and social service agencies).
- Note who will take responsibility for follow-up, and when this will occur.

6.7 *Confidentiality of abuse documentation on the medical record*

- Care must be taken to ensure the confidentiality of any information about abuse recorded in any records potentially available to family/whānau members.
- If the abuser finds out that the victim has disclosed the violence, the victim may be at increased risk of retribution for having revealed the "family secret".
- Children's health records are private to them. Parents can ask to access their children's notes until they are 16 years old, but they are not automatically entitled to them. All requests to access health records should be managed in accordance with DHB policy. There may be grounds for withholding information when the healthcare provider believes that it is not in the child's best interests to give the parents access.
- The health notes for each individual should be stored in a separate file.

Responding effectively to Maori

This procedure has been developed in accordance with the Treaty of Waitangi principles (Partnership, Participation and Protection. The concept of whānau ora is about supporting Māori families to achieve their maximum health and wellbeing, where violence exists within whānau, action needs to be taken to protect those who are at risk of harm. Health professionals, whānau, hapū, iwi and local community organisations all have a role to play in ensuring the safety and protection of victims of violence, and in helping to build whānau strength and resilience. CM Health also recognises the four elements of Te Whare Tapa Wha; taha wairua (spiritual), taha hinengaro (mental), taha tinana (physical) and taha whanau (extended family). This is consistent with cultural training offered and mandated within the CM Health Tikanga Best Practice Training (Maaori Responsiveness Programme).

He Korowai Oranga: Māori Health Strategy sets the overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori. The overall aim of He Korowai Oranga is Pae Ora – healthy futures for Māori. Pae Ora provides a platform for Māori to live with good health and wellbeing in an environment that supports a good quality of life and includes three interrelated elements:

- **mauri ora –** healthy individuals.
- **whānau ora –** healthy families.
- **wai ora** – healthy environments.

Solutions to family violence, which are based on traditional Māori values and beliefs (tikanga) and which involve the wider whānau may be more likely to achieve the best outcomes (Te Puni Kōkiri 2010). For this reason it is important for health professionals to be able to identify local Māori health providers and ensure that processes are in place to enable Māori individuals and whānau to access this specialist support, should they wish to.

Te Wanaga-o-Raukawa

Building on the principles of the Treaty of Waitangi, are 12 kaupapa which health professionals can build into their day-today practice. This will enhance effectiveness for services for Maori whanau as well as all people regardless of their cultural or ethnic background.

- **Wairuatanga -** Spirituality. According to Maori, spiritual connections exist between atua (gods and ancestors), nature and humankind. Every child is born with wairua (spirit), which is subject to damage as a result of maltreatment.
    - *Be aware that a person's wairua is likely to have been damaged as a result of physical, emotional or sexual abuse. Take care to treat victims of violence with compassion, warmth and respect.*
- **Whakapapa -** Geneological descent of all living things from Ranginui (Sky Father), Papatuanuku (Earth Mother), gods, ancestors and through to the present. Reciting whakapapa enables individuals to identify their genealogical links to one another and to strengthen interpersonal relationships.
    - *When building and strengthening relationships with Maori individuals, whanau, hapu and iwi or local Maori services, it is beneficial to share with each other information about your genealogical ties and where you and your ancestors come from.*
- **Atuatanga -** The qualities and wisdom of atua (gods, ancestors, and guardians) are considered to endure through people living in the present.
    - *Acknowledge the rich whakapapa of each individual.*
- **Ukaipotanga -** Nurturing and nourishing people and communities.
    - *Encourage parents and whanau to provide a safe and nurturing environment for their children. An example would be to promote parent-infant bonding within the maternity service and talk to parents about how to respond safely to a crying baby.*
- **Whanaungatanga -** Focuses on the importance of relationships. Individuals are seen as part of a wider collective, which has the potential to guide its members with guidance, direction and support.
    - *Work in partnership with whanau, hapu, iwi and Maori community organisations to provide support for individuals experiencing violence.*
- **Rangatiratanga -** Demonstrating the qualities of a good leader with altruism, generosity, diplomacy and the ability to lead by example or show self-determination.
    - *Demonstrate integrity and respect when engaging with whanau.*
    - *Ask the whanau (rather than assume) what tikanga they wish to follow.*

- **Manaakitanga -** Nurturing and looking after people and relationships. Here action is to enhance the mana of each individual. Relationships are based on compassion, generosity, reciprocity and respect.
    - *Convey a genuine, open, supportive, caring and respectful attitude.*
    - *Aim to pronounce Maori names and words correctly. This will convey a sense of care and respect.*
- **Kaitiakitanga -** Guardianship and protection of people, Taonga (cultural treasures) and the environment so that they can thrive from generation to generation.
    - *Recognise that safety should always be the priority. Ensure processes are in place to keep all vulnerable people and staff safe.*
    - *Be aware that the physical, emotional and spiritual well-being of mothers is important for the safety of their children.*
- **Oritetanga -** Refers to equality.
    - *Deliver the same high quality service to everyone, no matter what their age, gender, ethnicity or social background.*
    - *Understand that some whanau may have minimal information about the health sector and your role may be to empower them and inform them of their rights and responsibilities.*
- **Kotahitanga -** Exists when people work together in unity to support and achieve common goals.
    - *Take a collaborative approach to keep victims of violence within whanau safe. This should involve information sharing and planning with other professionals, community providers and whanau members.*
- **Pukengatanga -** Involves the achievement of progressive milestones and skills, enabling individuals to reach their full potential.
    - *Ensure individuals are aware of their options so that they have the opportunity to make informed choices and develop their own plans for the future.*
- **Te Reo -** Refers to the Maori language, which is the official language of New Zealand. Its preservation is essential as it is through language that Maori beliefs and traditions are passed from generation to generation. Te Reo carries with it the 'life force' (mauri) of the culture.
    - *Use Te Reo in signage and posters, and have key documents and resources available in Te Reo.*
    - *Aim to pronounce Maori names and words correctively. If you are unsure how to pronounce something then ask.*

Pacific Peoples

Nga Vaka o Kaiga Tapu (Ministry of Social Development Taskforce for Action on Violence in Families 2012) is a conceptual framework for addressing family violence within Pacific communities in New Zealand. There are seven main Pacific communities represented in New Zealand: Samoan, Cook Island, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan. The causes of violence within Pacific homes are complex and interrelated and occur within the context of social change and individual ability to manage or adapt to change. Throughout New Zealand's economic boom years in the 1950s, 60s and 70s, Pacific peoples enjoyed average incomes, high employment and participation rates in the labour market. Changes to New Zealand's

social and economic environment led to economic deregulation in the late 1970s and 1980s. High unemployment and the benefit reforms in the 1990s contributed to the legacy of low socio-economic status and impacted on the health status that many Pacific people live with today. As a consequence families are often unable to fulfil customary and religious obligations on limited disposable income.

Risk factors for family violence amongst Pacific people

- Situational factors including socioeconomic disadvantage, migration culture and identity.
- Cultural beliefs including women are subordinate to men, perceptions and beliefs about what constitutes violence, unresolved intergenerational issues, fusion of culture and religious beliefs.
- Religious factors including misinterpretation of biblical texts.

Protective factors for Pacific families

- Reciprocity.
- Respect.
- Genealogy.
- Observance of tapu relationships.
- Language and belonging are concepts shared across the seven ethnic specific communities as elements that protect and strengthen family and individual well-being.

Health care providers should ensure that the service they provide is safe and respectful of Pacific victims of family violence. The delivery of a culturally safe and competent service that responds to Pacific victims of family violence should be underpinned by the following principles.

- Victim safety and protection must be paramount.
- The provision of a Pacific-friendly environment.
- The provision of culturally safe and competent interactions.
- A collaborative community approach to family violence should be taken.

Staff Support and Safety

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 appropriately trained senior colleague. Staff may access Peer Support or the Employee Assistance Programme and can also access support following a critical incident.

Death of a Child and Sibling Assessment

In the event that a child is brought into the DHB and is deceased on arrival or the child dies in the DHB and the cause of death is suspicious, then an assessment of the safety of any siblings should be urgently undertaken. The Paediatrician on-call should determine if there are other siblings and if so report to Oranga Tamariki.

IMPORTANT PHONE NUMBERS

CMH Child Protection Service: Monday-Friday 0800-1630 hours

Co-ordinator	**276-0044 ext 57025 021-569-546**
CP Social worker or Clinical Nurse Specialist	**276-044 ext 52994 021-569-546**
CP Secretary	**276-0044 ext 57003**
Emergency care Social Worker	**021-245-1930**
Te Puaruruhau	**376-0000 (Ask for Doctor on Call)**
Oranga Tamariki National Call Centre 24/7	**0508-326-459 (0508 FAMILY)** NB: On weekends you will be put through to a duty social worker.

Definitions/Description

Terms and abbreviations used in this document are described below:

Term/Abbreviation	Description
CAMHS	Child and Adolescent Mental Health Service
Child	A boy or girl 0-11 years of age
Young Person	A boy or girl 12-18 years of age
CMH	Counties Manukau Health
CT	Computerised Tomography
DHB	District Health Board
FV	Family Violence
GP	General Practitioner
HEEADSSS assessment	Adolescent psycho-social assessment
IPV	Intimate Partner Violence
MOU	Memorandum of Understanding
Oranga Tamariki	Oranga Tamariki, Ministry for Children
ROC	Report of Concern
Child Abuse	The harming whether physically, emotionally, or sexually, ill treatment, abuse neglect or deprivation of any child or young person. (CYP&F Act 1994s2)
Emotional /Psychological Abuse	Any act or omission that results in impaired psychological, social, intellectual functioning and development of a child or young person
Neglect	Any act or omission that results in impaired physical function, injury and/or development of a child or young person
Physical Abuse	Any act or acts that may result in inflicted injury to a child or young person
Sexual Abuse	Any acts or acts that result in the sexual exploitation of a child or young person, whether consensual or not
Te Puaruruhau	Regional Child and Adolescent abuse assessment team (Starship). Provides acute assessment in cases of sexual assault/abuse

Associated Documents

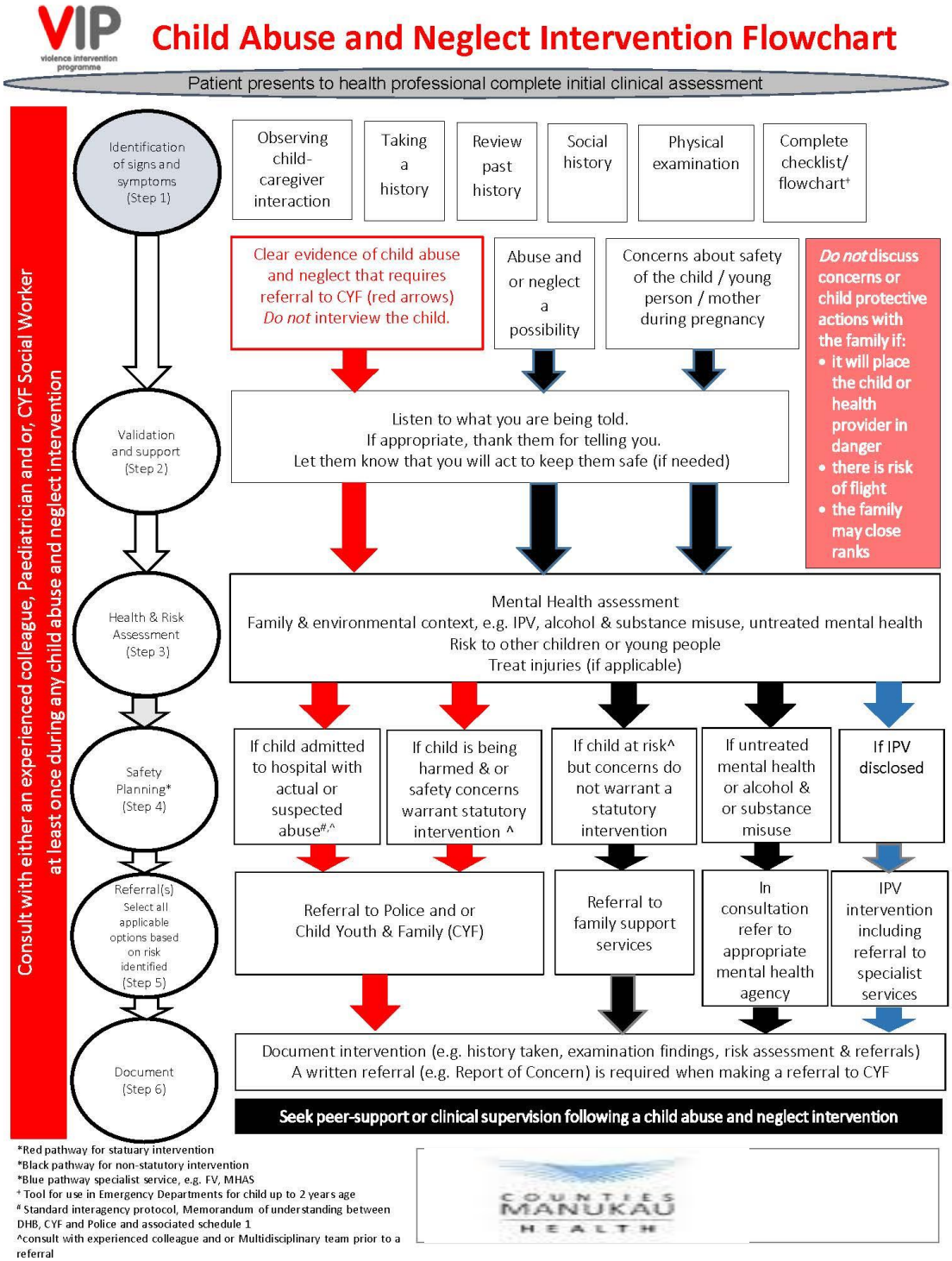
Other documents relevant to this procedure are listed below:

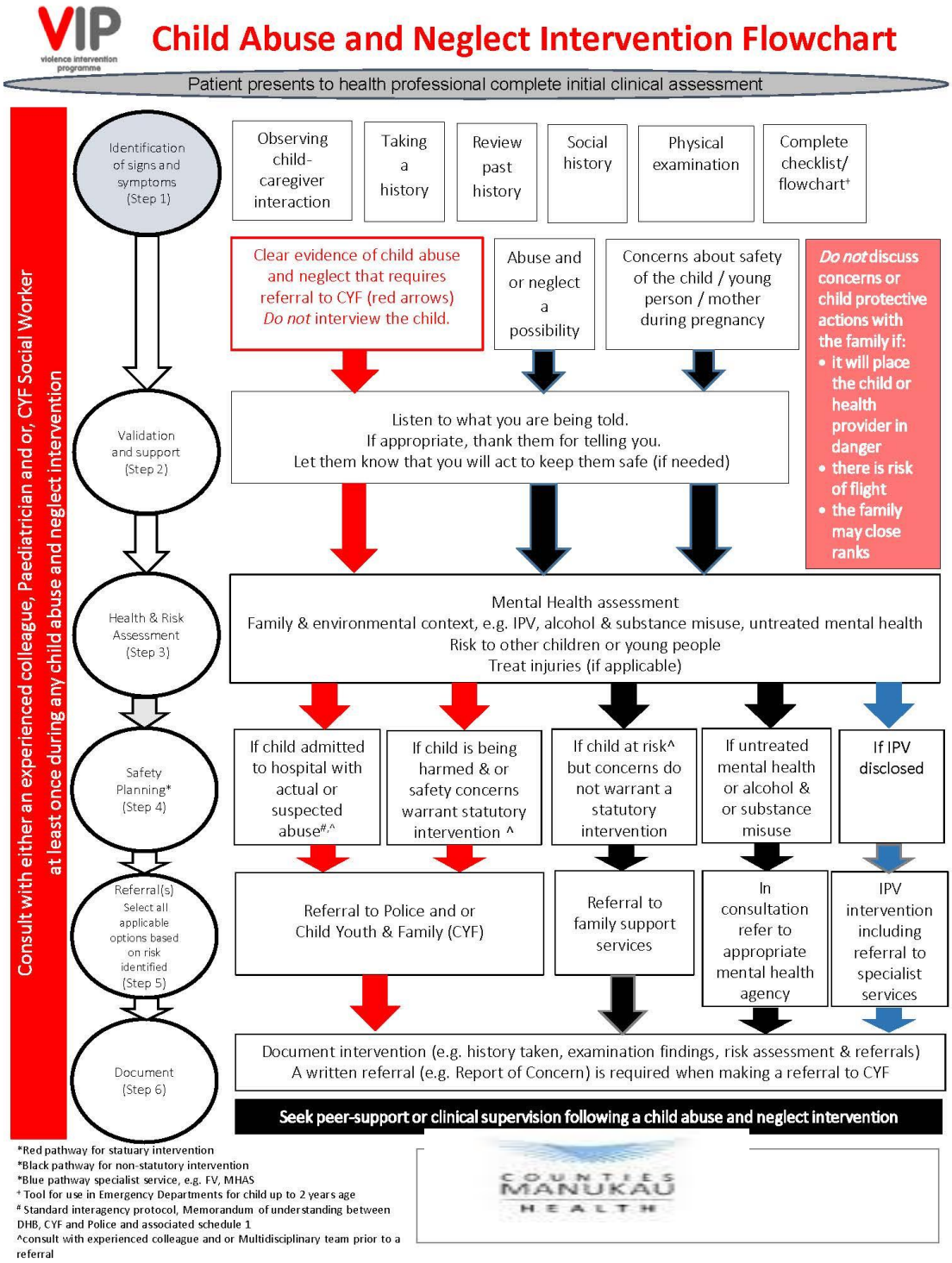
NZ Legislation / Standards	Oranga Tamariki Act and amendments. Care of Children Act. Crimes Act and Amendment. Family Violence Act Treaty of Waitangi. Health Information Privacy Code. Health and Disability Services Act. Privacy Act. Summary Offences Act.
CM Health Documents	Family Violence Intervention Policy. Informed Consent (Child and Youth) Policy. Clinical Photography Policy. Disclosure of Health Information – How a Third Party Requests Personal Health Information about a Patient. Employee Initiated Disclosure of Health Information. Tikanga Best Practice Policy. Security Policy. Child Abuse and Neglect Procedure. Temporarily Changing Patient Identity Procedure. Family Violence Intervention Procedure.
Other related documents	An interagency guide-Working together to keep children and young people safe (2011). Family Violence Assessment and Intervention Guideline (2016). Nga Vaka o Kaiga Tapu (Ministry of Social Development Taskforce for Action on Violence within Families 2012). He Korowai Oranga: Maori Health Strategy (Ministry of Health 2014b). Memorandum of Understanding between Police, Oranga Tamariki and DHB's (2016) with associated schedules: • Schedule 1 - Interagency management and safety of children and young people identified as experiencing abuse and neglect. • Schedule 2 - The role of Oranga Tamariki hospital Liaison Social Worker. • Schedule 3 – Guideline for the Management of children with Neglect of Medical Care. • Schedule 4 - Joint Standard Operating Procedures for Children and young Persons in Clandestine Laboratories.

APPENDIX 1

CONSULTATION

Should occur at least once throughout this process




VIP
violence intervention programme
Child Abuse and Neglect Intervention Flowchart
Patient presents to health professional complete initial clinical assessment
Consult with either an experienced colleague, Paediatrician and or, CYF Social Worker at least once during any child abuse and neglect intervention
Identification of signs and symptoms (Step 1)
Observing child-caregiver interaction
Taking a history
Review past history
Social history
Physical examination
Complete checklist/ flowchart+
Clear evidence of child abuse and neglect that requires referral to CYF (red arrows) Do not interview the child.
Abuse and or neglect a possibility
Concerns about safety of the child / young person / mother during pregnancy
Do not discuss concerns or child protective actions with the family if:
• it will place the child or health provider in danger
• there is risk of flight
• the family may close ranks
Validation and support (Step 2)
Listen to what you are being told.
If appropriate, thank them for telling you.
Let them know that you will act to keep them safe (if needed)
Health & Risk Assessment (Step 3)
Mental Health assessment
Family & environmental context, e.g. IPV, alcohol & substance misuse, untreated mental health
Risk to other children or young people
Treat injuries (if applicable)
Safety Planning* (Step 4)
If child admitted to hospital with actual or suspected abuse#,^
If child is being harmed & or safety concerns warrant statutory intervention ^
If child at risk^ but concerns do not warrant a statutory intervention
If untreated mental health or alcohol & or substance misuse
If IPV disclosed
Referral(s) Select all applicable options based on risk identified (Step 5)
Referral to Police and or Child Youth & Family (CYF)
Referral to family support services
In consultation refer to appropriate mental health agency
IPV intervention including referral to specialist services
Document (Step 6)
Document intervention (e.g. history taken, examination findings, risk assessment & referrals)
A written referral (e.g. Report of Concern) is required when making a referral to CYF
Seek peer-support or clinical supervision following a child abuse and neglect intervention
*Red pathway for statuary intervention
*Black pathway for non-statutory intervention
*Blue pathway specialist service, e.g. FV, MHAS
+ Tool for use in Emergency Departments for child up to 2 years age
# Standard interagency protocol, Memorandum of understanding between DHB, CYF and Police and associated schedule 1
^consult with experienced colleague and or Multidisciplinary team prior to a referral
COUNTIES MANUKAU HEALTH