

Child Protection – Organisational Guideline

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1. Overview

Purpose

This policy provides Waitemata District Health board (WDHB) staff with a framework to identify and manage actual or suspected child abuse and neglect. It recognises the important role and responsibility staff have in the accurate detection of suspected child abuse, and the early recognition of children at risk of abuse. This policy applies to all cases of actual or suspected abuse and neglect encountered by employees, students and those contracted by WDHB.

Scope

All WDHB staff

Definitions

All definitions relevant to this document are included in [Appendix A](#)

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2. Kaupapa / Principles

This document is based on the following kaupapa:

- Staff must report actual or suspected child abuse or neglect to Oranga Tamariki, Ministry for Children (previously known as Child, Youth and Family). Consultation is seen as a key part of the decision to report.
- “The welfare and interests of the child or young person shall be the first and paramount consideration” (Oranga Tamariki Act 1989)
- Staff are supported to become competent in the identification and management of actual or potential abuse. This is enabled through the WDHB Violence Intervention Programme (VIP).
- Wherever possible and as appropriate, the family participate in the making of decisions affecting the child or young person.
- Working in partnership with both external agencies and WDHB services is required in order to provide an effective and coordinated approach to child protection.
- Consultation is a key principle and is expected to occur throughout the six step process outlined in this document.

3. Training

The WDHB VIP team (consisting of the Family Violence Co-ordinator and Child Protection Co-ordinator) are responsible for the oversight of all Family violence/ Child Protection training within the DHB to maintain the MOH VIP standards. The coordinators will ensure quality improvement activities are undertaken in target services.

All WDHB clinicians who work with children and families are expected to have completed the MOH VIP core training programme. Core training is booked through WDHB Learning and Development with service manager approval. Annual updates are recommended and will be arranged by the VIP team in collaboration with individual service managers. Where staff have previously attended the MOH VIP core training at a different DHB, they are required to contact the WDHB VIP team to arrange orientation in lieu of further core training.

Training attendance records should be kept by the individual and service manager.

4. Legislation

The following legislation determines our legal responsibilities in regards to Child Protection concerns in NZ.

- **Oranga Tamariki Act (1989)**
 - Reporting of ill treatment or neglect
 - Protection of person reporting ill treatment or neglect
 - Government departments supply of information
- **Privacy Act (1993)**
 - Disclosure of information
 - Interagency information sharing
- **Health Information Privacy Code (1994)**
 - Disclosure of information
- **Health Act (1956)**
 - Disclosure of information
- **Vulnerable Children Act (2014)**
 - Child protection policy requirement
 - Worker safety checking
 - Subsequent children legislation

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Further detail regarding legislation is contained in pages 103-108 of the [Family Violence Assessment and Intervention Guidelines 2016 Ministry of Health NZ](#).

5. Cultural Considerations

Family violence is experienced across all cultural groups. The following information is provided to support staff in working with families from the identified groups.

Māori

Māori are significantly over-represented as both victims and perpetrators of whānau violence. This should be seen in the context of colonisation and the loss of traditional structures of family support and discipline. However, violence is not acceptable within Māori culture.

The WDHB Child Protection Policy has been developed in accordance with the principles of action including the Treaty of Waitangi principles, recognising Te Whare Tapa Wha and Kaupapa principles. This is consistent with cultural training offered and mandated within WDHB.

Key principles to be considered when working with Māori whanau are described in [Appendix B](#) and should be used in conjunction with active consultation with He Kamaka Waiora.

Pacific

Violence was defined by the working group for Nga Vaka o Kāiga Tapu (Taskforce for Action on Violence within Families 2012) as violations of *tapu* (forbidden and divine sacredness) of victims, perpetrators and their families. Violence disconnects victims and perpetrators from the continuum of wellbeing, and transgresses the tapu.

Key principals to be considered when working with Pacific families are described in [Appendix C](#) and should be used in conjunction with consultation with Pacific Support Services - Tautai Fakataha.

Asian, Middle Eastern and African

A resource has been developed by Waitemata DHB's eCALD® Services entitled "CALD Family Violence Resource for Practitioners: Working with Asian, Middle Eastern and African women and families". The resource provides a general guide, culture specific knowledge and tools around family violence intervention for health professionals working with clients from Asia, Middle Eastern and African background.

Key principals to be considered when working with Asia, Middle Eastern and African families are described in [Appendix D](#) and should be used in conjunction with the following:

- eCALD® Culture Competency Training and Resources - located through www.eCALD.com.
- WDHB Asian Support Services
- Shakti - Shakti is the specialist provider of culturally competent support services for women, children and families of Asian, African and Middle Eastern origin. Contact details should be accessed through www.shakti-international.org or 0800SHAKTI.

Use of interpreters

For child protection concerns professional interpreters must be utilised- **do not** use a family member.

Interpreters are booked through the Waitemata Translation & Interpreting Service ([WATIS](#)).

Once an interpreter has been arranged, health professionals should brief the interpreter on the situation and the areas to be covered before the interview begins. The interpreter may offer information to the health professional about relevant cultural factors relating to concerns identified. This information should be noted but should not be regarded as definitive. It must be noted that not all interpreters are familiar with family violence/ child protection perspectives within their own community and some may not be able to offer

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any views. Following the interview, the health professional should debrief the interpreter to ensure that the interpreter has an opportunity to share their concerns about any aspects of the case and to have these answered. It is important to thank the interpreter for their services.

It should always be remembered that the interpreter is not an advocate or a counsellor and should not be asked to provide advice, or an opinion on clinical matters (or any other assistance), beyond an interpretation of the interview between the patient/client and the health professional. Full details on working with interpreters can be found in the eCALD® Services **CALD 4: Working with Interpreters** course, which can be accessed on www.ecald.com

6. Management of Child Protection Concerns - 6 Step Process

All situations where child abuse and/or neglect is disclosed, detected or suspected must be acted on and reported using the following 6 step process outlined in this document. A flowchart showing the 6 step process is contained in [Appendix E](#)



CONSULTATION

Note: Consultation should occur at least once during the 6 step process. **At least one** of the following staff should be utilised for consultation:

- Oranga Tamariki Liaison Social Worker (Monday- Friday 8-5pm)
- Oranga Tamariki – 0508 FAMILY – Usual business hours are Monday to Friday 8-5pm but are available 24 hours for critical incidents)
- WDHB Social worker
- Nurse Advisor Child Protection
- Family Violence Prevention Co-ordinator
- Consultant paediatrician on call
- Violence Intervention Programme (VIP)Champion in your area
- A senior clinician with experience in managing child protection concerns

6.1 Step 1: Identification of signs and symptoms

Asking about abuse

Routinely enquiring about child abuse and neglect is not recommended. 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 question the child. Interviewing of the child regarding abuse is considered a specialist skill. It is important we do not traumatise a child by asking them to retell their story multiple times to multiple people.

If a child has an injury or discloses possible abuse you can ask simple, non-leading questions such as:

- What happened?
- When did this happen?
- Who was with you when this happened?
- Where were you when this happened?

Any conversations need to be undertaken with consideration to privacy and to the child's developmental age and stage. For adolescents the use of the HEADSS assessment tool is recommended, and is described in page 89 of the [Family Violence Assessment and Intervention Guidelines 2016 Ministry of Health NZ.](#)

If you have concerns about possible abuse or neglect, but there are other possible explanations for the things causing you concern then ensure you consult (see previous consultation box).

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Possible signs of abuse

There is no one size fits all approach for the identification of children or young people at risk. Utilise both observations and information gathered as part of your assessment.

Possible signs and symptoms should form part of your assessment. An abridged list of signs and symptoms is listed below and should be used in conjunction with the expanded detail provided in the [Family Violence Assessment and Intervention Guidelines 2016 Ministry of Health NZ](#) and the [Child Maltreatment: When to suspect child maltreatment in the under 18's - NICE Guidelines 2009](#).

Physical

Possible flags for physical abuse include, but are not limited to:

- Unexplained head injuries
- Unexplained bruises, welts, cuts and abrasions
- Unexplained bruise or injury in a baby who is not yet independently mobile
- Unexplained fractures
- Unexplained burns
- Child or parent can't recall how injuries occurred, or explanations change or don't make sense.

Sexual abuse

Physical signs and symptoms are often absent, whilst behavioural changes may be most evident. Concern may exist if:

- there is age-inappropriate sexual play or interest
- there is fear of a certain person or place
- other behaviour changes present (see emotional abuse)

Anogenital symptoms – such as redness, swelling, bruising or bleeding from the genital or anal area – do not necessarily indicate sexual abuse, but need to be evaluated by a doctor trained in the area of child sexual abuse. Therefore consultation should occur with the on call paediatrician.

Emotional abuse

Most forms of abuse, exposure to violence and neglect are accompanied by emotional effects, which may or may not cause behavioural changes.

Behavioural changes listed below are **not** specific for the emotional consequences of abuse and neglect but should be considered:

- Sleep problems
- Frequent physical complaints
- Signs of anxiety
- Other altered behaviour: withdrawing, self-harm, conduct disorder, aggressive behaviour, deteriorating school performance.

Neglect

Neglect is one of the most common forms of child maltreatment, but difficult to define. Types of neglect include:

- *Physical neglect*: not providing necessities of life
- *Neglectful supervision*: Leaving children home alone, or without someone safe to look after them
- *Emotional neglect*: Not giving children comfort, care, attention and love they need through every day play, talk and affection.
- *Medical neglect*: failure to take care of health needs
- *Educational neglect*: Allowing chronic truancy, failure to enrol children in school or inattention to special education needs.

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Key components of Step 1

Observe child –caregiver interactions

Possible cues to consider include:

- 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 would raise concern include: 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.

Take a history

Ensure history taken includes:

- 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? For example, if it was a fall, where did they fall; how did they fall; height of the fall
- When did the symptoms begin in relation to the accident? How were they noticed, and who noticed them?
- What is the child’s developmental capability?

Review past history

Review child or young person’s clinical record for previous presentations or admissions. Multiple presentations for illness and injuries may indicate risk.

Checking for child protection alerts is one aspect of reviewing past history.

Child Protection Alerts

- Check for the presence of child protection alerts when a child enters any WDHB service. Alerts are stored on concerto.
- Consider the information as part of the child’s assessment by consulting with another experienced colleague regarding the content of the alert and current assessment.
- If ongoing contact with a child, for example in a community setting, then ensure alerts are regularly rechecked to ensure new alert information is detected.
- Accessing and responding to a child protection alert is detailed in the child protection alert flow chart in [Appendix F](#). Please note that all requests for alerts from DHB’s other than WDHB or CMDHB, should be made via WDHB Clinical Records. All clinical records departments respond to these alerts as a priority, but there may be a longer response time after hours. Remember that the presence of an alert flags the clinicians that there have been child protection concerns at a point in time.
- We do not routinely disclose the presence of child protection alerts to family due to the risk that a child may then not present in the future for care required. However if asked directly we should respond honestly. This decision was made at a national level and is discussed in the [National Child Protection Alert System Privacy Impact Assessment \(2011\)](#).

Social history

A variety of factors may have an effect on the risk of child abuse and neglect, for example:

- Intimate Partner Violence
- Multiple changes of address
- Alcohol/drug abuse in the home
- 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

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- Untreated mental illness.

While these factors are relevant to the health and welfare of the child, they do not necessarily predict abuse or neglect in any individual case.

Information regarding the family structure and existing supports that are in place, will help to determine the impact of risk factors on a child.

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.
- **All cases** should be referred to the paediatrician on call for consultation regarding management.



Note: Physical assessment should be completed by Te Puaruruhau at Starship for:

- All cases of sexual abuse – actual or suspected
- All cases of severe physical abuse

Child Protection Checklist/ Screen (Emergency Department Use Only)

- All children presenting to ED should have the child protection screening tool completed. The tool has been developed primarily for the use of children under 2 but provides valuable prompts for consideration for all children.
- The tool is guideline only, not a diagnostic algorithm.

Child protection screen		<i>Ensure family violence screening is done as well</i>	
Complete for all patients	History of previous injuries or existing child protection alert?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is there concern about the child and/or family's behaviour?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Any unexplained injuries on examination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Any other concern?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Complete if presenting with an injury	Age under 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Delayed presentation without satisfactory explanation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	History inconsistent with injury or child's developmental level?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes to any above inform Paediatric Team or ED SMO.		Sign:	



Note: The screening tool is a checklist for clinicians to consider as a way to review the child's presentation. It is **NOT** a set of questions to be asked of the parent/caregiver/ child.

6.2 Step 2: Validation and Support

Handling Disclosure of Abuse

- If a child/young person discloses abuse, **listen**.
- Tell them that no one deserves to be hurt and that it was not their fault.
- Do not over-react. Try not to alert the alleged abuser. Seek advice and support.
- Ensure the child's immediate safety. Do not ask investigative or ask leading questions but assess safety by asking open ended questions as previously discussed.
- Discuss that you will need to seek help for them and their family/caregivers.

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Talking with parents/caregivers of the child

While your actions are intended to support and validate the child or young person, they may or may not (depending on the circumstances) be seen as supportive. You should be transparent about the actions you as a health care provider need to take and the reasons for them.

However there are situations where consideration needs to be given to what is shared with the parents (see below).



Parents/caregivers should be informed of the plan to make a report of concern **EXCEPT** in the following situations:

- 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.

6.3 Step 3: Health and Risk Assessment

A risk assessment is required in order to determine the intervention required. Risk assessment is complex, requiring the need to balance the identified child protection concerns with protective factors. A risk assessment and subsequent safety plan must be undertaken prior to children being sent home when there have been identified child protection concerns.



Note: Points to remember for Step 3

- Risk assessment should not be undertaken in isolation but should be considered as part of an inter-disciplinary approach.
- Do not jump to conclusions.
- Consult as you work to determine what level of risk the child might be facing
- Appreciate that other organisations (e.g. CYF) may hold information that is crucial to determining the safety of the child.

Further detail about risk assessment is included in pages 43-45 of the [Family Violence Assessment and Intervention Guidelines 2016](#). Prompts for the risk assessment are included in the [Child Abuse and Neglect: Preliminary risk assessment](#) (listed on the cue card provided at core training).

Key components of Step 3

Risk to the child or young person

- 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.
- 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

Mental health assessment

- 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

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- 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.
(See [Appendix G](#) for Assessment and Referral for Children under 12 at Risk of Suicide)
- 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.

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.

Co-occurrence of intimate partner violence

- If child abuse is identified, assess the mother’s safety. Follow the procedure outlined in the [Family Violence / Intimate Partner Violence \(IPV\) policy](#)
- Victims of IPV 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.

Other risk factors

- If the social history identified other risk factors 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.

Examples of risk

Determining the level of risk can be challenging and currently there is not a comprehensive tool that can be utilised. Therefore in order to support understanding of risk, examples of immediate risk, child coming to harm and child at risk are provided in [Appendix I](#).

It is important to understand that these examples have been formulated based on clinical experience only and cannot be used solely for decision making.

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6.4 Step 4: Intervention and Safety Planning



Note: If there are concerns about immediate safety (including your own), contact the Police

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. 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.

The purpose of risk assessment is to ascertain the likely level of immediate risk for a patient leaving the health care setting.

Assessing for positive/protective factors e.g., family's efforts to actively pursue the safety and well-being 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 a 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.



Ensure CONSULTATION is undertaken when determining your intervention and safety plan. It is important to ensure that you have an inter-disciplinary approach to decisions made. Ensure you do not work in isolation.

Safety plan for child at immediate risk

Where a child is assessed to have immediate risk, steps must be taken without delay to ensure safety.

Police: If there are immediate safety concerns for the child or health professional then the police should be called on 111. Oranga Tamariki staff are unable to provide an immediate response, whereas Police are. After contacting Police a report of concern should be made to Oranga Tamariki urgently.

Oranga Tamariki: Where immediate risk exists but the child is currently in a place of safety, then Oranga Tamariki should be contacted urgently by phone with a written report of concern also completed. Oranga Tamariki legislative powers to act are described in [Appendix H](#).

Trespass orders: Trespass Orders may be issued if high concerns regarding child safety exist. These are instigated by contacting security.

Suppress patient details (inpatient): In high risk cases it may be necessary to suppress patient details and or provide secure processes at the time of discharge. This decision is made with support of management to determine a plan regarding release of information, care on the ward, and safe discharge planning.

Admission to ward: Admission to the ward should be implemented for children where there is no safe discharge plan.

Watch (inpatient): If a child is admitted to the ward, then consideration should be given to the provision of a watch to ensure safety. This decision should be made in conjunction with CYF. At a minimum the consideration of placing the child in a room in the ward that is more easily visible to staff should be considered. [Schedule 1 of](#)

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[The Memorandum of Understanding between Police, Oranga Tamariki and DHB's](#) outlines that the cost of the watch will be paid by WDHB for the first 24 hours after a report of concern has been made and accepted.

Child being harmed

Oranga Tamariki: A child who, in the opinion of the health professional, is already coming to harm, should be notified to Oranga Tamariki as a 'report of concern'. Oranga Tamariki will form their own opinion on the level of risk for the child and triage accordingly.

A plan should be implemented as soon as possible and prior to discharge that includes:

- If the child requires an admission for safety, including the provision of a watch.
- Who will be following up the outcome of the report of concern with Oranga Tamariki
- If the parents/caregivers have been informed of the report of concern
- What concerns you identified
- What the outcome of your risk assessment was
- What has been put in place to ensure the child's safety
- What support services have been offered to the child/young person and their family
- How the GP has been informed of the child protection concerns
- Who will be working with the family or having oversight of the case

WDHB should consider what services can be offered to the family to support the care of the child as appropriate. For example a referral to CADS for a parent who wants assistance to manage an addiction, referral to Marinoto for a child with mental health concerns, referral to community agency for parenting support.

Any referrals offered and or implemented should be included in the report of concern to Oranga Tamariki.

Child at Risk

When considering children at risk it is important to 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. Consider if the family will accept this referral and what positive or protective factors exist that could be enhanced.

Discuss the situation and your concerns with Oranga Tamariki to determine if a formal report of concern should be made. If Oranga Tamariki determines that the family is actively pursuing the safety and well-being of the child or young person, and has the willingness and capacity to respond then a report of concern to Oranga Tamariki may not be indicated.

A plan of care should include:

- What risks were identified
- What support services have been offered to the child/young person and their family
- How the GP and other actively involved clinicians have been informed of the risks to the child
- Who will be working with the family or having oversight of the case

Co-occurrence of child abuse and intimate partner violence

Joint safety planning and referral processes need to be implemented when both intimate partner violence (IPV) and child abuse and or neglect are identified.

6.5 Step 5: Referral

Referral to Oranga Tamariki


- Oranga Tamariki should be notified of all cases of actual or suspected child abuse and neglect. ([Memorandum of Understanding between DHB, Oranga Tamariki and Police \(2011\)](#))

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- The referral should be completed by the health professional who has been directly involved with the case to ensure information is as close to the source of information
- Referral to Oranga Tamariki is via phone **AND** written referral using the Oranga Tamariki Report of Concern Template located on the Staff Intranet- Child Protection – [Oranga Tamariki referral](#).
- A copy must also be sent to the child protection co-ordinator for consideration of a child protection alert (details are listed on the back page of the report of concern template)
- 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
- 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.

 Parents/caregivers should be informed of the plan to make a report of concern **EXCEPT** in the following situations:

- 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.

The handling of these conversations requires sensitivity to help parents/caregivers understand that you want to help to keep the child safe and support them in the care of the child.

Ensure you consult prior to discussing concerns with family. (See box in section 6 re who to consult with)

Referral to Police

- If you have imminent concerns for the safety of the child as they are currently not in a safe environment then call 111.
- If the child has been harmed and a report of concern has been made to Oranga Tamariki, then Police will be notified by Oranga Tamariki if the injuries reach the threshold for serious injury.
- If forensic evidence is required to be collected then consultation should occur with the consultant paediatrician on call and may be arranged in consultation with Te Puaruruhau (Starship).
- The Police have Child Protection Teams that are available for consultation as required.

Referral for Cultural Support

- Referral to cultural support services previously identified should be considered as part of the plan put in place for child and family.

Referral to Other services/ Community agencies

- Consider if there are other health, social, or community agencies where you can refer the family, to reduce stressors and promote health. Where you are unsure of available services to refer to then you will need to consult with a social worker or senior staff member for advice.
- Referrals should be undertaken with the consent of the parents as appropriate
- If there are concerns for an unborn child, the mother should be referred to Te Aka Ora Vulnerable Families forum within WDHB by contacting the Te Aka Ora co-ordinator ([Te Aka Ora Forum TOR](#)).

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Referral to GP

Where there is an identified GP for a child a letter should be written to advise of concerns and actions taken. When providing written information consider how to mitigate the risk that the alleged perpetrator may be able to access the information.

Referral to Family Violence Specialist Services

There are specialist services in the community who offer support for families where family violence is occurring. An up to date list of available services is contained on the [WDHB Violence Intervention Programme Intranet page](#).

Follow up

It is the responsibility of the referrer to follow up or arrange for follow up in regards to the referral made. Where clinicians arrange another clinician to provide the follow up, the instructions should be clear and directive about what needs to be done. Ensure documentation of the follow up plan.

6.6 Step 6: Documentation



Thorough documentation of all steps is necessary and should occur throughout the process.

Include in the documentation:

- Date and time the child/young person was seen and time notes were written
- Who was present at assessment, and who provided which information
- Your name, legible signature and practice designation
- Behavior, signs and symptoms you observed
- History
- Examination – date and time of examination, features of injury – site, shape, size, characteristics
- Photographs – if photographs were taken they should be completed in accordance with WDHB photography policies with clear documentation regarding storage and consent.
- Result of your risk assessment – include suspected or confirmed risk to other family members
- Consultation – document who you spoke to, at what points
- Actions taken – record any referrals made or offered, follow up care arranged and who is taking responsibility for the follow-up
- Discharge plan

7. 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.

8. 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 counseling from an appropriately trained clinician.

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Staff may access [Employee Assistance Programme](#) (EAP), which provides a confidential counselling service for all WDHB staff. Self-referrals are accepted without management approval for an initial series of sessions.

9. Children in Oranga Tamariki custody - Data Entry

Where Oranga Tamariki has advised that they have custody of a child they will request the contact details be amended for the child in IPM. If a parent should subsequently present with the child and ask for the details to be amended, this should first be confirmed with Oranga Tamariki. Contact to Oranga Tamariki to confirm the change is best made through the Oranga Tamariki DHB Liaison.

10. Decision resolution

Where there are concerns held by a clinician in regards to the management by Oranga Tamariki of a case, the clinician should discuss these with the WDHB Oranga Tamariki Liaison. If after contact the concerns are still held by the clinician then these should be discussed with the clinician's line manager and the WDHB Child Protection Coordinator.

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Appendix A: Terms and Definitions

Child	Unborn children and children aged 0–13 years
Young person	14-17 years
Intimate Partner Violence (IPV)	Physical or sexual violence , psychological or emotional abuse or threat of physical or sexual violence that occurs between intimate partners
Family Violence	Family violence is violence or abuse of any type, perpetrated by one family member against another family member. It includes Child Abuse and Neglect, Intimate Partner Violence (IPV) , and Older Adult and Vulnerable Adult Abuse.
Child Protection	Means the activities carried out to ensure the safety of the child, young person 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, young person (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
Oranga Tamariki, Ministry for Children (Previously known as CYFS)	Government agency that carries out the legislative requirements of the Oranga Tamariki Act (Previously known as Children, Young Persons, and their Families Act 1989). Responsibilities are: <ul style="list-style-type: none"> ▪ 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.
Police	Government agency responsible for: <ul style="list-style-type: none"> ▪ Working cooperatively with Oranga Tamariki 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 Oranga Tamariki.
MOH	Ministry of Health
VIP	Violence Intervention Programme. This is implemented by the WDHB Family Violence Co-ordinator and Child protection co-ordinator.
Te Puaruruhau	Te Puaruruhau is the ADHB health service for children and young people who have experienced abuse or neglect. This service is located in a multi-agency centre with Police and Oranga Tamariki at 99 Grafton Road (opposite the Starship building).

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Appendix B: Māori and Family Violence

REFERENCE: The following Māori Model of Care and Kaupapa are abridged versions taken from the following WDHB Policy: *Te Whare Tapa Whā – Application to Practice in Child Health (2016)* and *Ministry Of Health Family Violence Assessment and Intervention Guideline – Child abuse and intimate partner violence (2016)*.

13.1 Te Whare Tapa Whā

Te Whare Tapa Whā is an accepted model of Māori health that transcends all cultures, published by Mason Durie in 1985². The model outlines four dimensions of health, with the balance of each of these being essential for wellbeing. The four dimensions of wellbeing within our social context are; taha whānau (family/social health), taha tinana (physical health), taha wairua (spiritual health) and taha hinengaro (mental health). When any of these four dimensions of health are impaired or contravened, a person becomes unwell. Within health services there is a primary focus on physical health; however it is important to understand all of these dimensions to deliver a holistic approach when addressing the health of all consumers.

Taha Hinengaro

Emotional Wellbeing.

Family Violence impacts on the emotional wellbeing of the family/whanau.

It is important to work in partnership with family/whanau to restore their dignity and power.

Taha Wairuatanga

Spiritual

Spiritual wellbeing acknowledges that the spiritual essence of a person is their life force. Durie refers to this as the “capacity for faith and wider communication”.

Be aware that a person’s wairua (soul or spirit) is likely to have been damaged as a result of emotional, physical and/or sexual abuse. Take care to treat victims of violence with compassion, warmth and respect

Taha Tinana

Physical safety and wellbeing

Taha tinana encompasses the need to ensure that as a service we create a safe environment for family/whanau that assists their wellbeing.

Support is given to ensure that family/whanau are safe in their community and free from all aspects of physical and emotional harm.

Taha Whānau Whānaunatanga

Extended family/whanau

Family Violence isolates family/whanau from their networks of support. It is essential to work in partnership with family/whanau and Māori community organisations to provide support for those experiencing violence.

“The best outcome is one where whanau members have a strong sense of identity, feel well cared for, are able to enjoy quality lifestyles with a sense of independence, yet remain concerned about the wellbeing of other whanau members” Mason Durie (Measuring Maori Wellbeing 1/08/2006)





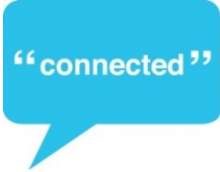
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13.2 Māori Kaupapa in Practice - Responding to Family Violence

Waitemata DHB Core Values and Māori Kaupapa In Practice

 <p>“Best care for”</p>	<p>Kaitiakitanga Refers to the guardianship or protection of family/whanau and the environment so that they continue to thrive from generation to generation.</p>	<p><i>Recognise that safety should always be paramount. Ensure processes are in place to keep all vulnerable people, and staff safe.</i></p> <p><i>Be aware that the physical, emotional and spiritual safety/wellbeing of mothers is important for the safety of their children</i></p>
 <p>“everyone matters”</p>	<p>Oritetanga Refers to equality</p>	<p><i>Deliver the same high quality service to everyone, no matter what their age, gender, ethnicity or social background.</i></p> <p><i>Understand that some whānau may need more information about the health sector and your role may be to empower and inform them of their rights and responsibilities.</i></p>
 <p>“with compassion”</p>	<p>Manaakitanga Is about nurturing an looking after people and relationships. Here action is taken to enhance the mana (prestige and integrity) of each individual. Relationships are based on compassion, generosity, reciprocity and respect.</p>	<p><i>“The capacity to care (Manaakitanga) is a critical role for whanau in respect of children and older members” (Mason Durie Measuring Maori Wellbeing 01/08/2006).</i></p> <p><i>Convey a genuine, open, supportive, caring and respectful attitude from first point of contact.</i></p> <p><i>Offer a comfortable and welcoming environment for Māori (including the physical environment and the behaviour and attitudes of health professionals).</i></p> <p><i>Aim to pronounce Māori names and words correctly. This will convey a sense of care and respect. If you are not sure how to pronounce someone’s name, ask.</i></p>
 <p>“better, best, brilliant”</p>	<p>Pukengatanga Involves the achievement of progressive milestones and skills, enabling individuals to reach their goals and their potential ie: mana wellbeing.</p>	<p><i>Work with the individual, whānau, and other professionals (where relevant) to identify achievable plans to ensure short, medium and longer term safety for victims of family violence. After short term safety is established, support them to take the next step.</i></p> <p><i>Ensure that individuals/whānau are informed of their options so that they have the opportunity to restore and enhance their mana.</i></p>
 <p>“connected”</p>	<p>Kotahitanga Exists when people work together in unity to support and achieve common goals.</p>	<p><i>Application of a collaborative approach to enable family/whānau to be safe. This should involve information sharing and planning with whanau, other professionals, and community providers.</i></p> <p><i>Build partnerships with whānau, and Māori organisations in your community.</i></p>

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Appendix C: Pacific Peoples and Family Violence

PACIFIC PEOPLES AND FAMILY VIOLENCE

This section draws on Nga Vaka o Kāiga Tapu (Ministry of Social Development Taskforce for Action on Violence within Families 2012), a conceptual framework, for addressing family violence in seven Pacific communities in New Zealand. Nga Vaka o Kāiga Tapu aims to assist practitioners and service providers, and mainstream organisations working with Pacific families, in:

- their work with victims, perpetrators and their families who have been affected by family violence
- grounding their experiences and knowledge in elements of an ethnic-specific culture in ways that are relevant to the diverse experiences of the families.

What family violence means in a Pacific context

Violence was defined by the working group for Nga Vaka o Kāiga Tapu as violations of tapu (forbidden and divine sacredness) of victims, perpetrators and their families. Violence disconnects victims and perpetrators from the continuum of wellbeing, and transgresses the tapu.

Risk factors for family violence amongst Pacific people

The following factors that contribute to family violence in a Pacific context:

- situational factors: including socioeconomic disadvantage, migration culture and identity
- cultural factors: including beliefs that women are subordinate to men; perceptions and beliefs about what constitutes violence; (mis)interpretation of concepts, values and beliefs about tapu relationships between family members including children and the elderly; unresolved historical and intergenerational issues; fusion of cultural and religious beliefs and their (mis)interpretations
- religious factors: including (mis)interpretations of biblical texts; fusion of cultural and religious beliefs and their (mis)interpretations.

Protective factors for Pacific families

- reciprocity
- respect
- genealogy
- observance of tapu relationships
- language and belonging are concepts that are shared across the seven ethnic specific communities as elements that protect and strengthen family and individual wellbeing.

Transformation and restoration

Education is identified as a critical process for transforming violent behaviour and restoring wellbeing to families. It is the responsibility of both practitioners and the communities. The following are four important features that must be practiced together when delivering an education programme aimed at building and restoring relationships within families:

- fluency in the ethnic-specific and English languages
- understanding values
- understanding the principles of respectful relationships and the nature of connections and relationships between family members within the context of ethnic-specific cultures
- the correct understanding and application of strengths-based values and principles.

Principles for action

1. Victim safety and protection must be paramount

The safety of the victim must be paramount. Any practices or interventions that health care providers engage in should not further endanger or disadvantage a Pacific victim of family violence (FV).

Actions and behaviours to ensure victim safety and protection:

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- routinely enquire about experience of IPV for women, and about intimate partner violence if there are signs and symptoms for men. Be alert for indication of abuse and neglect among children
- follow the health and risk assessment procedures outlined, and, wherever possible, involve the person in determining the plan of action they would like to take
- your communication style is important. Your language and tone should convey respect and a non-judgemental attitude. Preferably communicate in the language of the victim
- affirm the person's right to a safe, non-violent home
- offer referral to either specialist Pacific or mainstream family violence advocates.

2. *The provision of a Pacific-friendly environment*

The first point of contact is important in building trust, together with an atmosphere that conveys openness, caring and one that will not judge. Some Pacific peoples will have English as a second language, so communicate simply and clearly; or provide assistance from an appropriately trained (non-family) person who speaks the same language.

Actions and behaviours that contribute to Pacific people feeling comfortable:

- introduce yourself and acknowledge who you are speaking with
- start with some general conversation; do not be too clinical and business-like
- convey a genuine attitude that is gentle, welcoming, caring, non-judgemental and respectful – **first contact is vital**
- do not rush – leave time to think about and respond to questions
- ask open-ended questions
- offer resources and support that meets the ethnic-specific needs of the victim.

3. *The provision of culturally safe and competent interactions*

Health care providers are encouraged to seek training to develop their cultural safety and competence in working with Pacific peoples.

Actions and behaviours that contribute to the development of culturally safe and competent interactions:

- be cognisant of the factors contributing to FV for Pacific peoples
- identify and remove barriers for Pacific victims of FV accessing health care services
- develop knowledge of referral agencies appropriate for Pacific victims of violence.

4. *A collaborative community approach to family violence should be taken*

The implementation of interventions for Pacific victims of FV should occur in collaboration with other agencies or sectors to ensure that the needs of Pacific victims of violence are adequately addressed.

Actions and behaviours that contribute to a collaborative intersectoral approach:

- recognise that for solutions to be meaningful to Pacific victims of FV, other sectors may need to be involved
- take the time to know your local community and FV referral agencies. If possible, offer referral to Pacific advocates with expertise in FV
- do not assume that the family or church should be involved in supporting the Pacific victim of FV – ask what plan of action they want (it may or may not include the family and the church).

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Appendix D: Asian, Middle Eastern and African and Family Violence

This section is taken from the *CALD Family Violence Resource for Health Practitioners: Working with Asian, Middle Eastern and African Women and Families resource (WDHB eCALD® Services, 2016)*. The CALD Family Violence Resource complements eCALD® Services, CALD Cultural Competency Training Programme which can be accessed on www.ecald.com.

Family violence context

Culture influences how people view abuse, whether they seek help and how they communicate their experience and from whom they are likely to seek assistance (Weber & Levin, 2003). For migrant women in situations of intimate partner violence, cultural factors such as ostracism from family and community may serve to prevent disclosure. As well, perceptions of what constitutes violence differ culturally. In some communities verbal and physical violence are not considered abuse. Accordingly, women may not consider themselves the victims of crime, or that they have rights as victims (Lay, 2006).

Risks and vulnerability factors for Migrant Women

Ethnic community perceptions that family violence is a private matter and; women's desire to keep their marriage intact are significant barriers to reporting partner abuse. It is also important to remember that divorced women, even when there is known abuse, lose all their social status in their community and are often ostracised.

There are a number of factors which contribute to the migrant women's vulnerability. These include the following:

- Family, face saving, faith, custom and fate
 - Social Isolation and lack of family networks
 - Family values
 - Conflict with in-laws
 - Dependency through low or no English language and literacy skills
 - Uncertainty around accessing help
 - Forced Marriage
- A woman's immigration status plays a significant role in her susceptibility to abuse.
- Women from culturally and linguistically diverse backgrounds may face cultural and language barriers to using health services and may be under-served as health populations.
 - Migrant women in situations of family violence are particularly at-risk during pregnancy.
 - Asian, Middle Eastern and African women and children have the poorest access to women's refuge services in New Zealand compared to other groups in New Zealand society (Ministry of Social Development, 2011).
 - Family violence in Asian, refugee and other CALD migrant communities is heavily stigmatised and is under-reported (Boutros et al., 2011; Family Violence Prevention Fund, 2009; Mehta, 2012; Rees & Pease, 2007).

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Areas for consideration

1. *How to reduce fear of authorities - (Adapted from Weber and Levine, 2003)*

Fear of the Police	Fear of Immigration Authorities
Factors to consider	Factors to consider
The victim may believe that her immigration status prevents her from seeking police protection and assistance.	If a woman is not a New Zealand resident, her abusive partner may threaten to contact immigration officials to have her deported. Women should be informed that as a victim of partner abuse, they can seek protection from such deportation (<i>Immigration New Zealand, 2015</i>).
A refugee or migrant woman's negative experience with police in her country of origin or asylum may affect her expectations of police in New Zealand.	Women need to be reassured that it is safe to report family violence to police in New Zealand. Further, as above women need to be informed that they can seek protection from deportation, as a victim of family violence. Inform the victim of the <i>Residence Category for victims of domestic violence</i> (Immigration New Zealand, 2015). Refer to S4.5 Residence Category for victims of domestic violence on the Immigration NZ website: http://onlineservices.immigration.govt.nz/opsmanual/42635.htm .
Critical information for the patient	Critical information for the patient
Disclosing abuse to a health professional does not imply that the police will be contacted	The victim does not jeopardise her immigration status by seeking medical treatment for her injuries or her child's injuries
Health professionals can help establish a plan of safety and support for the victim and her children.	Counselling and other legal and social services ie: 0800SHAKTI may be available in the victim's language and may be offered by health professionals/services who understand her culture/religious background.
What you can do	
<ul style="list-style-type: none"> ▪ Emphasise that the health professional and the interpreter are bound by patient confidentiality-unless there is threat of serious harm to the patient, children or others. ▪ Confidentiality of disclosures – advise and reassure the patient/client that any details will be kept secure and not given out without authority – unless people are in danger. In the case of serious harm to the patient or others the Police and/or Child, Youth and Family will be informed. Consult with experienced staff first if possible. ▪ Where relevant, inform the victim of the <i>Residence Category S4.5 in Immigration NZ Legislation</i> ▪ Inform the patient that there is expert legal assistance available to her. ▪ Refer the victim to trustworthy and confidential cultural support (if available). 	

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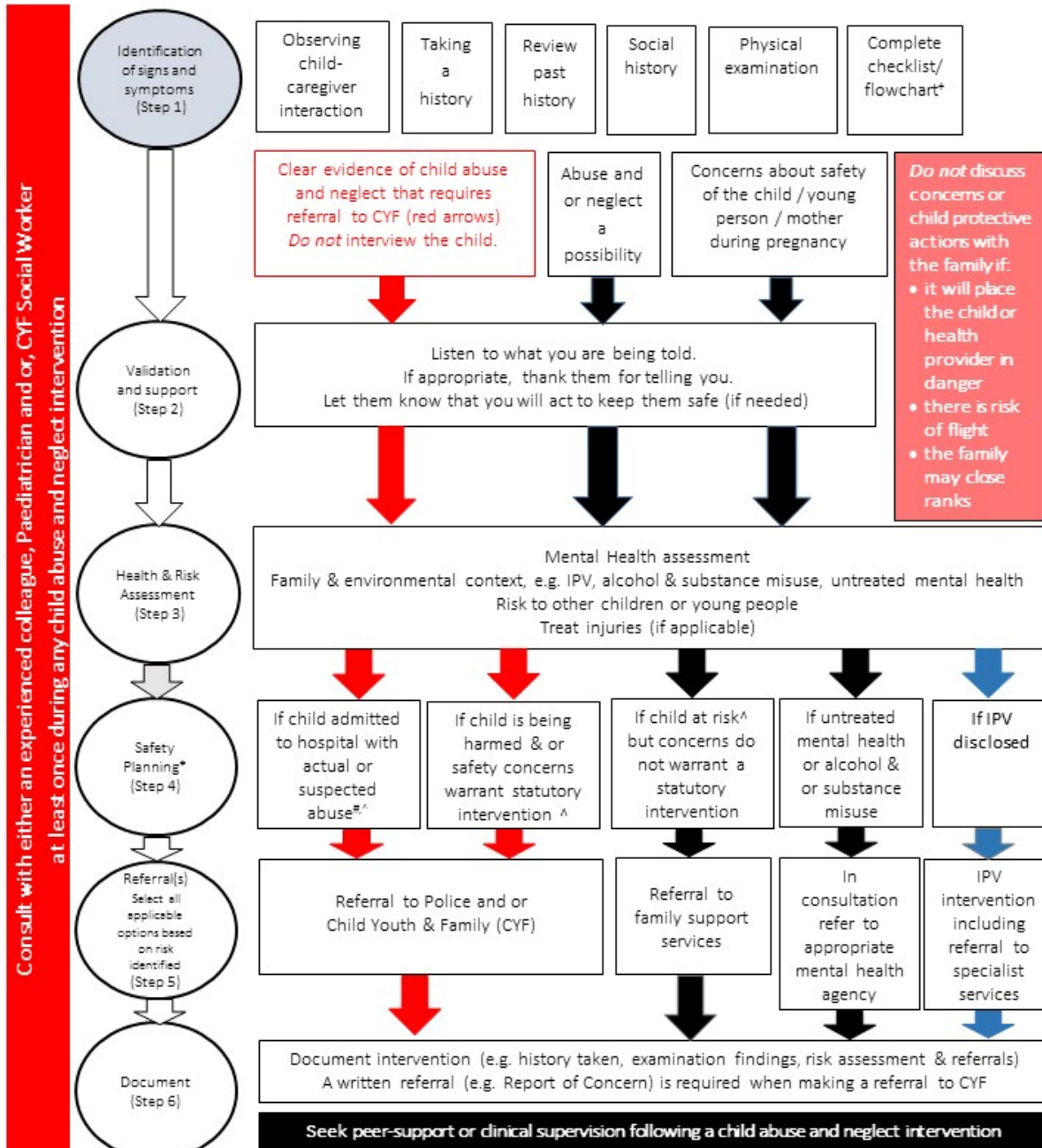
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Appendix E: Child Protection Flowchart - 6 Step Process



Child Abuse and Neglect Intervention Flowchart

Patient presents to health professional complete initial clinical assessment



*Red pathway for statutory 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

Appendix F: Responding to a Child Protection Alert

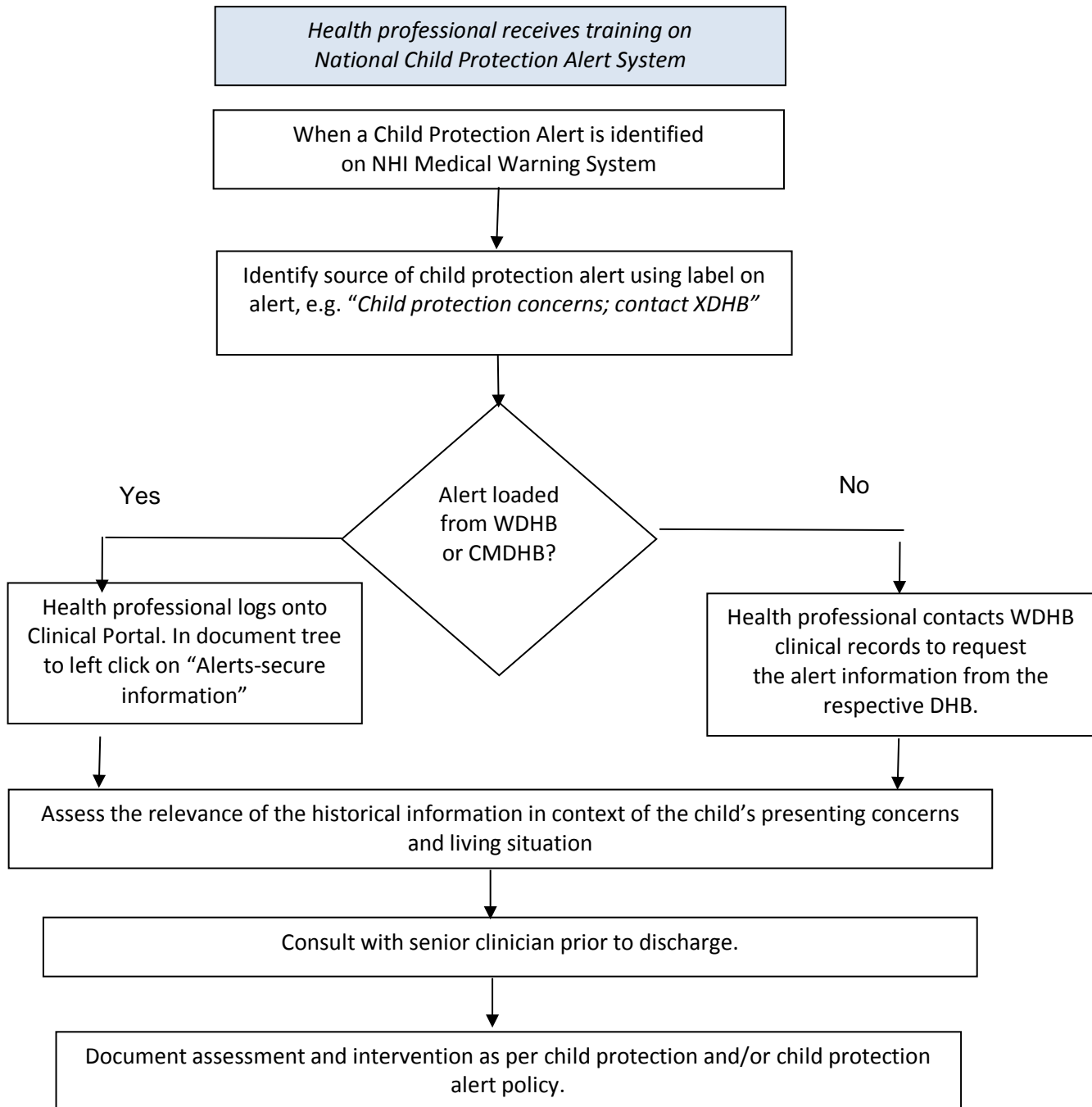
Refer also to WDHB Policy: *Child Protection Alert Management*

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An alert indicates there have been child protection concerns about an unborn baby, child or young person(0-17 years). It is vital that a thorough assessment is undertaken at each presentation.



Appendix G: Assessment & Referral for Children under 12 at risk of Suicide

Factors to consider when assessing the child's level of risk of suicidal behaviour (from [Family Violence Assessment and Intervention Guidelines 2016](#))

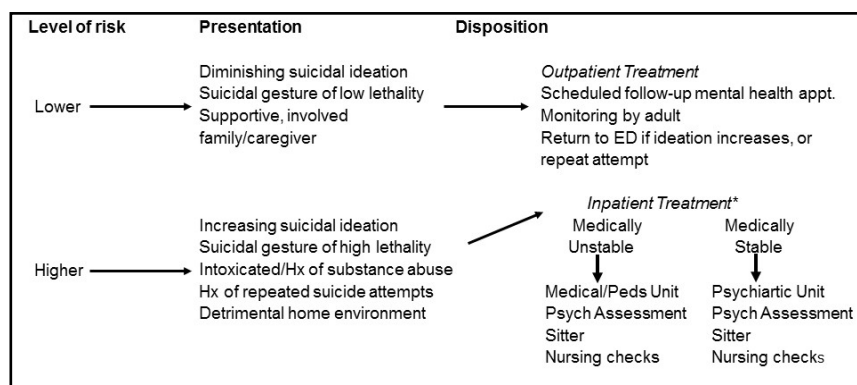
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<p style="text-align: center;">Seriousness of injury</p> <hr/> <p>Suicidality History History (Hx) of prior suicide attempts¹ Child's Hx of prior suicide attempts² Hx of suicidal ideation¹ Child's Hx of suicidal ideation²</p> <hr/> <p>Medical History² Hx of psychiatric diagnoses Hx of mental health treatment and/or psychotropic drug use Hx of substance use or abuse Number of previous ED visits for suspicious accidents Chronic illness-frequency requiring compliance</p>	<p>Current presentation Intend to die¹ Child's intent to die² Suicide plan, method, access to method¹ Current psychiatric symptoms (depression, psychosis, etc.)^{1,2} Child's reasons for living¹ Current substance intoxication <i>Cognitive level of child</i></p> <hr/> <p>Environmental factors^{1,2}</p> <p>Family Unsecured potential suicide methods (guns, medications, etc.) Recent suicide, death, or loss in family Suicidal ideation or suicidal attempts in family Presence of child abuse or neglect Supportiveness of parents or caregivers Family turmoil Marital Problems Domestic Violence Financial Crisis Incarceration Alcohol and Substance Use</p> <p>Child Social isolation (ask about the effects) Bullying or being bullied (ask about the effects)</p>
<p>Notes: 1 denotes questions addressed to the child, and 2 denotes questions addressed to the child's caregiver. The interviewer should also investigate with the child the impact of issues raised by the caregiver (e.g., how does being bullied make you feel?)</p>	

ED disposition of suicidal children



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Appendix H: Oranga Tamariki and Policy Legislative Powers

Oranga Tamariki and Police


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

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Appendix I: Examples of Risk

 The following descriptions of risk are provided as prompts only and cannot be relied upon solely for making decision making due to the complexity involved in individual cases. Remember when determining risk and the follow up required that consultation is key.

Immediate Risk

Assessment that **MAY** indicate immediate risk includes:

- Child home alone (see [Oranga Tamariki Home alone and the supervision of children and young people](#))
- Child currently not in place of safety
- Child currently in place of safety, but there is a threat of imminent harm
- Child is fearful or unsafe to return to their home environment AND there has been no identified safety plan put in place
- Imminent risk to safety of siblings or other children residing in the child’s home
- Child protection safety concerns identified and parents/caregivers are about to or have removed the child from DHB site

Child who is experiencing harm

The following are prompts to identify children who maybe experiencing harm:

- A child who is experiencing recent thoughts of suicide, attempted suicide or self-harm with no engagement with mental services (see also **Appendix G** re Children under 12 at Risk of Suicide)
- A child in a home where there is family violence - refer to [Family Violence / Intimate Partner Violence \(IPV\) policy](#)
- A child disclosing abuse of any type
- A child experiencing any form of abuse
- A child where there are few or no identified protective caregivers and child has unmet needs
- Child’s caregivers have untreated mental illness, alcohol or substance use that is impacting on care of the child.
- Unborn child where the mother is experiencing family violence
- Unborn child where the mother is regularly using alcohol and or other substances
- Ongoing patterns of neglect with lack of engagement to address concerns

Child at risk of harm

The following are examples of children at risk of harm:

- Previous history of exposure to family violence
- Child’s caregivers have untreated mental illness, alcohol or substance use, but there is a protective adult in the home.
- A child with high health care needs with carer fatigue and lack of supports
- Childs behavior is dysregulated with parents having limited strategies to manage
- Significant stressors in the home environment impacting on ability to consistently care for the children

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References

Legislation	Oranga Tamariki Act (Previously known as the Children, Young Persons and their Families Act (1989) and Amendments 1994/95
	Privacy Act (1993)
	Health Information Privacy Code (1994)
	Health Act (1956)
	Code of Health and Disability Services Consumers Rights (1996)
	Vulnerable Children Act (2014)
	Domestic Violence Act (1995)
	New Zealand Bill of Rights (1990)
	Crimes Act (1961)
	Summary Offences Act (1981)
	Care of Children Act (2004)
Publications	Nga Vaka o Kāiga Tapu (Taskforce for Action on Violence within Families 2012)
	CALD Family Violence Resource for Practitioners: Working with Asian, Middle Eastern and African Clients
	Family Violence Assessment and Intervention Guideline- Child abuse and Intimate Partner Violence (2016)
	Child Maltreatment: When to suspect child maltreatment in the under 18's - NICE Guidelines (2009)
	Neglect of Medical Guidelines(2016) –(contained within) Memorandum of Understanding CYFS, Police and WDHB (2011)
	National Child Protection Alert System Privacy Impact Assessment (2011)
	Memorandum of Understanding between WDHB, CYFS and Police (2011)
Policies	Clinical photography – request consent form (2012)
	Cell phone – General guidelines for use (2015)
	Security Service Protocol for North Shore and Waitakere Hospitals (2009)
	Informed consent (2006)
	Employee Assistance Programme (2006)
	Te Whare Tapa Wha- Application to Practice in Child Health (March 2016)
	WDHB Family Violence Policy (2016)
	Child Protection Alert Management (2014)

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