

Violence Intervention Programme – Child Protection

Policy Responsibilities and Authorisation

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Policy Review History

Version	Updated by	Date Updated	Summary of Changes
07	Gaye Andrews	October 2016	<ul style="list-style-type: none"> • Changes made to align our Policy with other DHB's Child Protection Policies and to our national training. • The intent has not changed but there is more explanation of what child protection is & what processes to follow after child protection is suspected, witnessed or disclosed. • We have 3 new Guidelines related to child protection. • We have changed our Policy name to fit with our national programme.
7.1	Gaye Andrews	August 2017	<ul style="list-style-type: none"> • Changed all references to 'Child Youth & Family (CYF)' to 'Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamariki)'.

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1. Introduction

1.1 Purpose

Waikato District Health Board (DHB) is committed to the prevention and management of suspected child and young person abuse and/or neglect, and to the protection of children/tamaiti and young people/rangatahi.

This policy provides Waikato DHB community and hospital based staff with a framework to identify and manage actual and/or suspected child abuse. It recognises the important role and responsibility staff have in the accurate detection and appropriate referral of suspected child abuse, and the early recognition of children at risk of abuse and adults at risk of abusing children.

Waikato DHB supports the role of statutory agencies (the NZ Police and the Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamariki)) in the investigation of suspected abuse and/or neglect, and shall report such cases to these agencies.

When any decision is made about a child/tamaiti or young person/rangatahi suspected of being abused or neglected the interests and welfare of the child/tamaiti or young person/rangatahi will be the prime consideration.

This policy acknowledges the principles of the Treaty of Waitangi in that the Māori child/tamaiti or young person/rangatahi has the right to be and feel empowered as a valued and unique individual, and as an integral member of whānau, hapū, iwi and the society of Aotearoa overall.

Te Puna Oranga (Māori Health Service) is available for cultural support.

A consultative team approach shall embrace the principles of partnership, participation and protection in working together with whānau, hapū, iwi, Māori communities to develop protection strategies for the Māori child and rangatahi. Engagement should be managed within the context of their whānau, hapū links and extensive iwi relationships.

The Ministry of Health's Family Violence Assessment and Intervention Guideline Child abuse and intimate partner violence released 2016 - guides this policy.

1.2 Scope

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

The scope of this policy includes children/tamaiti and young people/rangatahi from 0 to and including 16 years of age and includes the unborn child.

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2. Definitions

child abuse	“Child Abuse means the harming (whether physically, emotionally or sexually) ill treatment, abuse, neglect or deprivation of any child or young person”, and applies to any person under the age of seventeen years. (Children, Young Persons and Their Families’ Act 1989)
child emotional and psychological abuse	the lack of provision of emotional, physical and social support so that a child/tamaiti or young person’s/rangatahi development is seriously affected e.g. failure to provide with adequate food, clothing and health care.
Child Advisory, Protection & Education (CAPE)	<ul style="list-style-type: none"> • Waikato DHB service that provides education, advice & support for all Waikato DHB staff and other allied health professionals. - Phone: 07 858 0965 - Fax: 07 858 0969 or extension 94969 - Private Bag 3200, Hamilton - e-mail childprotection@waikatodhb.health.nz
Child Protection Alert Management Policy (2862)	<ul style="list-style-type: none"> • describes the steps to be followed when Waikato DHB staff consider a national child protection alert should be placed and the steps to follow when a national alert is identified from another DHB • when nationally approved - Waikato DHB will upload child protection alerts onto the Medical Warning System (MWS), linked to the National Health Index (NHI) number • the national alert system informs staff that clinical records relevant to child protection are held by the Waikato DHB • health professionals in other DHBs will also be aware of the national child protection alert if the child/tamaiti or young person/rangatahi attends another DHB in NZ. The system will allow Waikato DHB health professionals to see a national alert lodged in other DHBs as they would in Waikato DHB. • this policy also describes the process for removing a child protection alert
Child Sexual Abuse (CSA)	<ul style="list-style-type: none"> • This is any act or acts that result in the sexual exploitation of a child/tamaiti or young person/rangatahi, whether consensual or not.
Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamariki)	<ul style="list-style-type: none"> • A national statutory agency responsible for the investigation of suspected child abuse. • Call Centre contact details for advice and for making Reports of Concern (RoC): - Phone: Toll free 0508 FAMILY or 0508 326 459 - Fax: 09 914 1211 e-mail: contact@mvcot.govt.nz
child/tamaiti	<ul style="list-style-type: none"> • for the purpose of this Policy a child is a person aged from 0 – 14 years old. • Includes unborn child.
Ministry for Vulnerable Children, Oranga Tamariki /DHB Liaison	<ul style="list-style-type: none"> • Senior Oranga Tamariki colleague who promotes collaborative practise between Oranga Tamariki and the Waikato DHB to ensure children/tamaiti or young person/rangatahi at risk and/or suffering from inflicted injury have their safety needs addressed. • They also assist with child protection education. • Every DHB in NZ has a Oranga Tamariki /DHB Liaison currently

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Doctors for Sexual Abuse Care (DSAC)	<ul style="list-style-type: none"> A national professional organisation of doctors from many disciplines whose prime focus is education and support of medical practitioners to ensure maintenance of internationally recognised standards of best practice in the medical and forensic management of sexual assault. Police hold a list of DSAC trained doctors.
failure to thrive (FTT) or poor growth	<ul style="list-style-type: none"> Failure to thrive describes an infant who shows a decline from a previously established growth pattern or who falls well below the expected weight gain for their age. If there is no medical reason, then either the parents have a poor understanding of feeding requirements or it is highly likely that neglect is the cause. Sometimes a child/tamaiti or young person/rangatahi that is not wanted or is rejected fails to thrive.
home alone	<ul style="list-style-type: none"> Parents/guardians/caregivers are liable if they leave children/ tamaiti under the age of 14 years unsupervised, without making reasonable provision for the supervision and care of the child/tamaiti, for a time that is unreasonable or under conditions that are unreasonable.
inflicted injury	<ul style="list-style-type: none"> This is any act or acts that may result in inflicted injury to a child/tamaiti or young person/rangatahi. Has been referred to in the past as a non- accidental injury (NAI).
multi agency safety plan (MASP)	<ul style="list-style-type: none"> Oranga Tamariki leads this process in collaboration with health. Multi agency safety plans ensure the safety of the child/tamaiti or young person/rangatahi, but also provide for the child/tamaiti or young person's/rangatahi ongoing health and recovery and the wellbeing needs of the family. <ul style="list-style-type: none"> who will care for the child/tamaiti or young person/rangatahi how safety issues will be addressed how health needs of the child/tamaiti or young person/rangatahi will be responded to what and how support will be provided to the child/tamaiti or young person/rangatahi and family the roles and responsibilities of family and professionals how monitoring and review will occur. If the child/tamaiti or young person/rangatahi is the subject of court orders, a copy of the safety plan should be filed with the court plan or review of the child/tamaiti or young person/rangatahi.
Police Child Protection teams	<ul style="list-style-type: none"> The New Zealand Police is a national statutory agency and in each Police District there are Police Child Protection teams whose responsibilities include: <ul style="list-style-type: none"> working cooperatively with Oranga Tamariki in investigating child/tamaiti ora and young person/rangatahi abuse and/or neglect investigating cases of abuse and/or neglect where an offence has or may have been committed prosecuting offenders where an offence has been committed accept reports of suspected abuse and/or neglect and refer these/work alongside Oranga Tamariki in the combined investigation
primary client	<ul style="list-style-type: none"> This is the client or patient for whom Waikato DHB staff is directly responsible for.

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report of concern (RoC)	<ul style="list-style-type: none"> Sent to the Oranga Tamariki National Contact Centre when staff have serious concerns about the care and protection of a child/tamaiti or young person/rangatahi.
statutory agency	<ul style="list-style-type: none"> For the context of our Violence Intervention Programme: child protection policy we refer to 2 statutory agencies Oranga Tamariki and Police.
youth/rangatahi	<ul style="list-style-type: none"> For the purposes of this policy a youth is a young person aged 14 – 17 years old.
Children’s Teams	<p>Local children’s teams will bring together frontline professionals working with children to protect vulnerable children and young people in New Zealand.</p> <p>The teams will be made up of local education, health, and social sector professionals to respond to the needs of vulnerable children. The Children’s Teams will ensure:</p> <ul style="list-style-type: none"> vulnerable children’s needs are assessed all parties required to address those needs are brought to the table a single multi-agency plan for each vulnerable child is developed, implemented, and a lead professional is allocated to see the plan through local services are delivered according to the plan outcomes are achieved for each child.
Hamilton Children’s Team	To refer a child to the Hamilton Children’s Team, contact the Vulnerable Children’s Hub 0800 367 687
Intimate Partner Violence (also called partner abuse)	<p>Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners.</p> <p>Intimate partners include current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.</p>

3. Policy Statements

The Waikato DHB policy for the Violence Intervention Programme – Child Protection is that:

- Waikato DHB is committed to protecting and cherishing children/tamariki and young people/rangatahi.
- The rights, welfare and safety of the child/tamaiti and young person/rangatahi are our first and paramount consideration.
- Staff must follow the processes set out in this Policy and notify all suspected, witnessed, disclosed cases of child abuse to a statutory agency (Oranga Tamariki and/or Police) even when the child/tamaiti or young person/rangatahi is not their primary client. Any person making a notification about suspected child abuse or neglect in good faith to Oranga Tamariki and Police is protected from any criminal or civil proceedings. (See Sections 15 & 16 Children, Young Persons, and their Families Act 1989.)
- If abuse and/or neglect of a child/tamaiti or young person/rangatahi is identified staff must also always consider assessing the child/tamaiti or young person/rangatahi main caregiver

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for partner abuse because of the high risk of co-occurrence of partner abuse and child abuse. (See Violence Intervention Programme: Intimate Partner Abuse Policy 2202)

Wherever possible (and appropriate) the family/whānau, hapū and iwi participate in the making of decisions affecting that child/tamaiti or young person/rangatahi.

See Waikato DHB [Māori and Family Violence](#) guideline (Ref. 5676) for more information

The complexity of family violence is also evident with Pacific Peoples' culture for similar reasons.

See Waikato DHB [Pacific Peoples and Family Violence](#) guideline (Ref. 5677) for more information

- All staff are to recognise and be sensitive to other cultures.
- Waikato DHB provides an integrated service and works with statutory and other community agencies to provide an effective and coordinated approach to child/tamaiti or young person/rangatahi protection.
- Legal requirements for documenting and referring suspected, witnessed, or disclosed cases of child abuse must be met.
- A consultative team approach must be used in child protection because the work can be complex.
- Waikato DHB Child Advisory, Protection & Education (CAPE) can assist with advice and support for Waikato DHB staff with child protection concerns.
- Waikato DHB Executive will ensure relevant clinical staff are trained to identify, assess, manage and refer all victims of child abuse.

4. Policy Processes

4.1 Roles and Responsibilities

Executives

- Providing and maintaining a specialist child/tamaiti or young person/rangatahi protection service
- An organisation-wide policy for the management of child abuse and associated policies as indicated
- Regular training for staff in the policy
- Processes to ensure the policy is adhered to - such as clinical audit, and adequate support and supervision for staff engaged with interagency processes such as Memorandum of Understanding between District Health Boards, Oranga Tamariki and the Police that supports effective collaboration
- Regular workforce development for staff on the policy
- Processes to ensure the policy is adhered to, such as quality improvement activities
- Adequate support (e.g. access to consultation) and supervision for staff
- These activities need to be properly resourced and evaluated

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Staff

- Be conversant with and adhere to the processes that are set out in this Violence Intervention Programme: child protection policy.
- Attend training and regular updates appropriate to their area of work.
- Access specialist health services when required. These may include:
 - Cultural assessment
 - Interpreter's services
 - Mental Health assessments
 - Diagnostic medical assessments
 - Social Work services
 - Paediatric Medical assessment
 - GATEWAY assessment
 - Child Advisory, Protection & Education (CAPE)
 - Oranga Tamariki /DHB Liaison (sits with the child protection team)
- Clinicians have these responsibilities in all cases where child abuse or neglect is suspected or identified even if the child/tamaiti or young person/rangatahi is not their primary client:

To understand the referral and management of actual or suspected abuse and neglect

To take action when child abuse and or neglect is suspected or identified

To practice safely, for example consulting with a senior colleague during the intervention and seeking peer-support/supervision when child abuse is suspected or identified

Managers / Services

- Where staff have reported a concern regarding abuse, managers are responsible for ensuring appropriate action is taken and that debriefing for staff is provided if necessary.
- All services/departments will support the implementation of the policy within services as coordinated by the Violence Intervention Programme (VIP) Co-ordinator(s).

Child Advisory, Protection & Education (CAPE)

- CAPE is the Waikato DHB service established to provide child protection education and advice to all staff.
- CAPE shall work closely with the Waikato DHB's FV Intervention Coordinator to deliver training and education to all relevant Waikato DHB staff on family violence and care and protection issues in relation to children/tamaiti and young people/rangatahi.
- CAPE shall be available for consultation regarding child protection concerns
- Ensure the DHB-wide policy remains current and aligned with national standards
- Ensure provision of workforce development in accordance with the DHB VIP training plan; this will include ensuring that the VIP training is available cyclically

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- Ensure quality improvement activities in regard to policy compliance are undertaken and reported on at least biannually.
- Coordinate Violence Intervention Programme (VIP) implementation within services, working with service leaders to ensure the system supports are readily available
- To facilitate communication with Oranga Tamariki and other key community agencies

Human Resources

- Waikato DHB recruitment policies will reflect a commitment to child protection by including comprehensive pre-employment screening procedures (in accordance with the Vulnerable Children’s Act 2014).
- Where suspicion exists of child abuse perpetrated by an employee or volunteer in the organisation, the matter will be dealt with in accordance with the Human Resource disciplinary procedures, (See Waikato DHB [Performance Management & Discipline](#) policy (Ref. 5250)).

4.2 Training

- Staff who have client / patient contact shall receive education in the area of suspected child abuse or neglect.
- Training is mandatory for staff working in identified high risk areas.
- These areas may include but are not limited to:
 - Emergency Department
 - Paediatric wards/clinics or wards where children/tamaiti or young people/rangatahi may be admitted
 - Antenatal units/services
 - Community Health Services
 - Paediatric Community Clinical Nurse Specialist Team
 - Mental Health and Addictions Services
 - New Born Intensive Care
 - Waikato DHB Social Workers
 - Mothercraft
 - Post-natal wards
 - Rural Hospital staff working with children
 - Child Development Centre (CDC)

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5. Child Protection Processes

A SIX-STEP process for responding to actual or suspected abuse and or neglect

- All situations where recent or ongoing child abuse is disclosed, witnessed or suspected must be acted upon and using the following process.
- Further information on each step follows below and CAPE is available for consultation.

SIX STEP CHILD PROTECTION INTERVENTION

This policy outlines the intervention for identifying, assessing, responding to, and referring children who may be victims of child abuse. Appropriate documentation is also included in the six-step process.

All situations where recent or ongoing child abuse is disclosed, detected or suspected must be acted on and reported using the following procedure. Routine enquiry about child abuse 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 Waikato DHB [Child Abuse and Neglect \(CAN\) – Signs and Symptoms](#) guideline (Ref. 5693).

Consultation should occur at least once. The following staff are available:

- An experienced colleague
- Paediatrician
- CAPE/Violence Intervention Programme Coordinator
- CAPE Social Workers
- Waikato DHB Social Worker
- Oranga Tamariki DHB Liaison Social Worker.

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

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5.1 Step 1: Identification of signs and symptoms

There is no ‘one-size-fits-all’ approach for the identification of children or young people at risk. The healthcare provider should begin with their first point of concern. However, they should also be aware that, if they are concerned about a child or young person, all the aspects described in this first step need to be assessed. 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.

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 interrogate the child you may create more problems than you solve.

5.1.1 Observing child–parent/caregiver interactions

- Observe the child-parent/caregiver 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 child-parent/caregiver interaction
 - lack of emotional warmth, as opposed to strong attachment/bonding; dismissive/unresponsive behaviours as opposed to sympathetic/comforting responses
 - interaction between the child-parent/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.

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5.1.2 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? For example, if it was a fall, where did they fall; were they stationary or already moving; how did they fall (head first, feet first, arms out); what was the height of the fall (estimated on the eyewitness' own body); what surface did they fall onto; what was their position after the fall; were there any complicating factors, like use of a baby walker, or a fall in the arms of an adult?
 - 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.

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

- 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, 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.

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What should be asked?

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?

5.1.4 Sexual Abuse

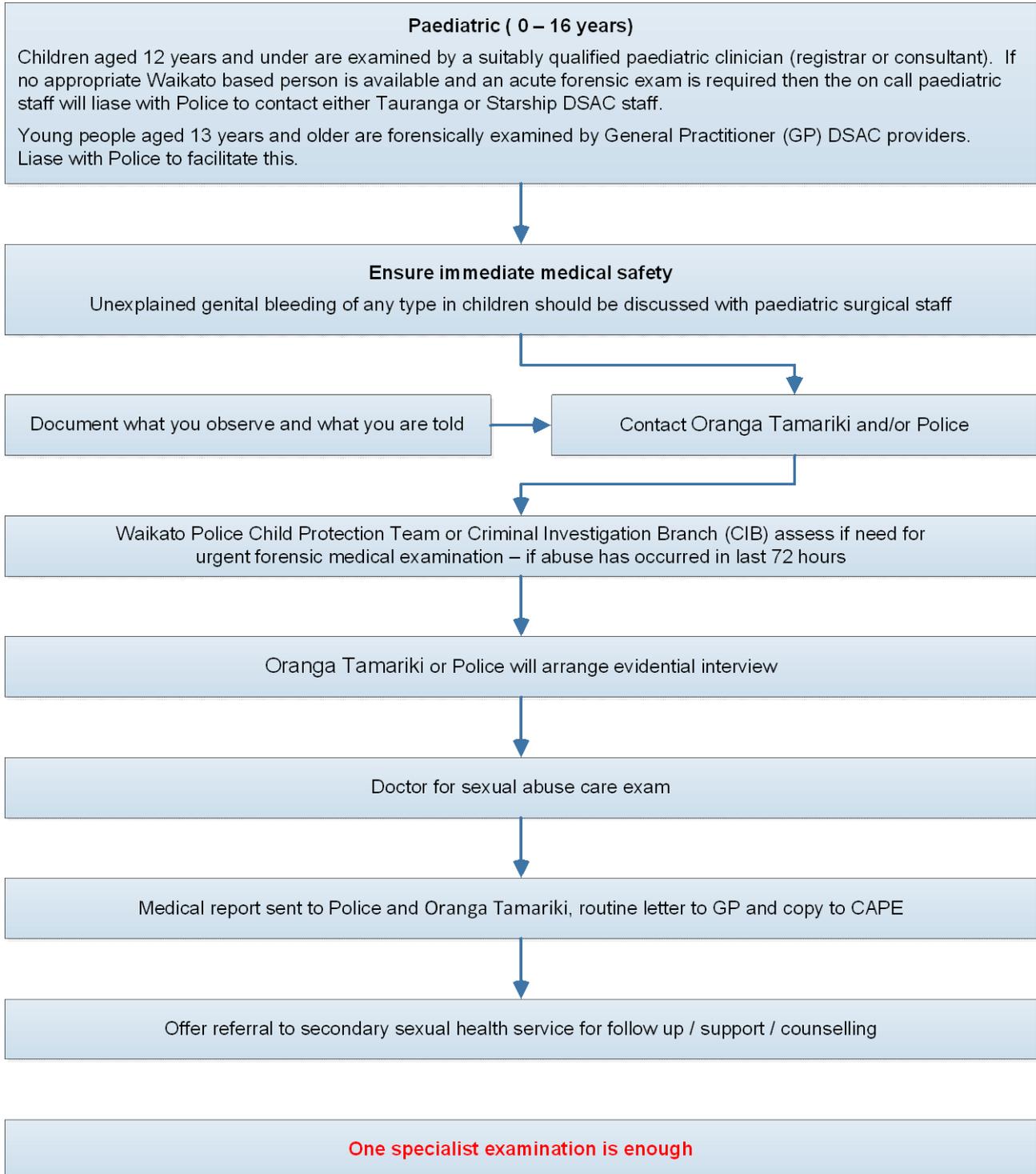
There are no evidence-based ‘screening’ questions for children about sexual abuse; if a presenting symptom has raised this concern for you then open-ended questions (which do not suggest the answer) are always best.

- In cases of suspected sexual abuse of children/young people, staff must follow the sexual abuse referral flow chart set out below. Referral must also be made to the paediatrician on call who will liaise with a Doctor for Sexual Abuse Care (DSAC) trained doctor, Oranga Tamariki and/or Police.
- If a medical examination is required, staff must ensure they obtain and document the appropriate informed consent either from the child/tamaiti or young person/rangatahi themselves (if they are competent) or from the child/tamaiti or young person’s/rangatahi legal guardian **before** any examination is undertaken (see Waikato DHB [Informed Consent](#) policy (Ref. 1969).

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Sexual Abuse Referral Flow Chart



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5.1.5 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 (Home, Education/Employment, Eating, Activities, drugs and Alcohol, Sexuality, Suicide and depression, Safety) 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.

See [Starship Clinical Guideline on Adolescent Consultation](#)

5.1.6 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 Waikato DHB Child Protection Alert Management Policy (2862) to access the health information behind the alert, and take it into consideration when assessing the child

5.1.7 Social history

- Take a social history; a variety of factors may have an effect on the risk of child abuse, 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.

5.1.8 Physical examination

- A thorough physical examination is indicated in all cases of identified or suspected child abuse, 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

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in some older children. Full blood count and coagulation studies may be required in the presence of bruising

- 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.

5.1.9 Using a child protection checklist in children under two years old

- All children under the age of two years presenting to the emergency department should have the Child Protection Checklist completed. This is on page 2 of the Emergency Department Nurse Assessment; it is only possible to answer the questions it contains, if you have conducted a thorough assessment following the principles outlined above.
- The tool may be relevant for older children presenting to ED where any of the listed concerns exist
- The checklist is only a guide to assist safe process, not a diagnostic algorithm.
- Never jump to conclusions.

5.1.10 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).
 - Consider taking photographs of items "in situ" on the child or young person prior to their removal.
 - 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.

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5.2 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

5.2.1 Talking with the parents/caregivers of the child

- If you are unsure about how to talk with the parents/caregivers; consult with a paediatrician / 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)
 - Don't 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 Puna Oranga/Maori Health Service. It is important that contacting such support does not delay any referral to Oranga Tamariki.
- For those families identifying as Māori a referral to Waikato DHB Kaitiaki Māori (Hospital) Service or Kaitakawaenga Māori (Mental Health) Henry Rongomau Bennett Centre shall be made.
 - Kaitiaki Māori Service, Waikato Hospital, phone 07 839-8899,
 - Thames Hospital – 07 868 0040, Tokoroa Hospital – 07 885 0600,
 - Te Kuiti Hospital – 07 878-7333, Taumarunui Hospital – 07 896 0020 & ask for a Kaitiaki Māori.
 - Kaitakawaenga Māori Mental Health, Henry Rongomau Bennett Centre – 07 839 8899 and ask for a Kaitakawaenga Māori.

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Note: if your area is not listed refer to Waikato Hospital contacts

- Offer appropriate cultural support where possible for other ethnic and cultural groups
- The family/whānau of a suspected witnessed or disclosed child abuse client must not be isolated or punished.
- Access approved translation services that are approved and are age and gender appropriate. 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

5.2.2 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 can't keep
- Ensure the child's immediate safety. Try not to alert the alleged abuser.

5.2.3 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

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5.3 Step 3: Health and Risk Assessment

5.3.1 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 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, 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, Police Officer or a Oranga Tamariki social worker about a child.
- Early communication with Oranga Tamariki and/or Waikato Police Child Protection Team 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.

5.3.2 Mental health assessment

See [5.1.5 HEADSSS assessment](#) for more information

- 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.

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- 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.

Staff must email/fax CAPE a copy of their Oranga Tamariki report of concern within 48 hours.

childprotection@waikatodhb.health.nz Fax: 078580969

5.3.3 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.

5.3.4 Co-occurrence of intimate partner violence

- If child abuse is identified, assess the mother’s safety. Follow the procedure outlined in Intimate Partner Violence (IPV) Policy (2202).
- 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.

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- 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.

5.3.5 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/Consultation Liaison Psychiatry or Community Alcohol and Drug Services via referral.

Red Flags

- uncorroborated history
- a discrepancy between the history and injury (especially in children/tamaiti under one year of age)
- varying or changing history
- history of repeated trauma
- delay in seeking medical advice
- inappropriate parental response
- sudden change in child/tamaiti or young person/rangatahi behaviour
- unusual child/tamaiti or young person/rangatahi and parent interaction
- unwitnessed injury
- failure to thrive or poor growth

All Waikato DHB staff may access any of the following people / statutory agencies for advice and support regarding the SIX-STEP process.

- CAPE available 8 – 4.30 pm, Mon - Fri. DDI: 07 858-0965, Fax: 07 858-0964
Information sourced via their intranet child protection page
Email: childprotection@waikatodhb.health.nz
- Oranga Tamariki /DHB Liaison sits with the CAPE team and is available for consultation, Monday – Friday, 8-4.30pm
- Waikato DHB paediatrician / paediatric medical registrar on call. Phone 07 839-8899 and ask for them to be paged (24 hour cover).
- All Waikato DHB social workers (8 – 4.30 pm, Mon – Fri). Contact in the usual manner for your area.
- Colleagues experienced in the recognition and referral of child abuse.
- Oranga Tamariki National Call Centre (available 24 hours a day, 7 days a week). Phone 0508 326 459 or 0508 FAMILY
- Waikato Police Child Protection Team (available Mon – Fri 8 – 9:00pm; Sat-Sun 8-4pm.). Contact 111 for urgent enquiries and the Hamilton Police Station - 07 858 6200 for non-urgent enquiries.
- Waikato DHB Legal Service, Corporate Solicitor DDI: (07) 834 3676 or Solicitor DDI: (07) 834 3654. After hours - contact via the hospital operator.

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5.4 Step 4: Intervention/Safety Planning

5.4.1 When a child/tamaiti or young person/rangatahi presents to a Waikato DHB facility with suspected abuse and/or neglect and no perpetrator has been identified

If a child/tamaiti or young person/rangatahi presents to a Waikato DHB Emergency Department or is admitted to hospital with suspected, witnessed or disclosed abuse and/or neglect paediatric services must be consulted. (This includes young babies and children with disabilities who may have very stressed and tired parents.)

If child abuse 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

If there are concerns about immediate safety (including your own), contact the Police (or in-house security if available) and contact Oranga Tamariki (phone followed by written referral).

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 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 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.

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5.4.2 Child being harmed

- A child who, in the opinion of staff, is already coming to harm, should be notified to Oranga Tamariki and/or Police as a 'report of concern'. Oranga Tamariki or Police can form their own opinion on the level of risk for the child and triage accordingly. Police have emergency powers to take the child or young person into custody when critically necessary.
- 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.
- **Oranga Tamariki and/or Police must be contacted at the earliest opportunity.**
- The Waikato DHB is responsible for keeping the child/tamaiti or young person/rangatahi safe in hospital. Once Oranga Tamariki is notified then responsibility for the child/tamaiti or young person's/rangatahi safety is shared between Waikato DHB and Oranga Tamariki.
- If a child/tamaiti, young person/rangatahi or their family identified as being victims of child abuse and/or neglect or family violence requires an immediate place of safety or transport to a place of safety, Waikato DHB staff are responsible for ensuring this is carried out.
- Keep the child/tamaiti or young person/rangatahi safe and report immediately to Police if:
 - there is immediate danger of death or harm
 - abuse has occurred and is likely to escalate or recur
 - the child/tamaiti or young person/rangatahi is at home alone, call the Police and stay with the child/tamaiti or young person/rangatahi until the Police arrive
 - there is immediate risk to the child/tamaiti or young person/rangatahi, or the environment to which the child/tamaiti or young person/rangatahi is returning is unsafe
 - your safety is compromised

These concerns should also be reported to Oranga Tamariki.

The level of supervision required to keep the child/tamaiti or young person/rangatahi safe will be decided following a comprehensive risk assessment which should be completed at the earliest opportunity.

The final decision about the level of supervision required will be decided in consultation between Clinical Nurse Manager (out of hours- ward co-ordinator & duty manager), the paediatrician on call and the Oranga Tamariki social worker.

Multiagency safety planning (MASP), led by Oranga Tamariki, in collaboration with health is essential. This is a continuous process but must be completed by discharge.

A clear plan must be documented in the clinical records including: – any strategies used to protect the child/tamaiti or young person/rangatahi (e.g. a name change, being put in a single room, being near the office, name not being up on the notice board,

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security guard present etc.). *Note: If video surveillance is used this must be in accordance with the Waikato DHB [Surveillance policy](#) (0124).*

- specific responsibilities for any parties
- visiting rights and any specific requirements for supervision or exclusion of visitors (consider the impact on the child/tamaiti or young person/rangatahi when making this decision) see *Waikato DHB Visitors to Patients policy*
- supervision options for a child/tamaiti or young person/rangatahi with care and protection concerns, e.g.:
 - place the child/tamaiti or young person/rangatahi in a site visible to staff
 - engage a “watch” for the child/tamaiti or young person/rangatahi
 - security staff may be required
 - transport to a safe discharge will be provided by Waikato DHB

The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in Appendix 10.

- Duty managers and security staff can be called to assist as required when concerns regarding child safety are identified.
- **For emergency response ring 99777**
- Oranga Tamariki or the Police can obtain a Place of Safety Warrant. This means the child/tamaiti or young person/rangatahi must remain in a named safe location and only persons named by the Oranga Tamariki social worker may visit the child/tamaiti or young person/rangatahi.
- If necessary trespass orders are instigated by contacting the duty manager.
- Access to the paediatric wards is limited at all times through locked doors except during visiting hours. Following the risk assessment staff may further limit access throughout the visiting period if required.
- A child protection alert must be discussed by the multidisciplinary team that includes a paediatrician and then placed on the computer system as well as noted in all relevant documentation. (see Child Protection Alert Management Policy (2862))
- Whenever possible collaborate with representatives of the child/tamaiti or young person’s/rangatahi cultural group on safety planning.
- 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.

5.4.3 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

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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 and/or the Waikato Police Child Protection Team to determine if a formal report of concern should be made
- If Oranga Tamariki determine that the whānau 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. Likewise if you consider that engagement by an agency with the family is likely to achieve positive outcomes and the family is willing to accept the referral(s), Oranga Tamariki is also likely to suggest that a formal report of concern may not be necessary
- If there is a children’s team in your area, this may provide another avenue for effective action.
- Hamilton has a Children’s Team; this currently covers only the Hamilton City boundary.
- CAPE has a team member who is .2FTE Health Navigator and they give Waikato DHB’s health information to the Hamilton Children’s Team when requested and write on Clinical Work Station (cws)/OP progress notes that the Hamilton Children’s team has requested information/engaged or exited our families.

5.4.4 Co-occurrence of child abuse and Intimate partner violence

Remember, JOINT safety planning and referral processes need to be implemented when both IPV 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 IPV 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.
- If the abuser is present in the health care facility, ask the abused partner whom they would like to inform the abuser about the report, e.g., would they like the health care provider to do it? Does the abused partner want to be present when the abuser is told? Do they want to do it?
- Make sure the abused partner has information on how to contact support agencies (e.g., Police, Women’s Refuge, Oranga Tamariki) if problems arise.

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5.4.5 Talking to parents and caregivers about referral to the statutory authorities

If it is safe to do so, discuss a referral to Oranga Tamariki and/or Police 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
- 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 and/or Police
- However, be clear that your role is to keep the child safe. Do not seek permission to consult with Oranga Tamariki and/or Police. You may do this at any time. See Waikato DHB [Disclosure of Health Information](#) Policy (1365)

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5.5 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
 - 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?
 - If staff decide the child protection concerns requires a Report of Concern (RoC) to Oranga Tamariki then a written referral is sent to Oranga Tamariki and a copy of the RoC is sent to CAPE in accordance with the Waikato DHB's policy Child Protection Alert System (2862) Contact details for the Oranga Tamariki National Call Centre are on the Oranga Tamariki notification template available on the Waikato DHB child protection site on the intranet or from CAPE.
- A copy of the report of concern and documented details of any phoned report of concern should be filed into the clinical record. A copy will also be placed on clinical work station (cws)/documents.
- CAPE must be faxed/emailed a copy of all reports of concern made to Oranga Tamariki within 48 hours.
- Other Health Professionals working with the child/tamaiti or young person/rangatahi should also be advised of staff concerns of care and protection issues (e.g. GP/LMC/Tamariki Ora provider).

5.5.1 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.

5.5.2 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 and/or Oranga Tamariki
- There are opportunities for early intervention (even when a report of concern is not made) so:
 - 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. the Children's

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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).

- Consider referring to an appropriate community agency to enlist support for the family, e.g. Barnardos, Parentline, Open Home Foundation, Women’s Refuge, – and document in the child/tamaiti or young person’s/rangatahi clinical record. (Areas throughout the Waikato DHB will have their own community agencies to refer to - enlist the support of local Waikato DHB social workers for this information)
- For those families identifying as Pacific consider a referral to K’aute Pasifika Services or the South Waikato Pacific Island Health Committee as both these services have social and well child/Tamariki Ora programmes.
- Ensure that this information is also included in correspondence (e.g. on the GP’s copy of the discharge summary, clinic letter etc.) to the primary health provider.
- If no abuse or neglect is identified but there are concerns about aspects of care, referrals can be made to a Waikato DHB social worker or obtain parents’ permission to refer them to an appropriate community agency for:
 - parenting skills
 - social support
 - well-child/tamaiti ora services
 - Māori/Iwi provider agency
 - Pacific Island services
 - other culturally appropriate agency

5.5.3 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.

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5.6 Step 6: Documentation

5.6.1 Document all observation, process and assessment thoroughly

- 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. Include name, legible signature and practice designation. And when you wrote your notes (if different from the time you saw the patient) (see Waikato DHB [Clinical Records Management](#) policy (Ref. 0182)).
- Clearly and thoroughly document the behaviours, signs and symptoms you observed.
- If the child/tamaiti or young person/rangatahi is not the primary client, as much information as possible must be documented on a clinical notes sheet and sent to CAPE who will create a clinical record for the child/tamaiti or young person/rangatahi or ensure the information is incorporated into the current clinical record.
- All documentation of an injury or an event needs to be accurate and objective and should contain as much information as the recipient needs to act in the best interests of the child/tamaiti or young person's/rangatahi health and safety.
- Document the following features for each injury: site, shape, size (use a tape measure), characteristics (e.g., colour, depth, edges, surroundings, margins, swelling, 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.

5.6.2 Document facts and observations as soon as possible after the event or discussion.

- Record facts and/or observations and concerns.
- Clearly differentiate between what was seen and heard and what was reported or suspected and by whom.
- Detail who was present at the time of the injury.
- Include date and time of the event.
- Where there has been a disclosure, write what was said in quotation marks (verbatim).
- Document the consultative process you undertook – who did you speak with and at what points?

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5.6.3 Photographs

- Many healthcare organisations now regard photography as a routine supplement to the medical records.
- The taking of photographs should be done by a suitably qualified person in accordance with Waikato DHB [Consent and Storage of Client Video & Photographic Images](#) procedure (Ref. 1357)

Note: that thorough documentation and body maps are always required, and cannot be replaced by photographs.

- A body diagram can be used to record bruises, cuts and other injuries. (See child protection intranet site for body diagram copies).
- If obtaining clinical images, written consent must be obtained where from the patient (where the patient is competent to give consent) or from their guardian. If it is not possible to get appropriate consent or consent is declined, assistance can be obtained from Oranga Tamariki and/or Police.
- After hours a paediatrician must formally request images to be taken. Photography and Audiovisual staff after hours contact details are held with Duty Managers and Communications staff.

5.6.4 Medical Reports

Note: A medical report must be written by a registered medical practitioner.

- All medical reports sent to Police or Oranga Tamariki from Waikato DHB must be counter-signed by the clinical director, or consultant paediatrician under whose supervision the child was seen.
- If evidence is required to be given in Court a deposition statement will usually be obtained from the client's documentation and/or medical report/s. If you are asked to provide evidence you must discuss this with your manager and/or the Waikato DHB legal counsel.
- Forensic evidence e.g. specimens must be processed according to legal requirements. This involves maintaining a chain of evidence that is done following discussion with the laboratory. Maintaining the chain of evidence includes: – the hand delivery of specimen/s by the examining doctor to the laboratory and the signing of a form by each specimen handler in the lab
- Blood taken for a coagulation screen must be labelled and countersigned at the lab by the collecting doctor
- Follow the Sexual Abuse Procedure Form that is available from Microbiology for obtaining laboratory specimens
- Ensuring drug testing samples are legally valid by being placed in a Toxicology Kit (available from the Emergency Department or the Police) and handed to Police
- Staff must work with Police at all steps of the process of collecting drug testing samples

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5.6.5 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).

5.6.6 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.

5.6.7 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 information
- 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 Waikato DHB policy “Disclosure of Health Information” (1365); 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.

Advising other Health professionals of our concerns

- Staff should consider advising other Health Professionals working with the child/tamaiti or young person/rangatahi of concerns about care and protection issues (e.g. GP/LMC/ Tamariki Ora provider).

Death of a child/tamaiti or young person/rangatahi and assessment of other children/tamaiti or young people/rangatahi in the household

- In the event that a child/tamaiti or young person/rangatahi is brought in to the Waikato DHB and is deceased on arrival or the child/tamaiti or young person/rangatahi dies in the hospital and the cause of death is suspicious, then an assessment of the safety of any child/tamaiti or young person/rangatahi in the household should be urgently undertaken.
- The paediatrician on-call should determine if there are any other siblings and if so Oranga Tamariki must be notified.
- If a child/tamaiti or young person/rangatahi identified as having care & protection concerns is admitted to hospital and subsequently dies the Coroner must be notified. (See Waikato DHB [Care of the Deceased/Tūpāpaku](#) policy (Ref. 0133)).

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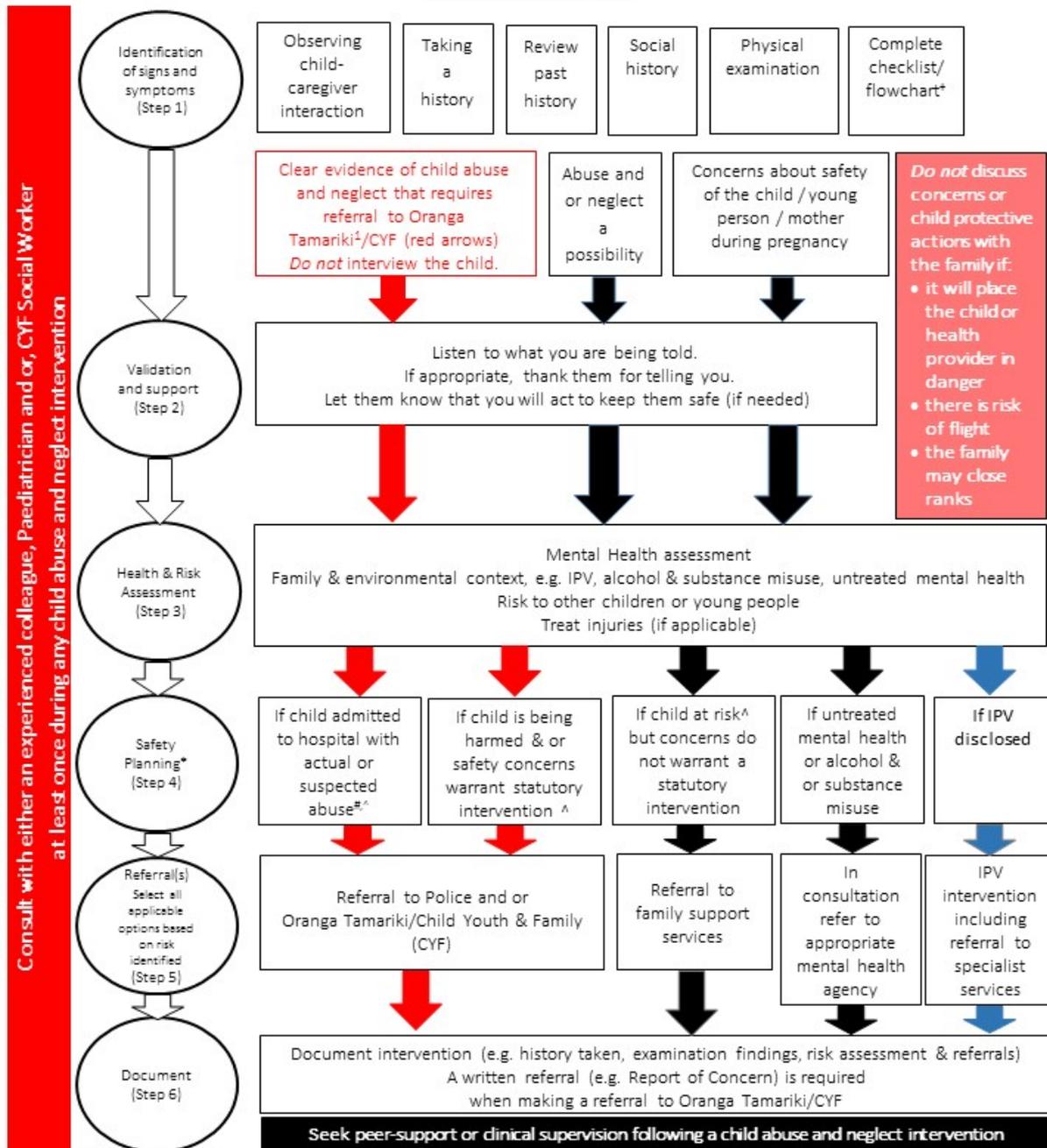
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FLOWCHART FOR RESPONDING TO ACTUAL OR SUSPECTED CHILD ABUSE



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. PV, 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
 1 Ministry for Vulnerable Children, Oranga Tamariki (Oranga Tamariki) formerly known as Child Youth and Family



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6. Audit

6.1 Indicators

- Staff are competent in the identification and appropriate referral of suspected, witnessed or disclosed abuse and/or neglect of a child/tamaiti or young person/rangatahi
- Staff involved in the direct care of children shall contact CAPE within 12 weeks of orientation to arrange attendance at the Violence Intervention Programme Intimate Partner Abuse and child protection training
- Reports of concern to Oranga Tamariki and/or the Police comply with policy requirements
- All staff are aware of the processes outlined in this policy
- Documentation of suspected, witnessed and disclosed abuse is accurate and objective
- A copy of the Oranga Tamariki /Police Report of Concern is sent to CAPE
- Data returned to CAPE will accurately reflect the number of Reports of Concern to statutory agencies from Waikato DHB

7. Legislative Requirements

Waikato DHB must comply with the following legislation (this list is not exclusive):

- Children, Young Persons and Their Families Act 1989
- Children, Young Persons and Their Families Amendment Act 1995
- Code of Health and Disability Services Consumers Rights 1996
- Crimes Act 1961
- Domestic Violence Act 1995
- Care of Children Act 2004
- Health Act 1956
- New Zealand Bill of Rights Act 1990
- Privacy Act 1993
- Summary Offences Act 1981
- Treaty of Waitangi Act 1975
- Vulnerable Children Act 2014

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8. Associated Documents

- Towards Maori Health Gain Framework 2002
- Waikato DHB [Care of the Deceased/ Tūpāpaku](#) policy (0133)
- Waikato DHB [Clinical Records Management](#) policy (0182)
- Waikato DHB [Incident Management](#) policy (0104)
- Waikato DHB [Family Violence Intervention - Partner Abuse](#) policy (2202)
- Waikato DHB [Māori Health](#) policy (0108)
- Waikato DHB [Information Privacy](#) policy (1976)
- Waikato DHB [Surveillance](#) policy (0124)
- Waikato DHB [Security](#) policy (0120)
- Waikato DHB [Visiting Patients at Waikato DHB Facilities](#) guideline (0125)
- Waikato DHB [Interpreters and Translation](#) policy (0137)
- Waikato DHB [Employee Assistance Programme](#) policy (0286)
- Waikato DHB [Informed Consent](#) policy (1969)
- Waikato DHB [Risk Management](#) policy (0118)
- Waikato DHB [Child Protection Alert Management](#) Policy (2862)
- Waikato DHB [Disclosure of Health Information](#) (1365)
- Waikato DHB [Performance Management and Discipline](#) policy (5250)
- Waikato DHB [Child Abuse and Neglect - Signs and Symptoms](#) guideline (5693)
- Waikato DHB Tikanga Best Practice Guidelines (2118)
- Breaking the Cycle – Interagency Protocols for Child Abuse Management, Children, Young Persons and their Families Agency 1996
- Breaking the Cycle - an interagency guide to child abuse. New Zealand
- Children and Young Persons Agency 1987
- MOH Family Violence Assessment and Intervention Guidelines Child abuse and intimate partner violence released 2016
- He Korowai Ōranga- National Māori Health Strategy MoH 2002
- A Draft Charter of the Rights of the Māori Child ECD 2002
- United Nations Convention on the Rights of the Child 1989
- Zero Tolerance to Family Violence Charter – Hamilton Safer Communities 1996
- Memorandum of Understanding and its two Schedules (Children Admitted to Hospital with Suspected or Confirmed Abuse or Neglect and the role of the Oranga Tamariki /DHB Liaison Social Worker in the DHB) were first implemented in 2011/12
- [Children's Teams | - Children's Action Plan](#) childrensactionplan.govt.nz/childrens-teams/

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