ABUSE AND NEGLECT

Introduction

These guidelines are intended to help guide you in the appropriate assessment and initial management of children who may have been abused or neglected.

"Our children are our taonga. All children have a right to full emotional, spiritual and physical well-being, to develop their own potential in an environment which is nurturing and protective and in which they feel safe from abuse." (Extract from the original Auckland Area Health Board Child Abuse Policy, November 1990).

ADHB Child Abuse policy is based on interagency guidelines ("Breaking the Cycle": *Interagency protocols for child abuse management*, Children Young Persons and their Families Service 1996; and *An interagency guide to child abuse*, CYP&FS 1997). The second of these documents is still in print as *"Let's stop child abuse together",* Child Youth and Family 2001.

Our assessments and interventions should be carried out with regard to the Principles of the Treaty of Waitangi, the Children & Young Persons and Their Families Act (1989) and its amendment (1994), the Health Act (1956) and Amendments 1993, the Privacy Act (1993) and Health Information Privacy Code (1994) and the Care of Children Act 2004.

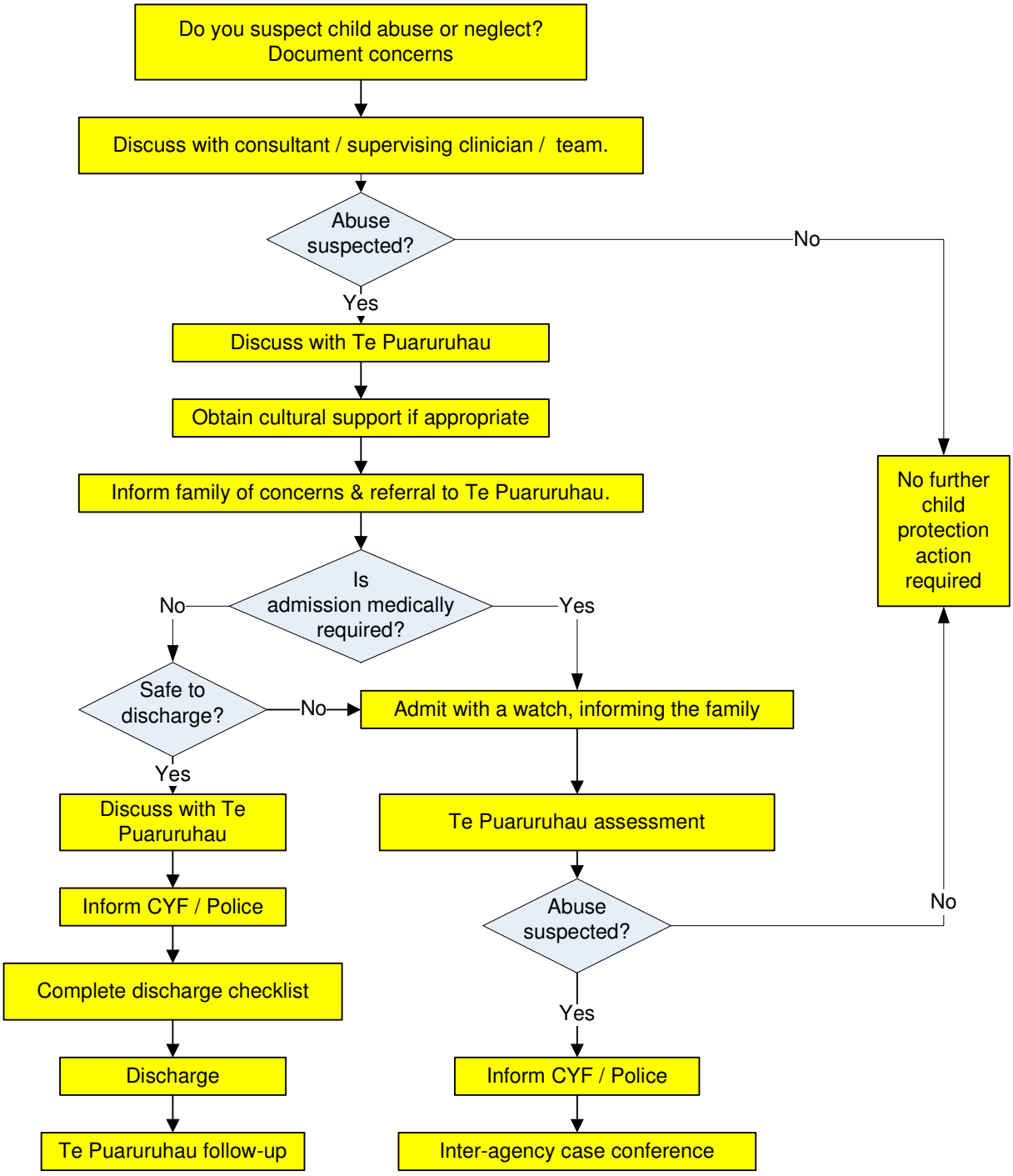
Other Resources

A number of resources are available on the Ministry of health website, including the Ministry of Health Family Violence Intervention Guidelines (http://www.moh.govt.nz/familyviolence).

ADHB Policies and Procedures are available on the Intranet, under P

- Access to Patient Information
- Bicultural Policy
- Child Abuse and Neglect, Care and Protection
- Child Protection Alerts, Management of.
- Critical Incident Stress Management
- Family Violence Policy
- Informed Consent
- Legal Issues Relating to Children
- Puawaitahi Operational Guidelines
- Tikanga Recommended Best Practice
- Watch Policy for Inpatient Children At Risk From Possible Child Abuse or Neglect
- Witnesses Giving Evidence

Flow chart for suspected child abuse or neglect



Guidelines to be used with the flow chart

Do you suspect child abuse or neglect?

This section refers primarily to issues around non-accidental injury and neglect. For guidance around issues related to sexual abuse, please refer to the relevant section.

Whether or not you suspect abuse, a family violence screen should be done on the accompanying caregiver, as per the ADHB family violence policy. There is a strong association between child abuse and other forms of family violence. If you have not been trained how to do this, training is available. Check the schedule through the Family Violence website (under F on the intranet).

Non-accidental injury includes injury and violence to a child or young person. Emotional abuse may occur along with this, or in isolation. Exposure to family violence, even when it does not result in physical harm, is a form of emotional abuse. Neglect is the failure of caregivers to provide adequately for the health, safety and well-being of a child or young person.

Many abused children have presented before. If so, there may be a child protection ALERT. Always check for an ALERT, and if one exists, look for further information (see Alert section).

If a child has come to harm from abuse or neglect, and the diagnosis is not made, there is a high risk of further injury or death. Therefore, if you suspect abuse, a careful evaluation is critical. Although very obvious presentations of child abuse do occur, often the presentation is more subtle. The caregiver will almost invariably conceal the true cause of the injury. Child abuse must therefore be included in the differential diagnosis of a number of presentations.

It is good practice with all childhood injuries (regardless of cause) to take a clear and highly detailed history of the mechanism of injury. Hospital staff must ensure that they understand who saw an incident resulting in injury, and exactly how it is said to have occurred. In many cases, a diagram of the layout of the scene (room, driveway etc) is very helpful.

An injury assessment flowchart is now included in the clinical record for every child under 2 years assessed in Starship Children's Emergency Department. You should use this as a prompt.

Any member of the clinical team (medical, nursing or allied health) may develop a concern about possible abuse or neglect. It is important that this concern is discussed with senior members of the clinical team, and a clear decision is made to consult with Te Puaruruhau.

You should include child abuse and neglect in the differential diagnosis when:

- A discrepancy exists between the history and the injury, e.g. a spiral fracture of the humerus from a simple fall. This is entirely dependent on the quality of the history you take. Any injury may be abusive. (Note: accidental spiral fractures of the lower limbs are common in toddlers).

- There is no history of injury, the history is uncorroborated, the history is very vague, changes over time or differs between caregivers.

- The injury is inconsistent with the developmental age of the child. For example, any infant who has any bruise or fracture and is not yet cruising, climbing or walking.

- There is a history or findings of repeated trauma.

- A young child presents with a skull fracture or head injury (up to 80% of deaths from head injury in children < 2 years may be due to abuse). Note that an apparently trivial bruise to the head of a young infant with no signs of concussion may be a marker of serious risk.

A child presents with injuries which (in the absence of a serious and consistent accidental mechanism) have a high specificity for abuse:

- Subdural haematomas, or other intracranial injury
- Retinal haemorrhage
- Complex skull fractures
- Injuries in and around the mouth
- Rib fractures
- Metaphyseal fractures
- Fractures in unusual places (end of clavicle, hands, feet, sternum, scapula, spine)
- Ruptured internal organs without major accidental trauma
- Trauma to the genital or perianal areas, without a straddle injury
- Patterned bruises, or bruises in parts of the body usually shielded from accidents
- Bizarre injuries such as bites, cigarette bums or rope marks
- Sharply demarcated 2nd and 3rd degree burns in unusual areas

- A child comes repeatedly for symptoms and signs which are never witnessed by hospital staff, or whose pattern of presentation requires multiple investigations but does not fit into any recognised diagnosis (possible “Induced Illness Syndrome”)
- You observe possible signs of neglect or emotional abuse (failure to thrive, poor hygiene or clothing, verbal abuse, “frozen watchfulness”).
- You observe evidence of family violence between caregivers or towards children, or a caregiver discloses family violence on routine screening
- The caregivers have an unusual response to the injury: delay in seeking help, inappropriate behaviour, a refusal to follow medical advice

What do I do if a child discloses abuse?

Listen. Do not put words in a child’s mouth. Allow them to tell only as much as they want. It is not your role to judge whether a child is telling the truth. Although false allegations can occur, they are uncommon, and it is far safer to act on the assumption that the child is telling the truth.

A child old enough to disclose is probably old enough to be evidentially interviewed at a later date. It is therefore important not to interrogate the child, which may only cause distress and may confuse any subsequent evidential process. Keep questions to a minimum, keep them open-ended, and document the conversation carefully in the clinical notes immediately afterwards.

If appropriate, there are five good principles to follow:

- Let them know you believe them
- Let them know you’re glad they told you
- Let them know you’re sorry it happened
- Let them know it’s not their fault
- Let them know you’ll help

Do not over-react. A child’s first disclosure is a critical moment. He or she will be monitoring every reaction, and may well be very frightened if the abuser has threatened them or said no-one will believe them. The abuser may have involved the child in “our secret”, or may have threatened the safety of other members of the child’s family.

Do not panic. If the child judges you unable to handle the situation, he or she may stop talking. Good listening with supportive, minimal encouragers allows the child space to say all they need.

Do not criticise. Don’t say “You should have told me sooner” or “Why did you let him?”. It may help to say that these sort of things happen to other children too sometimes.

Ensure the child’s immediate safety. Try not to alert the alleged abuser. Seek advice and assistance, and find support for yourself.

Who to consult about suspected child abuse

Unless it is an emergency, you should always discuss the child or young person with your consultant, team or other supervising clinician before you consult with Te Puaruruhau.

Contact Te Puaruruhau through the referral cellphone on 021 492 365. This is carried Monday to Friday from 0800 to 1700, except Public Holidays. Alternatively, try 307 2860, or extension 6584. Do not leave a message on these phones if it is after hours and you need urgent assistance.

After hours, contact the Te Puaruruhau Paediatrician on call, through the operator.

On the weekends, there is a social worker and supervisor on call for Women and Children's Health, from 1700 Friday through to 0800 Monday. The supervisor can be contacted through the ADHB operator, or you can try the duty phone (021 442 142). If your concern is possible child abuse, the social worker will work in conjunction with the Te Puaruruhau paediatrician on call.

It is always advisable to consult as early in the process as possible. Time is often of the essence, particularly if involvement of the statutory authorities is likely to be needed.

You must always consult before discharging the child.

Obtain cultural support

It is important to be sensitive to every family's cultural needs. If language is an issue, always use an interpreter. Do not use family members or cultural support staff as interpreters.

When working with Maori whanau, it is always appropriate to consult with Kaiatawhai. On call Kaiatawhai are available from 0800 to 2100, Monday to Friday, and on the weekends 0900 to 2100. This includes Public Holidays. The single contact number is extension 29200, which goes automatically to the cellphone (021 938 580).

When child protection issues arise, Kaiatawhai should be contacted as soon as possible. In consulting with Te Puaruruhau, you can decide whether this contact is best made by the primary team, or by Te Puaruruhau. It is desirable for the Kaiatawhai to be present when the Te Puaruruhau team meet the whanau.

For Pacific families, staff from the Pacific Island Family Support Unit are available 0800 to 2000, Monday to Friday, through the ADHB operator. Outside these hours, in an emergency, contact Julie Guthrie, Manager, Pacific Health Provider Arm, through the operator.

Medical assessment

Use Te Puaruruhau Record Booklet

A complete medical assessment is likely to take several hours. If it is apparent at the outset that this is a case of probable child abuse, contact Te Puaruruhau as soon as possible. After hours, in discussion with Te Puaruruhau, the call-back paediatric registrar will normally be called in to perform the initial assessment, if the presenting concern is non-accidental injury.

History and examination need to be thorough and to be documented completely. Record the date and time with all documentation, and document clearly who gave you the history. If there were several historians, record who said what, and who was present for the conversation.

While informed consent should be obtained for all physical examinations and investigations, this does not need to differ from the usual manner in which you obtain or infer consent for routine clinical practice. Consent does not need to be written, if that is not standard practice for the procedure. However, it is wise to record the manner in which you satisfied yourself that consent had been given. Some relevant aspects of the law are summarized in the appendix.

All children assessed for possible abuse must be discussed with the Te Puaruruhau Paediatrician on call, and if they have physical injuries, these must be seen in person by a consultant.

All examinations for sexual abuse require the presence of the Te Puaruruhau Paediatrician on call.

A general approach for suspected abuse includes:

- **Brief assessment** to determine whether there is actual or suspected child abuse or neglect. Ensure that the child has adequate first aid and pain relief. Discuss with your senior / team.
- **Contact Te Puaruruhau**. In normal working hours, ring Te Puaruruhau direct on 6584 or cell 021 492365. After hours, contact the Te Puaruruhau paediatrician on call through the operator.
- **Complete history.** A complete history includes the timing and nature of any injuries, a full past medical / family medical / developmental history, and a full social history. Ideally, the social history should be taken as part of a full assessment by a trained social worker (see below). After hours, this may not be possible.

  Risk factors for non-accidental injury include factors particular to the child (disabilityor behaviour problems), factors particular to the family (unplanned pregnancy, a family history of abuse or neglect, alcohol or drug abuse, family violence, mobility, depression or other mental illness in caregivers, absence of support for caregivers), and wider environmental factors (poverty, homelessness). However, risk factors have a very low specificity for abuse – that is, abused children may present with no risk factors at all, and non-abused children with multiple risk factors. A decision should never be made on the basis of "risk factors" alone.
- **Contact primary healthcare providers.** If possible, contact the child's usual GP or, in the case of a young infant, the midwife and/or Plunket nurse.
- **Consider contacting ACC.** In some situations of suspected non-accidental injury, you may be able to obtain details of previous injuries by contacting ACC. During working hours, ring the ACC National Database on 915 9400, or an ACC Claims Manager on 915 8322.
- **Complete Examination**
    - This must be a complete physical exam including percentiles for height and weight (and head circumference if less than 2 years old).
    - Careful physical inspection from top to toe, including scalp, ears (including behind the pinna and the side of the scalp), oral cavity (including the frenula), trunk (including the axillae and the buttocks) and limbs (including the inner aspect of the upper arms).
    - Careful documentation of **all** bruising and external injuries on a diagram. Comment on the colour, shape, outline and size of bruises. Describe in detail any pattern of injury. Note tenderness / swelling. Whether or not photographs will be taken, always document on the premise that photographs may be inaccurate or misleading. Avoid making any statement about the age of bruises based on their colour (this is not a reliable method).
    - In infants under the age of 2 years, consider examining the fundi through dilated pupils (Cyclopentolate 1% and Phenylephrine 2.5% are available in CED and 25B). In infants requiring hospital admission, this examination is best done by the ophthalmology registrar on call, using an indirect opthalmoscope. If retinal haemorrhages are found, urgent confirmation by a consultant ophthalmologist is mandatory, and the ophthalmologist will arrange for Retcam photographs to be taken.

- **Investigations.** These are suggestions only

    - FBC and coagulation screen (APTT, INR) if there is bruising or bleeding. If there is a strong personal or family history suggestive of a bleeding disorder, consider a Von Willebrand's screen. (Establish the child's blood group, as VW Factor levels vary between blood groups). Do not perform a bleeding time - the sensitivity and specificity of this test is poor. If you remain concerned about the possibility of a bleeding disorder, discuss with a haematologist.

    - Urine organic acids. This is a screening test for Glutaric Aciduria Type I, a condition that may rarely be confounded with non-accidental head injury.

    - Skeletal survey in infants less than 2 years old. (A skeletal survey may be justified in an older child as well). Organise this with the radiology department in advance. Skeletal surveys can be done over the weekend, but require special arrangements, and will not be done overnight.

      Ensure that the family understand the number of X-rays, and the reasons for them. Te Puaruruhau have a parent information pamphlet about this (SSH/3021/012).

      Radiology will request a nurse from Te Puaruruhau to help position the child for the survey, but the ward may need to supply another nurse. Parents, social workers and other staff are not asked to help restrain the child. For children > 1 year, sedation may be advisable. If an abnormality is reported on X-ray, always ***obtain a consultant radiologist's opinion before you speak with the family.***

    - In infants, a repeat skeletal survey 2 weeks later is usually indicated – this may detect recent bony injury not visible on admission.

    - In most infants, an acute bone scan is also indicated. These are particularly helpful with rib fractures, and with fractures in unusual places (scapula, pelvis). They are not specific around the physes of the long bones, and false negatives may occur. The combination of a bone scan and two skeletal surveys is the most comprehensive approach.

    - CT head scan (without contrast) is always indicated along with skeletal survey for non-accidental injury in an infant < 12 months, even if the infant has no signs of head injury. Many centres would regard a CT scan as a necessary investigation in all children under 2 years with suspected non-accidental injury. If there is a skull fracture, always ask the radiographers to perform a 3-D reconstruction of the skull. In Starship Radiology in a young baby, CT scan can often be performed as a 5 minute "feed-and-wrap" procedure, if there is good co-ordination between the ward and the radiology department.

    - MRI brain scan if you suspect non-accidental head injury. Include the cervical cord, and a full set of sequences appropriate for NAI (including gradient echo sequences and diffusion-weighted images). MRI is much more sensitive than CT for parenchymal injury and small subdural collections, and more useful in assessing the possibility of repeated injury. Any child with non-accidental injury who has equivocal or positive findings on CT, will also require MRI. This will almost always require a general anaesthetic.

    - Other investigations as appropriate.

- **Photographs.** Photographs may be helpful to document soft tissue injuries, especially if they are complex. Even when not necessary for documentation, they may be helpful in explaining the injuries in a Family Group Conference or Court. In hours, contact the Hospital Photographic Department extension 25166. After-hours it may be possible to obtain a photographer through the photography business manager on 021 555 309.

  In Children's Emergency Department, there is a digital camera in the safe, which can be accessed by CED senior staff. Photographs taken using this camera must be downloaded immediately afterwards into the photograph folder on the CED L drive and labelled with the NHI. They must then be emailed to Te Puaruruhau (TEP@adhb.govt.nz), for review at the next Te Puaruruhau peer review. Te Puaruruhau will ensure they are forwarded to the photography department for entry into the clinical record.

  If the Police are involved, they may be able to arrange photographs through their on call photographer, in which case the photographs will be the property of the New Zealand Police. You may be able to request a copy from the Police for the hospital record. Record in the clinical notes the name and contact details of the Police officer involved.

- **Management**
  - Relieve symptoms and support the child and family
  - Provide appropriate health care
  - Determine if admission is necessary
  - If there is injury, complete an ACC form

- **Safety**

  If the child needs admission in the context of suspected non-accidental injury, a Watch will be required, who must be in the room with the child at all times. This is the default policy, although in exceptional circumstances, a variation can be agreed by the Te Puaruruhau paediatrician.

  Apart from the Watch, safety can only be addressed as a carefully planned collaborative procedure between ADHB, Police and the Department of Child, Youth and Family Services. Further details are provided below, but this will usually be managed by staff from Te Puaruruhau who are familiar with the procedure.

Sexual abuse

Suspicion of sexual abuse usually arises either when a child or young person makes a disclosure, or when they present with concerning physical symptoms or signs, or behaviour changes.

Physical symptoms or signs that may arouse concern include anogenital symptoms (difficulty in walking or sitting, discomfort on going to the toilet, recurrent vulval rash or vaginal discharge, bleeding, unusual odours), anogenital injuries, genitalia that appear abnormal, missing or torn underclothing (for example, in an intoxicated adolescent) or a vaginal foreign body in a child.

Behaviours that most often cause concern are dramatic changes in behaviour (regression to more infantile behaviour, inexplicable hostility or aggression, withdrawal, depression, anxiety, obsessive handwashing, changes in sleeping or eating, attention-seeking behaviour, psychosomatic symptoms), sexualised behaviour (obsessive masturbation, acting out explicit sexual acts, precocious sexual knowledge, explicit artwork) or unexplained fear of particular places or people.

Young children go through several stages of sexual play and exploration as part of normal development. If you have concerns about a child's behaviour, and are unsure whether you should be raising the issue of possible sexual abuse, feel free to discuss that with Te Puaruruhau or the Starship Consult Liaison Team.

All of the above features are non-specific, and must be evaluated carefully in the context of the presenting history and circumstances of that child or young person. One must never jump to conclusions. There are of course findings that are diagnostic of sexual contact (pregnancy, sexually transmitted infections, sperm in the vagina) or penetrating genital injury, but even these must be interpreted in the light of a young person's age and history of consenting sexual activity.

In general terms, the approach to suspected sexual abuse is similar to that for other kinds of abuse, as already documented. If forensic evidence of sexual assault is required, this will be collected by the Te Puaruruhau doctor on call using the Police Medical Examination Kit.

If you are dealing with a patient where there are concerns about sexual abuse (for whatever reason), always discuss the matter with the Te Puaruruhau paediatrician on call, before the family leave the hospital.

- **Initial assessment of concerns about sexual abuse**

This may be simply a brief history from the referrer. You need a description of the timing and nature of injuries and symptoms. If the referrer is the child / adolescent or caregiver, take the briefest history necessary to determine whether there is in fact a child sexual abuse problem and its severity and acuity. This needs to be done in a non-judgmental style using open questions as opposed to leading questions. If the child or adolescent is Maori, involve Kaiatawhai.

  - **Open questions** allow the child / adolescent to provide the answer: *"What happened then?", "How come your fanny is sore?", "Is there any part of your body you're worried about and you'd like me to check?"*
  - **Avoid leading questions,** which suggest the answer: "*Did Uncle Bob touch your fanny?*", "*Did he pull your pants down*?"
  - **Avoid "did" questions.** Try to use "*what*" or "*how*". Try to record verbatim what you ask, and the response.

- **Deciding if genital examination is urgent**

  Factors influencing the urgency of the examination include:

  - **Acute symptoms** (e.g. bleeding, pain, vaginal discharge)
  - **Forensic Issues**. Forensic evidence may be obtained up to one week after acute sexual assault, but the best chance is within 72 hours (in children, 24 hours). If there may be semen or saliva on the skin, a few hours make a big difference. **Note**: If the young person has not changed or washed, evidence may be obtained from clothing and skin. If he or she wishes to urinate while awaiting their forensic exam, ask them not to wipe the genital area.

- **Involve Te Puaruruhau**. Decisions about initial management should be made in conjunction with Te Puaruruhau. During the day contact the team directly. After hours contact the on call Te Puaruruhau paediatrician. In most cases, this doctor will need to speak to the referrer direct.

Talking to Families

Honesty is the best policy. The family must be told of your concerns, and of referrals you will make (whether to Te Puaruruhau, or to Child, Youth and Family), unless you believe that doing so will endanger the child. In that case, you must discuss the case with Te Puaruruhau or the statutory authorities before you speak with the family.

This conversation should not be left to junior staff, and is best done with another staff member. In the case of a Maori whanau, include the Kaiatawhai. In the case of a Pacific Island family, offer the support of a member of the Pacific Island Family Support Unit, if available.

It is essential that all interactions with the child and family should be non-judgmental. This is a particularly stressful and threatening situation for families. You should expect anger or distress and be prepared to deal with this. Your consultant or the Te Puaruruhau team will help you with this.

Examples of how to tell the family of your concerns:-

"In our experience an injury like this is very unusual after such a minor fall. We are worried that the injury might have been caused some other way. In particular, we are worried about the possibility that someone may have injured your child. The policy in Starship is, that whenever we have this concern, we must involve the Starship Child Protection Team. They are experts in this area. They will talk to you, examine your child and arrange other tests. We realise that this is very upsetting for you, and we want to make it very clear that no-one is jumping to any conclusions. However, we do have a responsibility to check things out, to make sure everything is OK for you and your child".

"From what you have told us, we are concerned about the safety of the children who are being left alone while you are at the pub. A social worker will be coming to discuss this with you."

"From what you have told me I am concerned that someone may have sexually abused your child. However, I am not an expert in that area. It's really important we don't jump to any conclusions, and it's really important for her that we do things right. I will go and ring someone from our child protection team, and they will probably need to arrange to see you."

A pamphlet about Te Puaruruhau (SSH/3021/013) is available for you to give to the family

Social Work Assessment

Where a child or young person presents with concerns about care and protection, hospital staff should immediately consult with Te Puaruruhau. If it is agreed that referral to Te Puaruruhau is necessary, Te Puaruruhau will conduct an assessment. This is a multi-disciplinary assessment involving a social worker and a paediatrician or nurse specialist. After hours, the Te Puaruruhau paediatrician on call will work in conjunction with the after-hours social worker, if available.

On the weekends, there is a social worker and supervisor on call for Women and Children's Health, from 1700 Friday through to 0800 Monday. The supervisor can be contacted through the ADHB operator, or you can try the duty phone (021 442 142). If your concern is possible child abuse, the social worker will work in conjunction with the Te Puaruruhau paediatrician on call.

Hospital staff should also complete an internal referral form. Te Puaruruhau is based in a multi-agency centre (Puawaitahi), at 99 Grafton Road, across the road from Gate 4. You are welcome to come over any day during the week to discuss a case (although we suggest you ring first). The daytime phone is 09 307 2860, fax 09 307 4930, and referral phone 021 492 365.

ADHB policy is that all cases of suspected abuse or neglect must be notified to the Department of Child, Youth and Family Services. Often, this referral will be made by Te Puaruruhau, after they have completed their assessment. This referral is usually made by the social worker (see below).

- **Ward Social Worker.** The social worker will help the hospital team to identify children who present with concerns that may be care and protection issues. He / she will consult with Te Puaruruhau staff if care and protection concerns have been identified. In some of these cases, it may be appropriate for the ward social worker to complete a psychosocial assessment.

  The Ward Social Worker may also act as a support person for the family through the Te Puaruruhau investigation, in close consultation with Te Puaruruhau and cultural support staff.

- **Te Puaruruhau Social Worker.** Contacted through the Te Puaruruhau referral phone (021 492365). Each Te Puaruruhau social worker carries their own cellphone, and once assigned to the child, will leave their contact details clearly recorded in the clinical notes.

  The Te Puaruruhau social worker will complete a psychosocial assessment when a child is accepted as a referral to Te Puaruruhau, usually in conjunction with a Paediatrician or Nurse Specialist from Te Puaruruhau. If it is felt appropriate, a referral to Child, Youth and Family will be made (see below). After the referral is made, the Te Puaruruhau Social Worker will:

  - Continue to liaise with Child, Youth and Family until the child or young person is safe.
  - Provide any written requested information from the hospital, after CYF has provided a written request under section 66 of the Children, Young Persons and their Families Act.
  - Keep hospital staff informed of developments relating to the care and protection concerns.
  - Ensure a comprehensive safety plan is placed on the child's file for all hospital staff, and update this plan at regular intervals.
  - Invite the Child, Youth and Family Social Worker to relevant hospital meetings.
  - Provide a discharge date for the Child, Youth and Family Social Worker if this is known.
  - Consult with the ADHB Child, Youth and Family Liaison Practice Leader if any concerns arise that they are unable to resolve

- **ADHB Child Youth and Family Liaison Practice Leader (917 5391).** This is a CYF Social Work Practice Leader position, funded jointly by ADHB and CYF, based on Grafton site. The position exists primarily to address systemic issues of communication and case management between the two organisations. During business hours, the liaison Practice Leader is available for consultation by staff of either organisation in relation to these issues. He / she may also be involved in assisting the referral process and working through any issues or areas of concern that arise. Feedback will be given to all staff involved in the concerns.

Safety

This is a problem for the Department of Child, Youth and Family Services and the Police to resolve. However, you must consider it, in conjunction with the Te Puaruruhau team.

Generally speaking, children presenting to Starship and considered to be at serious risk from abuse or neglect, should be admitted to hospital. However, admission to hospital does not in itself ensure safety (see below). Admission must be followed by close liaison with CYF and the Police to develop and implement detailed plans to ensure safety.

In most cases, this liaison will be undertaken by the Te Puaruruhau team. Unless it is an emergency, your first step should be to consult with Te Puaruruhau. Puawaitahi (the multi-agency centre of which Te Puaruruhau is a part), has a detailed set of operational guidelines to guide the process of liaison with CYF and the Police.

In the case of children admitted with suspected non-accidental injury, this guideline requires a face-to-face inter-agency case conference within 24 hours of admission.

There are, of course, regular situations where, after assessment by Te Puaruruhau, ADHB is able to conclude that there are no child protection concerns. In these cases, the matter does not usually proceed to a case conference, and the Watch (see below) may be discontinued after a day or two of assessment and investigation in hospital.

- **The child who is seen not admitted.**

A child where abuse is suspected may only be discharged if the discharge checklist (see below, and in the Te Puaruruhau Record Booklet) can be completed. If hospital staff are not confident that the arrangements proposed for safety are adequate (even if those arrangements are proposed by a statutory social worker), the child should not be discharged.

- **Caregivers who threaten to walk out with the child**.

In an emergency, alert the Duty Manager, call Code Orange (dial 777) and the Police. If the caregivers are threatening to remove the child, you cannot physically prevent them doing so unless their action will result in "immediate and serious injury" to the child (e.g. taking the child off the operating table or off a ventilator). You can usually negotiate, and if necessary point out that if they leave, you will be asking the Police to bring them back.

- **Caregivers who threaten the child or staff in hospital**.

Again, call Code Orange and the Police. The ADHB Duty manager can issue a Trespass Order against a parent or caregiver who is behaving in a threatening fashion.

- **Admitting a child to hospital does not ensure the child's safety**

It *may* temporarily reduce the risk. Usually, we do not know at the time of admission who caused the injuries. Hospital staff do not have the statutory authority to prevent a child's removal from hospital (except in extreme circumstances), nor to prevent the visit of suspected offenders.

Any child admitted to ADHB for concerns about possible non-accidental injury, must have a Watch in the room at all times. The only exception might be a circumstance where non-accidental injury is such a remote possibility, that a Watch is not felt to be justified. Such a decision can only be made by the Te Puaruruhau team. (Refer to the ADHB Policy: Watch Policy for Inpatient Children At Risk from Possible Child Abuse or Neglect).

You must clearly explain to the family at the time of admission, the reason for the Watch. It is not the role of the Watch to explain to the family, the reason why he/she has been asked to be there.

The Nurse Watch should receive clear instructions from the Charge Nurse, Charge Midwife or Duty Manager, and will record observations on a watch record sheet which will become part of the Clinical Record. The presence of a Watch offers benefits to the family as well as the child.

The Te Puaruruhau information handout provides written information about the Watch.

Safety Plan

Every child under investigation for child abuse should have a safety plan clearly recorded in the clinical notes, a copy of which is sent to the Duty Manager.

This is usually completed by the social worker.

This should Include a sticky label with the child's NHI etc, and an outline as follows:

Current Situation:	Brief summary of current care and protection concerns
Custody / Guardianship:	Who will be signing consent forms
24 Hour Watch:	Details
Plan (if family try to remove the child)	Code Orange / Police / CYF
Access:	How it will be managed, requirements
Social work support:	Including after hours social work
Who to contact if child is likely to die:	Police / CYF / Te Puaruruhau

Other considerations:

If a watch is not deemed necessary, consider placing a child near the nurses station.

For a child who is old enough to understand, explain how they can keep themselves self, e.g. press the buzzer for a nurse.

Inform security if there are identified safety concerns regarding a person visiting a child.

Referral to Child, Youth and Family Services (CYF)

General Principles.
The Department of Child, Youth and Family Services has the statutory responsibility for ensuring the safety of children. If you suspect abuse, after consultation within the ADHB as described above, the matter must be referred to Child, Youth and Family.

Referrals should be made by phone, followed by an emailed referral (see hyperlink next page).

This table summarises some key differences between statutory and hospital social workers. However, CYF social workers also work in partnership with families/whanau, and under the "Differential Response" (DR) approach, work with community agencies to support families.

Child Youth and Family	Hospital or community social workers
Non voluntary involvement	Voluntary involvement
Statutory obligation (CYPF Act 1989)	Partnership with client
Powers of investigation	Facilitate empowering processes
Powers to uplift / over-ride parental rights	No statutory powers
Investigative / assessment approach	Therapeutic approach

If we have care and protection concerns, there are two ways to notify Child, Youth and Family:

- Under section 15 of the Children Young Persons and Their Families Act (CYPFA), where we report a matter of concern for assessment. This is the usual path from ADHB. All such referrals go through the National Contact Centre. The call centre will identify which office will be responsible. (There are 14 site offices in metropolitan Auckland, and a case will go under a particular site according to residential address).
- Under section 19 of the CYPFA to a Care and Protection Co-ordinator. Seldom used by ADHB.

If any concerns arise in relation to a child / young person who is already involved with CYF, then contact should be made with the relevant site office through the Contact Centre. When ADHB social workers are available, this contact would usually be made through them.

If the child or young person is from outside the Auckland area, Grey Lynn CYF will assist with the case, with the originating office retaining on-going responsibility. If the referral occurs after-hours, Grey Lynn will take interim responsibility for the case.

Specify an ADHB contact person

It is important that ADHB tells Child Youth and Family who will be the designated contact person within ADHB, and that person's contact details. This should usually be the person who makes the referral to Child Youth and Family. If not, it should be a person who will be a key clinician in the case, and who is usually available. This person is referred to from here on as "the notifier".

How to contact the Contact Centre.

Ring 0508 326 459 (FAMILY) and request the site or staff member you are after. The Contact Centre now operates 24 hours, from Monday 0830 to Saturday 0600.

From Saturday 0600 to Monday 0830, the phone goes to Answer Services NZ. If for some reason there is no answer at that number after hours, ring Answer Services NZ directly on 377 1209, fax 309 9180. Answer Services NZ will contact the on-call social worker for each area. The social worker will ring you back, although this may take 30 minutes.

If unable to contact the on-call social worker, ask for the CYF Social Work Supervisor. If this person is also unavailable, ask them to contact the Site Manager for the office involved, or if necessary the Regional Manager.

See appendices for detailed individual addresses and contact numbers for Auckland site offices.

If you can't contact CYF and you are concerned for the safety of a child, contact the police.

Child, Youth and Family Triage Categories.

Child, Youth and Family will respond to a section 15 report from ADHB within the time frames established for the service. These are:

- **Critical**

  Response time: **immediate response** (must be same day)

- **Very Urgent**

  Response time: **within two days;** same day or day following the notification

- **Urgent**

  Response Time: **within seven days;** date received plus six calendar days

Refer to the appendices for details used when CYF are determining the urgency of response.

Child, Youth and Family Process.

Once initial contact is made by phone, a referral should be emailed to the Contact Centre, using the CYF referral template. (This email should be copied to Te Puaruruhau TEP@adhb.govt.nz).

Once the referral is received on site, the case should be allocated to a specific social worker within the time-frame of the designated response category.

The allocated social worker will:

- Contact the notifier to get any update of the concerns for the child or young person
- Liaise closely with the notifier throughout the investigation.
- Recognise that Consultant Paediatricians in ADHB have specialist expertise in the identification of child abuse and neglect
- Be responsible as the lead agency throughout the investigation.
- Provide a written request for information under section 66 if asked to do so.
- Complete the Child, Youth and Family Information Sheet for the hospital records, if the child or young person is admitted. This is an ADHB form (CR2150). The CYF social worker can add to the information on this sheet by requesting a hospital clinician to remove it from the chart, allow them to update it and then replace it in the chart.
- Inform hospital staff at the beginning and end of a visit to a child or young person on the ward and be able to produce Child, Youth and Family Identification.
- Inform hospital staff of the plan for the child or young person after each visit. Child, Youth and Family social workers will ensure that as plans develop and after each visit, they discuss what is to occur with the relevant ADHB staff member and ensure that the information is recorded clearly.
- Invite relevant hospital staff to any case conferences.
- Be responsible for investigating the care and protection concerns and determining if the concerns are substantiated.
- Contact the CYF ADHB Liaison Practice Leader if any concerns arise about the relationship between ADHB and the Department.
- Find a placement for the child or young person once he/she is medically ready for discharge and it is not safe for the child or young person to return home.

Case Conferences and Discharge Meetings.

CYF social workers should be invited to all discharge meetings and relevant case conferences for a child or young person where care and protection concerns exist.

CYF social workers will attend discharge meetings for children/young people who are in the custody of the Chief Executive of the Ministry of Social Development.

Feedback to notifier.

Any person who makes the section 15 report must be informed as soon as practicable after it has been investigated or a decision has been made not to investigate the report (s17(3)).

If ADHB notifies a case, the Child, Youth and Family Social Worker must report to ADHB, at the end of the investigation, what the outcome was. This will be done by talking with the notifier (not by leaving a message), or in writing.

Referral to the Police

Should the Police be notified?

The simplest answer is "Yes". Children who present with any form of definite abuse should be notified to the Police. Usually, this decision will be made either by Te Puaruruhau, or in consultation with Te Puaruruhau.

If there is a critical issue of safety, such as a child who is about to be removed from the Starship and in your opinion is in imminent danger, call the Police.

When a child presents with severe or potentially fatal injuries, notify the Police at once. Although it may not be possible for them immediately to interview family, inspecting the scene where the injury took place may be crucial to success in identifying the person responsible.

By agreement, CYF and the Police should notify each other of any child abuse referral received. This does not always occur. It is safe practice to notify both agencies of any case referred to either.

There are five Police Child Abuse Teams (Takapuna, Auckland, Henderson, Counties Manukau North, Counties Manukau South). They are not available after hours, when the CIB deals with the case initially. There is one 24 hour number for the Northern Communications Centre (302 6400).

When contacting the Police it helps to speak with officers who are experienced in child abuse, usually working in the Child Abuse Team (CAT). These officers, unless they happen to be on call for the general CIB roster, are only contactable on the specific numbers below during business hours. If there is no urgency to contact the police you may wish to leave this to Te Puaruruhau.

Station	Phone number	After hours
Auckland	302 6400	302 6400 (all areas)
Auckland CAT	367 0291 (Child abuse team, in hours)	
Henderson	839 0600	
Henderson CAT	839 0639 (Child abuse team, in hours)	
Counties Manukau	261 1300	
CAT North	259 1060 (Child abuse team, in hours)	
CAT South	259 1068 (Child abuse team, in hours)	
North Shore	488 6200	
North Shore CAT	477 5103 (Child abuse team, in hours)	

Release of information to Statutory Authorities

ADHB staff are able to release information to CYF or the Police if we hold concerns for the safety of the child or young person, or if ADHB holds information relevant to care and protection issues that are under investigation by CYF or the Police.

If ADHB is making the notification to CYF then we should provide all relevant information at the time of the referral. If CYF approach ADHB for information about a child or young person, they will usually do so under Section 66 of the Children, Young Persons and Their Families' Act. This states that every government department or statutory body must supply information about any child or young person to a Care & Protection coordinator, a statutory social worker or a member of the police for the purposes of:

- Determining whether the child or young person is in need of care or protection (other than on the grounds of section 14(l)(e))
- Any proceeding under the care and protection provisions of the CYP&F Act.

No application to the Court by CYF is required. These provisions override the Privacy Act 1993 and the Official Information Act 1982, which normally govern the release and use of such documents.

Maintaining medical records on the ward

The child's medical record is the property of the ADHB. The contents of that record are private to that child or young person. In the context of child abuse, the caregivers do not have automatic right of access to the medical record. It is therefore recommended that the medical record is kept in the charge nurse's office, and not on the medical record trolley.

It is important that all staff observations relevant to the possible diagnosis are recorded in the notes. If you observe verbal abuse, unusual parent-child interaction or aggressive behaviour, document it. Documentation of the facts of what was observed is legitimate, and may be extremely important in ensuring the safety of the child.

In most cases, good communication between hospital staff and caregivers should ensure that there is nothing in the hospital notes that the caregivers do not already know. If caregivers formally request copies of the notes, this request should go through the Consultant responsible for the child's care. If the request is refused, the child's guardians have the right to appeal to the Privacy Commissioner for a review of that decision.

The child who dies

Every year, several children die in Starship (usually in PICU) from injuries resulting from child abuse. In this situation, the death automatically becomes a Coroner's case, and a post-mortem will be required. The procedures followed in the case of any death should of course be followed here also. See the Guideline 'Deaths reported to the Coroner'. Points to note are as follows:

Notify the Police early in the admission, so a scene inspection can be conducted if indicated. The Police will treat this as a homicide. They will put in place a designated investigation team. If you have contacted the Police well in advance of an expected death, you can plan how the Police will be introduced into the scene and how the transfer of the body to the Police will be managed.

The Police have an Iwi liaison officer, whom they will involve when dealing with Maori whanau. Once again, this should be planned in conjunction with Kaiatawhai and ADHB social workers.

The Paediatrician involved should attend the autopsy, to ensure full communication and co-ordination with the forensic pathologist. All these cases are reviewed at an Inter-Agency Case Review meeting. Hospital personnel involved in the case are welcome to attend, and this provides a forum where any difficulties in the management of the case can be addressed.

Follow-up

Adequate follow-up by health-care services must be arranged prior to discharge, either through Te Puaruruhau or ADHB outpatients, or by referral to locality-based health services.

Infants with non-accidental head injuries must be followed up comprehensively, as would be the case for any infant with a severe head injury. This involves adequate education of proposed caregivers prior to discharge, provision of car seats, formal referral via ACC to visiting therapists, and regular follow-up through outpatient clinic. It may also require the co-ordination of ophthalmology follow-up, outpatient audiology and sub-specialist appointments.

In most cases, a formal discharge planning meeting will be required, and strenuous efforts should be made to have the CYF caseworker (and the child's prospective caregiver) present at this meeting.

It is important to document thoroughly in the notes the names, addresses and phone numbers of CYF social workers, and caregivers likely to be involved in the child's care after discharge. Record this on the "Child Youth and Family Services Information Sheet" (CR2150).

Copies of all appointments should be sent to the allocated CYFS social worker. If a child leaves hospital in the custody of CYF, then the postal address and phone number recorded in the hospital information system should be the address of the CYF site office involved, and the DDI (Direct Dial In phone number) of the allocated CYF social worker.

Medical reports

Children assessed for non-accidental injury, sexual abuse or neglect should always have a formal typewritten medical report. This should be written by, or in conjunction with, the consultant ultimately responsible for the child's care. Guidelines on how to write such a report are available in the Te Puaruruhau Registrar Manual. This report must be provided to Child, Youth and Family and the Police as soon as possible.

Medical reports should be dictated on Winscribe, using the Soprano MedDocs Child Protection Report format. This is accessed as Department 112, and the Job Type ID is 34. These reports must be read and counter-signed by the consultant with whom the child was discussed.

Once approved, the "Child Protection Report" is automatically transferred into CRIS, where it automatically generates a Child Protection Folder, which can be accessed by any clinician with access to CRIS seeking child protection information.

If you are asked to provide a brief of evidence for the Police, always discuss with the consultant paediatrician or other senior clinician who supervised you.

Case Review

Four days a week (Monday, Tuesday, Thursday and Friday), Te Puaruruhau discusses all referrals received, in a multi-agency referral meeting. Every Thursday morning, beginning at 0900, the Te Puaruruhau team reviews all children and young people seen by the team in the previous week.

If you have referred a case to Te Puaruruhau, you are welcome to attend the referral discussion. You are also welcome to join the case review on Thursday. This is an essential part of quality assurance in an often difficult area of practice, and you are encouraged to attend.

At these meetings, the team decides whether to register a "Child Protection Alert", including siblings (see below). If you believe an ALERT is warranted, follow the process detailed in the Watch Policy. Once again, you are welcome to join Te Puaruruhau for this discussion.

If you have any concern about a breakdown or failure in ADHB processes that have led to difficulties in management of a case, consider lodging an "Incident Report" through Risk Monitor Pro, the ADHB system for monitoring and responding to quality issues.

Alerts

An ALERT system exists because child abuse is serious, it recurs and it is often missed. The system alerts us that there have been care and protection concerns in the past, and prompts a thorough assessment to ensure we do not miss any indicators of continuing abuse.

Who may need a Child Protection Alert?

- Any child up to 17 years where child abuse is suspected and ADHB refers to CYF.
- Any ADHB patient up to 17 years who is currently a client of CYF for care and protection

Sexual abuse and Child Protection Alerts.

Unlike other records relating to child protection, sexual abuse records are maintained separately in Te Puaruruhau. This is because the information is often highly sensitive, the clients are often adolescents, and the circumstances may be such that continuing care and protection issues do not arise. Unless there are continuing safety issues warranting an Alert, an Alert is not placed routinely on victims of sexual abuse.

Sometimes, an Alternative Child Protection Report may be placed on CRIS with a young person who has presented for sexual abuse, but disclosed ongoing issues such as family violence.

Siblings and Child Protection Alerts.

Siblings may also be at risk, particularly siblings under 5. Every such sibling of a child referred to CYF by ADHB for abuse, should also be assessed for abuse. If a sibling is identified to be at risk, referral to CYF is mandatory and a Child Protection Alert must be placed.

Placing a Child Protection Alert.

Discuss the need for an Alert with your consultant or other supervising clinician. Forward the necessary documents (see Policy) to Te Puaruruhau for a decision about placing an Alert. An Alert request will not be accepted if it is not accompanied by enough information for Te Puaruruhau (and therefore any future clinician accessing the clinical notes) to make an informed decision.

Checking for a Child Protection Alert.
When the child or young person presents to ADHB services, a red exclamation mark will appear on the electronic whiteboard. This exclamation mark is used for a wide variety of Alerts, e.g. “Clinical Trial” or Medication Allergy. If you click on the exclamation mark, you will find out what type of Alert this is. If it is a Child Protection Alert, there should be relevant information under the Child Protection tab (either a copy of the CYF Referral, a Soprano Meddocs Child Protection Report, or an Alternative Child Protection Report).

If there is no child protection information on CRIS, contact the clinician who requested the Alert (the name on the Alert Notification / Cancellation Form in the Alert folder on CRIS). Please also email the Te Puaruruhau Team Support (TEP@adhb.govt.nz), so we can follow this up.

What do I do if I find a Child Protection Alert?
Don’t panic, jump to conclusions or be judgmental. Most parents will not know an Alert exists. Find the information which prompted the Alert, take it into consideration, perform a thorough assessment and discuss the patient with a senior clinician prior to discharge.

Have a low threshold for discussing these cases with the Te Puaruruhau team

Discharge Safety Checklist

The child who presents as suspected or proven abuse may only go home, if ADHB can answer "YES" to all of the following.

Is the child safe at home?	Yes	No
Is the child medically fit for discharge?	Yes	No
Have you discussed discharge with another senior medical person?	Yes	No
NAME:		
Have you completed an ACC form?	Yes	No
Have you made a referral to Te Puaruruhau, or to the Child Youth and Family Services on call Social Worker?	Yes	No
NAME OF CYF SITE OFFICE:		
NAME OF CYF SOCIAL WORKER:		
Have you acted with cultural safety ? (For example, have you involved Kaiatawhai if the child is Maori; or the Pacific Island Family Support Unit if the child is of Pacific Island ethnicity)	Yes	No
Has someone been appointed to write a formal medical report?	Yes	No
NAME:		
Have you tried to contact the General Practitioner?	Yes	No
NAME OF GP:		
Has appropriate follow-up been arranged?	Yes	No
Have the caregiver and CYF been told the follow-up arrangements?	Yes	No
DATE AND TIME: PLACE: PERSON:		
Do you have a reliable address and contact phone number?	Yes	No
Do you have an alternative contact address?	Yes	No
ALTERNATIVE CONTACT ADDRESS AND PHONE NUMBER:		

Note: Although it may not be necessary to notify the Police immediately if the safety of the child has been assured, as a general rule any case notified to the Department of Child, Youth and Family Services should also be notified to the Police.

References

American Academy of Pediatrics. Visual Diagnosis of Child Abuse on CD-ROM, 2nd Edition, 2001. http://www.aap.org. This is available on the ADHB intranet, through the CETU website. Contact Victoria Larbalestier (VictoriaL@adhb.govt.nz) to gain access.

Kleinman PK (ed). Diagnostic imaging of child abuse (2nd Edition). Mosby: St Louis, 1998. Reece RM, Ludwig S (eds). Child abuse. Medical diagnosis and management (Second Edition). Lippincott Williams & Wilkins: Philadelphia, 2001. Available Starship Radiology and Te Puaruruhau.

Reece RM, Christian C (eds). Child Abuse. Medical Diagnosis and Management (3rd edition). American Academy of Pediatrics, 2007. Available Te Puaruruhau.

Many other references are available in Te Puaruruhau and Puawaitahi (99 Grafton Road)

Appendix 1: Guardianship, day to day care and contact

This is a summary. For further information see the Legal Issues Relating to Children Policy

NOTE: From 1 July 2005 the Guardianship Act 1968 was replaced by the Care of Children Act 2004. Custody and access were replaced by 'day to day care' and 'contact', with a greater emphasis on shared care arrangements. Parents may agree an arrangement or the courts may impose it through a parenting order. Existing custody and access orders continue with the terminology changed accordingly.

Guardianship
Duties, powers, rights and responsibilities of a parent in relation to the upbringing of a child, including: • day to day care of a child (except in the case of a testamentary guardian); • contributing to the child's intellectual, emotional, physical, social cultural and other personal development • determining, for or with the child, questions about important matters such as medical treatment (not of a routine nature - routine medical care falls within 'day to day care') • Other rights and responsibilities vested by statute

Day to Day Care	Contact
• Rights and responsibility for routine care of a child, for a defined period. • Includes care for specified days or parts of days (unlike custody both parents are likely to have day to day care for specified periods). • Includes medical treatment that is routine in nature. • May be agreed by the child's guardians or dictated by a parenting order.	• Direct or indirect interaction with the child, for a guardian who has no day to day care responsibility for the child. • A guardian with contact only, retains their residual guardianship rights and responsibilities

Who is Guardian?

(Note: the identity of mother and father can be presumed if recorded on the child's birth certificate)

- The mother;
- The father. Unless:
    - Where the child was conceived before 1.7.05, the parents were not married at any time from conception to birth, and were not living together as de facto partners at birth;
    - Or, where the child was conceived on or after 1.7.05, the parents were not married or living as de facto partners at any time from conception to birth;
- A testamentary guardian (appointed to be guardian after parent guardian's death);
- The partner of a parent where appointed by the parent(s) – appointment must be documented in prescribed form and approved by a Court Registrar;
- A person appointed by the Court as guardian in general or for a specific purpose.
- The Court, in cases where the child is placed under the guardianship of the Court. The Court may appoint one or more persons to act as agent of the court, e.g. a clinician for treatment purposes and the parents for all other care.

Consent to treatment

Consent to treatment for an incompetent child under 16 must be provided by a guardian, if one is available (see Informed Consent policy).

Health Information

For health information purposes the representative of a child under 16 is "parent or guardian". Information must be provided to a representative unless disclosure is contrary to the interests of the child. A guardian with no day to day care responsibility still retains the right to be involved in important decisions and should be provided sufficient information to do so.

Visiting a Child in Hospital

When a child is in hospital, ADHB controls access to the hospital and therefore the child.

The day to day care arrangement should be taken as a guide to parent/guardian involvement.

Where necessary to ensure the safe and efficient provisions of services, the Duty Manager may authorise restriction of access (to the service/ward) to certain times or under conditions.

Only where there are direct safety concerns or the child's clinical condition will be significantly compromised (and the risk cannot be avoided by limiting contact), or a protection order exists, should a guardian be excluded entirely

Children, Young Persons and Their Families Act 1989

The Chief Executive of Child, Youth and Family Services or any other person / agency may be appointed by the Court as:
1. Additional guardian
2. Sole guardian (natural guardian rights are suspended)
3. Guardian for a specific purpose

Adoption Act 1955

When a final adoption order is made, the adoptive parents become parents and guardians as if the child was born to them in lawful wedlock.

Appendix 2: Informed consent for medical examination

Permission of a parent or guardian is normally required for any medical examination of a child under 16 years. There are exceptions to this, both general and in suspected child abuse.

General exceptions

The Care of Children Act provides that, if there is no guardian in New Zealand, or no such guardian can be found with due diligence or is capable of giving consent, a person who has been acting in the place of a parent can give consent.

Under the Code of Health and Disability Services Consumers' Rights (Right 7(4)), it is possible to examine and treat without guardian / substitute consent if:

- No-one legally entitled to consent is available
- It is in the best interests of the child, and
- Reasonable steps have been taken to ascertain the views of the child, and:
    a. Either, if the child's views can be ascertained, the proposed treatment is consistent with the informed choice she would make if she were competent
    b. Or, if the child's views cannot be ascertained, you take into account the views of other suitable persons who are interested in the welfare of the child and can advise you (if none are available there is no obligation to find them).

"Gillick principle" (common law). A child does not, merely by reason of being under a certain age, lack legal capacity to consent to medical treatment. A child or young person has a right to make decisions for himself or herself when he or she reaches a sufficient degree of understanding and intelligence to be able to make up his or her own mind. This principle is of particular relevance in adolescents.

It should be noted that the Gillick principle has not yet been formally tested in a New Zealand court.

Suspected child abuse or neglect

Children and Young Persons Service social workers can seek a medical examination under a warrant taken out under the CYP&F Act, or under a court order. [CYP&F Act 1989 s.49-55].

No examination carried out under section 53 shall include an internal examination of the genitals or anus, unless the doctor believes the child or young person may have been subjected to recent physical or sexual abuse and the child or young person consents to examination. The need for the child or young person's consent is waived in cases where the child or young person is too young to consent.

Examinations of the genitals or anus carried out under section 53 of the CYP&F Act may not be carried out under General Anaesthetic.

A child is entitled to nominate, and to have a supportive adult to be present during a medical examination. [CYP&F Act 1989 S.54].

The Court may impose conditions regarding medical examination that must be complied with.

If the child or young person is placed in custody of the Director-General by sections 39, 40 or 42 of the CYP&F Act, the restrictions under sections 53 to 55 of the Act still apply. A CYP&FS Social Worker can give consent for medical examination if the Social Worker has made reasonable efforts to obtain the consent of a parent or guardian.

When the Director-General of Social Welfare has custody of a child or young person (under a section 139 Temporary Care Agreement, a section 78 or 101 Custody Order, or a Section 110 Guardianship order), the Director-General is not required to obtain parental consent to medical examinations.

- The opinion of the Department of Child, Youth and Family Services is that the usual restrictions on the nature of the medical examination, or the procedures to be used in carrying out that examination (see 2.1) would not apply.

- However, the opinion of the Auckland District Health Board differs. In the opinion of the ADHB, examinations of the genitals or anus under s 53 of the Children, Young Persons and Their Families Act 1989 may not be carried out under general anaesthetic without the consent of the child's guardian (subject to the general exceptions already noted above). This is regardless of who has custody of the child. It is recommended that legal advice is obtained on a case by case basis where a CYF social worker requests examination of the genitals or anus under general anaesthetic.

Specific exceptions.

Authorised persons working under section 125 have the statutory power to enter a school or early childhood centre to examine a child without a court order or parental consent (Health Act 1956 s125 part 2, Ministry of Health Guidelines July 1993). These authorised persons are:

- A medical officer employed by the ministry

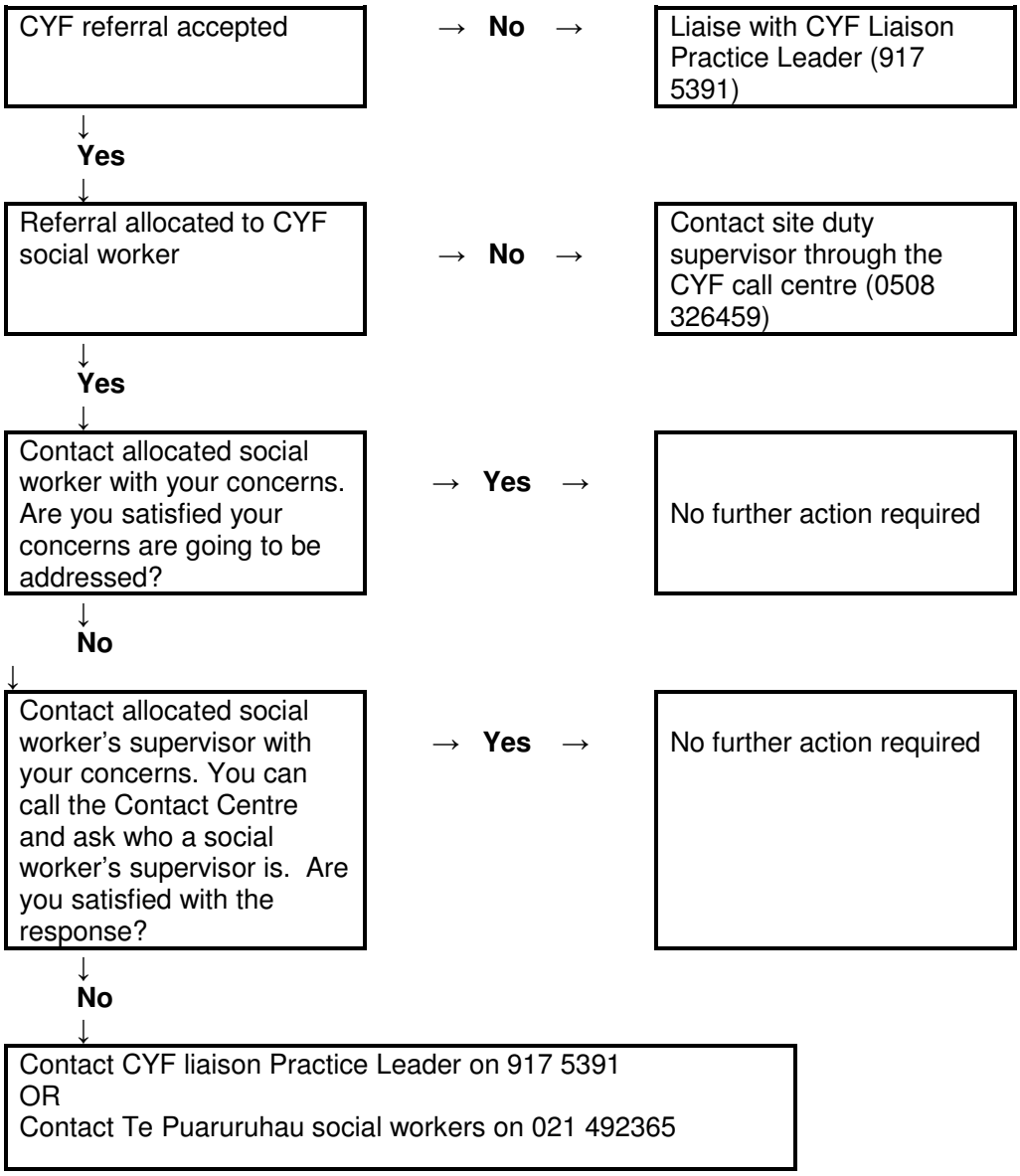
- A person authorised by the ministry (e.g. Public Health Nurses of Auckland Healthcare)

- A person employed by the Royal New Zealand Society for the Health of Women and Children (Plunket Society)

Appendix 3: Resolving problems with CYF

ADHB staff experiencing problems in working with CYF:

If problems arise once ADHB staff have made a referral to CYF, or in attempting to make a referral, the following provides a guideline to address concerns:



NOTE: When concerns are referred to the CYF liaison Practice Leader, he/she will liaise with the relevant ADHB staff and CYF staff to address the issues. If concerns continue to exist, the CYF liaison Practice Leader will consult with the site manager at Practice Leader level.

Appendix 4: How CYF determine Urgency of Response

Each notification is triaged according to the question of whether the notification is likely to indicate risk of child abuse, or need for support. If "risk" is determined to be the predominant concern, the notification proceeds down a child protection pathway. If "need" is regarded as the key concern, the case will be diverted to community agencies through "partnered response". Once the Contact Centre has allocated a response time, the notification will be sent to site. Each site prioritises its own cases, but is required to meet the nominated time-frame for response.

Factors	***Critical (Same Day)***	***Very Urgent (Day of notification + 1 day)***	***Urgent (within 7 days)***	***Partnered Response***
	Immediate Protection Required	***Immediate Investigation Required***	***Investigation Required***	***Exploratory Interview Required***
Nature of Concern	Child or young person has been severely abused and/or neglected, is in immediate danger of death or harm or there is no adult supervision of the cyp or they are notified s.48 by police.	Child or young person is not in immediate danger but has been abused and/or neglected, there is risk of abuse and/or neglect and/or harm or there is an escalation of concern.	Child or young person is protected from harm in the short term but there is an allegation of abuse and/or neglect or other serious concerns.	Child or young person has not been abused or neglected but the reported situation may impact on the well-being of the child or young person.
Vulnerability of CYP	Child or young person is unable to protect self. The alleged perpetrator has easy access to the child or young person. There is no adequate protector present, or cyp is in police custody on s.48.	Child or young person has only marginal ability to protect self. The alleged perpetrator is able to secure access to the child or young person. There is a protector present but their capacity or willingness to act is not satisfactory.	The child or young person is able to adequately protect and/or care for self. The alleged perpetrator has no access to the child or young person. An adequate protector is present.	No abuse or neglect alleged. No alleged perpetrator. Parent or caregiver is actively pursuing the well being of the child or young person.
Actual or potential severity of current injury or condition	Severe life threatening injury or condition requiring immediate medical attention; sexual penetration or injury, torture, chronic long term harm, acute neglect; suicidal thoughts or plans. Injuries to head, face, genitals, internal organs, torso, soft tissue areas and fractures, bleeding injuries, burns or scalds. Immediate medical or evidential requirements.	Physical injury/sexual maltreatment or chronic/persistent neglect or emotional abuse which is not life threatening but which may re-occur or continue in the short-term. Injuries to arms, legs, knees, elbows, buttocks that do not require immediate medical attention or contribute to evidential requirements.	Allegation of physical injury, sexual maltreatment or neglect that will not re-occur in the short term. The child or young person is no longer exposed to the source of harm. Injuries that would not normally require medical attention or contribute to evidential requirements.	Behavioural problems or relationship difficulties which **do not** constitute abuse or neglect or self harm. No injury.
Pattern of injuries or conditions	Prior confirmed incidents of severe abuse, neglect or self harm. Chronic or persistent neglect. A trend of increasing or constant severity.	Prior confirmed incidents of abuse, neglect or self harm. Trend is increasing or constant.	Prior concerns and/or notifications of abuse, neglect or self harm. Trend is constant or decreasing.	No prior notifications of abuse, neglect, self harm or suicide.
Other considerations: Violence Stress Substance Abuse Mental illness/incapacity Social isolation Potential for flight – Other concerns that impact on child safety or well-being.	A family or situational context that is severely disordered, volatile, dangerous and/or unpredictable. Or cyp has been picked up unaccompanied (s.48) and no parent or guardian is willing or able to have custody. Clear and present danger.	A family or situational context which is disordered and potentially dangerous.	A family or situational context which is disordered but does not present immediate danger.	A family or situational context which may impact on the well-being of the child or young person but does not appear to present danger to the child or young person.

Appendix 5: Auckland CYF Offices

SITE	POSTAL ADDRESS
Clendon	PO Box 75-544, Manurewa, Auckland 2103 Ph: 09-919 3920. Fax: 09-267 0263
Grey Lynn	PO Box 78901, Grey Lynn, Auckland 1245 Ph: 09-914 1190, Fax: 09 913 4032
Mangere	PO Box 43100, Auckland 2102 Ph: 09-919 3830. Fax: 09-255 1350
Manurewa	Private Bag 76930, Manurewa, Manukau City 2102 Ph: 09- 917 5642, Fax: 09-269 6174
Onehunga	Private Bag 92-915, Onehunga, Auckland 1345 Ph: 09-919 4420. Fax: 09-913 4199
Orewa	Private Bag 306000, Orewa, Auckland 0740 Ph: 09-904 4620. Fax: 09-421 0729
Otahuhu	PO Box 22444, Otahuhu, Auckland 1640 Ph: 09- 912 9135, Fax: 09-912 6559
Otara	Private Bag 61 900, Otara, Manukau City 2159 Ph: 09-914 0246 Fax: 09-913 3325
Panmure	Private Bag 14950, Panmure, Auckland 1072 Ph: 09-919 4629. Fax: 09-574 6850
Papakura	Private Bag 9, Papakura, Auckland 1140 Ph: 09-917 5600 Fax: 09-296 8152
Pukekohe	Private Bag 76-930, Manurewa, Manukau City 2102 Ph: 09-917 5642. Fax: 09-269 6174
Takapuna	PO Box 33 049, Takapuna, North Shore City 0740 Ph: 09-917 5318. Fax: 09-912 6950
Waitakere	Private Bag 93 117, Henderson , Auckland 0650 Ph: 09-913 0200. Fax: 09-912 6864
Whenuapai	PO Box 84054, Westgate, Auckland 0650 Ph: 09-913 0200. Fax: 09-912-6864

Appendix 6: CYF Care and Protection Processes