QCPCI Tendered in Chambers

QUEENSLAND CHILD PROTECTION COMMISSION OF INQUIRY

Date: 17.12.2012

Exhibit number: 134

STATEMENT OF JOANNA GURD

I, **Joanna Gurd**, of c/- 147 – 163 Charlotte Street, Brisbane in the State of Queensland solemnly and sincerely affirm and declare:

1. I am a Manager in the Strategic Policy Priority Areas of the System Policy and Performance Division, Department of Health.

2. I have been appointed to this Manager level position since 1 July 2012.

3. When planning and reviewing my work and seeking approval for decisions, when required, I report to Graham Kraak, Director, Strategic Policy Priority Areas Unit.

4. Prior to this appointment I held the positions of:

    a. Manager, Child Health and Safety Unit, Primary, Community and Extended Care Branch (2008- 2012)
    b. Principal Policy Officer, Queensland Health Child Safety Unit and Southern Area Health Service (2007 – 2008)
    c. Nurse Unit Manager, Children's Sunshine Ward, Ipswich Hospital (2003- 2007)

5. I hold a Bachelor of Nursing (University of Southern Queensland).

ROLE

6. The purpose of my role, as the manager, Strategic Policy is to identify and analyse critical and emergent child health and safety information and provide high level advice and support to senior officers within Queensland Health.

7. My key responsibilities have included:

    a. Providing timely and accurate advice and progress reports to senior officers, including the Deputy Director-General, Director General and Minister for Health, in relation to Queensland Health's child health and safety position at a whole-of-government level, including:
        - Child protection reforms
        - Helping out Families initiative
        - National Framework for Protecting Australia's Children 2009 - 2020
        - Briefing and health contributions to the Commission for Children and Young People and Child Guardian reports

    b. Convening, consulting and receiving advice from child health and safety experts to ensure that strategic advice is based on a comprehensive consideration of critical issues, including:
        - Consultation with paediatricians, Child Protection Liaison Officers, and Child and Youth Mental Health Services

    c. Representing Queensland Health at an inter-agency/ whole of government level to progress implementation of child health and safety initiatives, including:
        - Suspected Child Abuse and Neglect (SCAN) team system
        - Child Protection Guide trial

Signature of officer _____ Witness Signature _____

JUSTICE OF THE PEACE (QUALIFIED) QUEENSLAND DEPT. OF JUSTICE & ATTORNEY-GENERAL Reg No.: 78867

- Health Home Visiting Program of the Helping Out Families Initiative
- Unborn child high risk alerts processes

d. Overseeing, formulating and managing the development of appropriate Departmental strategic and inter-agency child health and safety policies, protocols and communication strategies including:
   - Queensland Health policy, standards, protocols and procedures
   - Web and intranet information sites

e. Providing authoritative, accurate, timely and high level advice and guidance to internal and external stakeholders regarding the development and implementation of child health and safety initiatives, including;
   - Interagency SCAN team model training
   - Queensland Health Expert witness court training and guide

f. Establishing, maintaining and effectively managing complex organisational issues, including capacity for negotiation and communication with a range of internal and external stakeholders, including:
   - Attendance at interagency and partnership forums
   - Providing advice and support to a range of stakeholders on specific interagency matters

RESPONSE TO SPECIFIC ISSUES

Service delivery to children and young people in, or at risk of entering, the child protection system who have experienced sexual abuse

8. To support health professionals to recognise and respond to children and young people who have, or are at risk of sexual abuse, a range of resources are available, including:
   a. Education resources – a fact sheet of clinical indications of sexual abuse of children and young people (Attachment 1); a child safety education module that includes information on sexual abuse (Attachment 2); and a fact sheet on reporting sexual harm (Attachment 3).
   b. An implementation standard for Conducting child sexual assault examinations (Attachment 4) which sets out the minimum requirements for health professionals when conducting sexual assault examinations.

9. These resources have been developed in consultation with Child Protection Liaison Officers, Child Protection Advisors, Child Safety Clinical Chairs and Child Protection Network coordinators within Queensland Health.

10. These resources have been shared with non- government health professionals, including General Practitioners, Practice Nurses and Private Hospital Services.

11. Child Protection Liaison Officers and Child Protection Advisors within Hospital and Health Services to act as a resource to support health professionals to identify report and respond to children and young people who have experienced, or are at risk of, sexual abuse.

12. Challenges for health professionals include the differences in the legislative requirements of mandatory reporting under the *Public Health Act 2005*, and the statutory agency threshold in the *Child Protection Act 1999*, that underpins the intake decisions of Child Safety Services. Health professionals are required to report 'harm *to a child, that has a*

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detrimental effect on a child's physical, psychological and emotional wellbeing that is of a significant nature and has been caused by physical, psychological or emotional abuse or neglect or sexual abuse or exploitation'.

13. Whilst a health professional has an obligation to report all harm of a significant nature caused by abuse or neglect, Child Safety Services are only able to act on reports that relate to abuse or neglect where the family has not acted protectively. Health professionals are not always able to determine the circumstances or indeed if the family has acted protectively as their focus is on the health needs of the child. Bringing a child to hospital or a health service for treatment does not necessarily indicate that a parent or carer is acting in a protective manner or did not have a role in the abuse or neglect.

Declared before me at this 19th day of October 2012.

Signature of officer _____ Witness Signature _____

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4.5 Sexual abuse – clinical risk factors and indicators

Sexual abuse occurs when a male or female adult, or a more powerful child or adolescent (including a sibling), uses power to involve a child in sexual activity. It can be physical, verbal or emotional and includes any form of sexual touching, penetration, sexual suggestion, sexual exposure, exhibitionism, and child prostitution

Indicators of sexual abuse in children may include:

0-2 years

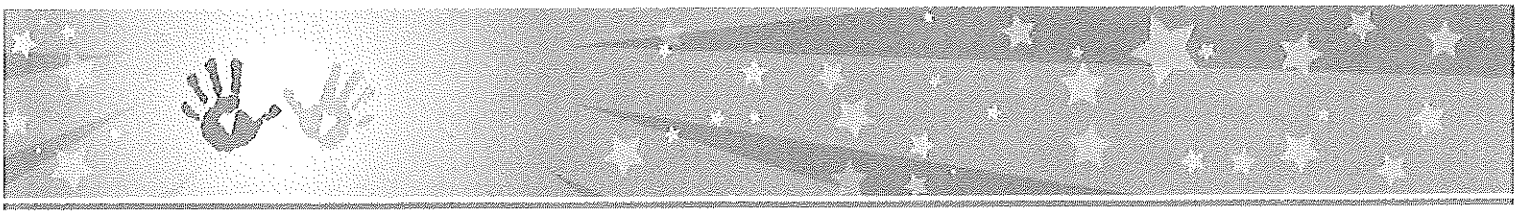
- injuries and / or trauma such as tears, bruising or bleeding to the genitalia and anus or perineal region
- petechiae at the back of the throat

3-5 years

- describing sexual acts
- presence of Sexually Transmitted Infections
- presentation behaviours such as - going to bed fully clothed, soiling, wetting, poor sleep, anxiety or fear, behavioural problems
- age-inappropriate sexual behaviour
- injuries or trauma such as tears, bruising or bleeding to the genitalia and anus or perineal region
- unexplained accumulation of gifts or money

6-13 years

- describing sexual acts
- presence of Sexually Transmitted Infections
- presentation behaviours such as - going to bed fully clothed, soiling, wetting, poor sleep, anxiety or fear, behavioural problems
- age-inappropriate sexual behaviour
- injuries or trauma such as tears, bruising or bleeding to the genitalia, anus or perineal region
- unexplained accumulation of gifts or money



14-18 years

- adolescent pregnancy
- presence of Sexually Transmitted Infections (consider consensual sex)
- risk behaviours such as drug taking, engaging in sex for money or drugs, suicide attempts
- injuries or trauma such as tears, bruising or bleeding to the genitalia, anus, or perineal region
- unexplained accumulation of gifts or money

Risk factors and indicators that a parent or carer is sexually abusing a child may include:

- intentional exposure of child or young person to sexual behaviour of others
- the parent or carer has committed or is suspected of child sexual assault
- coercing a child to engage in sexual behaviour with other children
- verbal threats of sexual abuse
- exposing a child or young person to prostitution or child pornography or using a child for pornographic purposes
- inappropriate curtailing or jealousy regarding age-appropriate development of independence from the family
- denial of adolescent pregnancy by family
- perpetration of spouse abuse or physical abuse
- parental alcohol or drug abuse or psychiatric illness

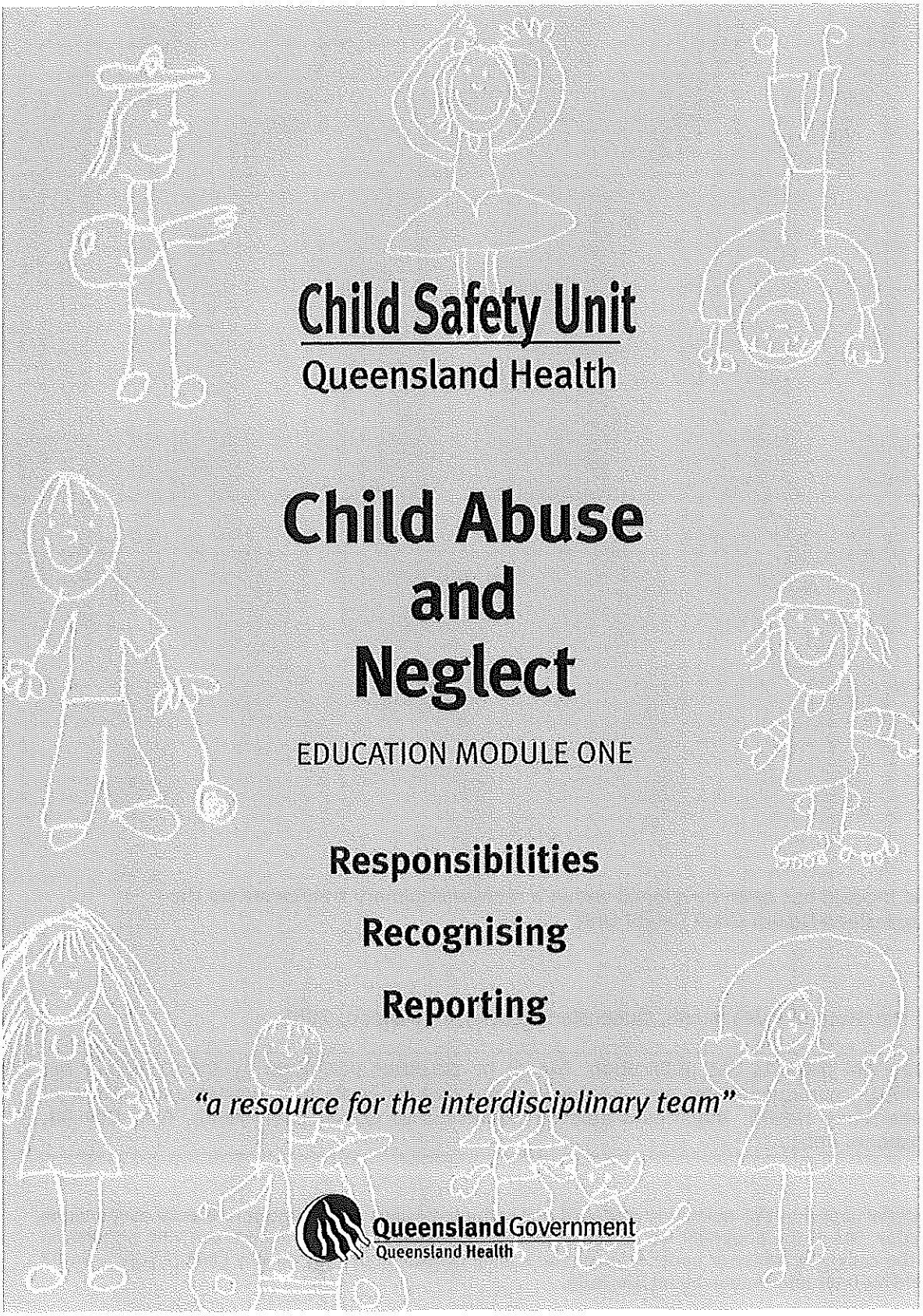
Remember, this list is a guide only and is not exhaustive. The presence of one of these factors does not prove the existence of abuse or neglect. Each characteristic needs to be considered in the context of other factors and the child's or young person's presentation and circumstances.

This fact sheet contains clinical information that may assist in the formation of a reasonable suspicion of sexual abuse.

Further information

Please refer to the *Protecting Queensland Children: Policy Statement and Guidelines for the Management of Child Abuse and Neglect of Children and Young People (0 – 18 years).* Information is available by visiting the Child Health and Safety Unit website at http://qheps.health.qld.gov.au/csu or emailing CSU@health.qld.gov.au

Queensland Government
Queensland Health



Child Safety Unit
Queensland Health

Child Abuse and Neglect

EDUCATION MODULE ONE

Responsibilities

Recognising

Reporting

"a resource for the interdisciplinary team"

Queensland Government
Queensland Health

The module has been developed within a multi-disciplinary framework by the Queensland Health Child Safety Unit.

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Table of Contents

Section 1 – Introduction

Target Group

This is the first in a series of education modules in child safety. The target group for this module is:

> *"All Health Professionals who in the course of their duties are required to provide care to children and young people."*

It is intended to support the learner in developing their capability in relation to their responsibilities, ability to recognise and confidence to report their suspicion of child abuse and neglect. This module is not intended to support the development of advanced practice. Those health professionals where more advanced abilities are required should complete either an additional module of study or enrol in an approved tertiary award program.

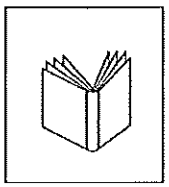
Module Assessment

The Participant Guide for Education Module One contains detailed information on the assessment framework for this module. You should access this guide and discuss the assessment requirements with your line manager / team leader or educator prior to commencing the module.

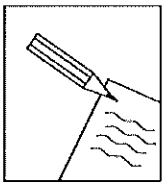
Legend for Icons

Throughout the module you will encounter symbols that generally require you to undertake a specific action. Explanatory descriptions are provided for your information and to assist with your progress through the module.

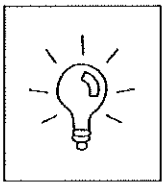
Reflect/review: Requires the participant to think about or revisit experiences (professional and/or personal), previous readings or activities.



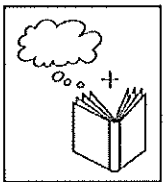
Reading: Directs the participant to a required reading.



Activity: Requires the participant to consolidate learning through an action such as seeking information, analysing a scenario or performing clinical practice.



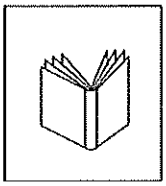
A Key Point to Think About: This is an important point for your practice.



Recollection of Previous Content: This is a summary of previous content that is important for the current section.

Why Learn About Child Abuse and Neglect?

"When Kempe and his colleagues first drew attention to the battered child syndrome, little was known or understood about their causes and correlates of abusive behaviour. Today a great deal is known: we know that poverty and disadvantage provide the milieu for this violence, that isolation and ignorance exacerbate the stresses of parenting and that the experience of being a victim of child abuse has important consequences for later adult behaviour. It is vital that adequate resources be committed to the provision of assistance beneficial to all parents and essential to identifiable high risk parents, in order to reduce the levels of abuse, both fatal and non-fatal, which exist in our society"[1].



Kempe HC. and Helfer RE., et al editors: *The Battered Child.* 5th edition, Chicago: Chicago University Press, 1997

This resource can be accessed through the Queensland Health Central Library. It will provide additional reading for those health professionals seeking more information on the topic.
http://qheps.health.qld.gov.au/library/centlib/home.htm

"A century that began with children having virtually no rights is ending with children having the powerful legal instrument that not only recognises but protects their human rights"[2].

[1] Child Abuse Homicides in Australia: Incidence, Circumstances, Prevention and Control by Health Strang
[2] Carol Bellambi, UNICEF Executive Director referring to the Convention outcome
http://www.unicef.org/crc/crc.htm

Personal Considerations

Responding to children and young people who have been harmed or who are at risk of harm can be demanding, upsetting and even shocking. No one is immune to the impact of its occurrence or exposure.

In undertaking this education module you may be exposed to content, scenarios and reactions that you can clearly identify with due to your own experiences as a child. You may be confronted with painful reminders and feelings associated with those times. You may identify that you have some unresolved issues associated with those experiences that continue to impact on your life and subsequently on your career as a professional within the health system. If this is the case, it is important that you seek assistance and support from your colleagues and managers. In some cases, referral to the Employment Assistance Scheme (EAS) for counselling may be very beneficial. Please refer to your District's EAS policy that will identify how to access this service should you need support as a result of the content of this program.

Key Reflective Exercise

Before commencing this module you need to recall a clinical scenario where there was suspicion that a child or young person had been abused or neglected. As you progress through the module you will be asked to reflect on varying aspects of this scenario and consider if there would be changes to the way in which you responded after completing the different learning elements in this module.

If you have never had this level of involvement – Appendix One provides two scenarios to use as you progress through the module.

Section 2 – Responsibility

Capability Statement One – "Responsibility"

The expectation is that you are able to;

1. Demonstrate that you have acquired and retained in practice, the necessary knowledge concerning your legal responsibilities in child protection.

2. Interpret and apply your specific disciplines' professional and/or competency standards, code of conduct and/or ethical behaviours to child protection.

Crime and Misconduct Review – a catalyst for change

The 2003/4 inquiry into the abuse of children in foster care conducted by the Crime and Misconduct Commission (CMC) identified that the child protection system was failing in its duty to protect children and young people. The CMC report into "*The Abuse of Children in Foster Care*" (2004) included 110 recommendations to transform the child protection system, and the subsequent *Blueprint* report (2004) documented the reform agenda and timetable for implementation.

These recommendations have resulted in

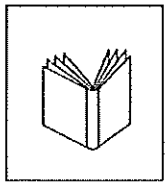
- The disbandment of Department of Families and the creation of the **Department of Child Safety** (DChS) to focus exclusively upon core child protection functions and be the lead agency in a whole-of-government response to child protection matters.
- **Directors-General Coordinating Committee** to coordinate the delivery of multi-agency child protection services and comprising the Directors-General of all relevant departments including the Department of the Premier and Cabinet.
- **Child Safety Director** positions within those departments identified as having a role in the promotion of child protection.
- **Child Guardian** position within the office of the Commissioner for Children and Young People with responsibility to oversee the provision of services provided to, and decisions made in respect of children within the jurisdiction of the DChS.

These and other proposed recommendations from the CMC's Public Inquiry reflect the Queensland Government's commitment to create an effective, holistic and whole of government response to child protection issues. It is driven by the shared vision that "*A society.... maximises opportunities for the safety, well-being and development of Queensland children and young people*".[3]

Practically this means;

[3] Child Protection Queensland:2004 Child Protection System 'Baseline' Performance Report, page16

- Legislation changes and
- Policy review and development
- Additional service provision capacity in some practice areas, in the creation of a truly responsive system.



WEB: http://www.cmc.qld.gov.au/library/cmcWEBSITE/ProtectingChildren.pdf

The Department of Child Safety

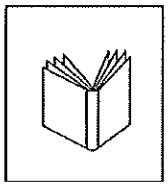
The Department of Child Safety (DChS) was established (November 2004) to meet the needs of children at risk and to focus upon the wellbeing of Queensland children.

The Child Protection Act 1999 is administered by the DChS and is the overarching legislation relating to the protection, welfare and best interests of children and young people.

The specific role of the DChS is to:

- Investigate reports that allege that a child has been harmed or is at risk of harm; and
- Ensure an ongoing provision of services to children who have been assessed as experiencing, or being at risk of experiencing, significant harm in the future.

It also acts as the lead agency in facilitating a whole-of-government response to child protection issues including the Suspected Child Abuse and Neglect (SCAN) system. SCAN will be discussed later in the module.



WEB: http://www.childsafety.qld.gov.au

Queensland Health

Implications for Health Professionals

These reforms have resulted in several critical practice implications for all *health professionals*. They are:

- Mandatory reporting for registered nurses
- Amended mandatory reporting responsibilities for doctors
- SCAN System - a new model

- Therapeutic care for children with severe psychological and behavioural problems
- Disclosure of confidential health information between government agencies where the information directly relates to the welfare or protection of a child or young person
- Legislative changes that enable statutory intervention where it is suspected that an unborn child may be at risk of harm after birth

Queensland Health Child Safety Unit (CSU)

In July 2004, Queensland Health (QH) established the Child Safety Unit to support the Child Safety Director[4].

The Unit's role is to:

- Contribute to whole-of-government and whole-of-system promotion of child safety
- Promote an understanding of child safety issues within Queensland Health.
- Promote an understanding of the whole of government reforms for child safety from the CMC Inquiry and their implications for Queensland Health.
- Work with other government departments to implement the CMC recommendations and child safety reforms
- Ensure that QH employees are aware of legislative and policy changes in the area of child safety through the provision of information and education about child safety.
- Encourage participation in the promotion of child safety.
- Report on QH's progress in relation to meeting child protection obligations
- Encourage a collaborative approach across Queensland Health services
- Work in partnership with other government departments involved in child safety

The CSU contact details are:
Tel: 3235 9461
Email: CSU@health.qld.gov.au
QHEPS: http://qheps.health.qld.gov.au/csu

Legislation and Child Safety

The implementation of the CMC's recommendations has resulted in four key changes to legislation that impact specifically on the responsibilities of registered nurses and medical officers. They are:

- **Mandatory Reporting by registered nurses** of suspected child abuse and neglect[5].
- **Mandatory Reporting directly to Department of Child Safety** by registered nurses and medical officers of suspected child abuse and neglect[6].
- **Authorised Involvement by the Department of Child Safety** in circumstances relating to unborn children who may be at risk of harm after birth and notification to hospitals of **Unborn Child High Risk Alerts[7].**

[4] http://www.cmc.qld.gov.au/library/CMCWEBSITE/ProtectingChildren_Summary.pdf
[5] *Section 191 of the Public Health Act 2005*
[6] *Section 191 of the Public Health Act 2005*
[7] Section 21A of the *Child Protection Act 1999*

- **Disclosure of confidential information** between the DChS and other government departments[8].

Reporting Responsibilities

All health professionals have an obligation to report their concern if they suspect that a child or young person has been abused or is at risk of abuse and neglect. This responsibility rests in the common law principle of duty of care. This legal principle requires all health professionals to exercise proper professional care in the way they perform their duties and responsibilities and to take all reasonable and practical steps to prevent harm[9].

Mandatory reporting is an additional **legislative** requirement.

Mandatory Reporters

Mandatory reporting aims to overcome the reluctance of some professionals to become involved in suspected cases of abuse by imposing a public duty to do so[10].

The CMC considered whether the extension of mandatory reporting in Queensland would result in a demonstrated benefit upon children subject to abuse[11]. It recognised that nurses tend to have more contact with children and families particularly in rural and remote communities and believed that they are well placed to make objective and reliable assessments of possible abuse.

The CMC was persuaded that "requiring registered nurses to report suspected child abuse will empower them to make complaints in appropriate circumstances, and provide statutory protection to them in this function, allowing them to meet the requirements within their code of conduct"[12]. Consequently, under *Section 191 of the Public Health Act 2005*, registered nurses are mandated to report all suspicions of child abuse and neglect to the DChS. This mandatory reporting responsibility relates only to concerns or suspicions that they ***recognise in the course of their professional practice.***

Medical officers and registered nurses who fail to report their suspicions may be deemed as having committed an offence and may receive a prescribed penalty under the Act.

The CMC report also recommended that mandated medical officers amend their reporting directions so that their concerns are made directly to the DChS rather than to delegated *authorised officers* nominated in the *Health Regulations 1996.*

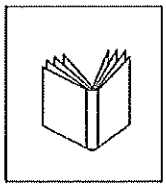
Non-Mandatory Reporting

Whist medical officers and nurses must report, ***all other health*** professionals are able to report instances of child abuse and harm under Section 1590 of the *Child Protection Act 1999*. In doing so, under Section 22 of the *Child Protection Act 1999,* they do not breach

[8] Section 159M and 159N of the *Child Protection Act 1999*
[9] http;//csu.edu.au/favulty/arts/humss/bioethic/duty1.htm
[10] Child Abuse Prevention Resource Sheet No.# June 2004 National Child Protection Clearinghouse
[11] http://www.cmc.qld.gov.au/library/CMCWEBSITE/ProtectingChildren_Summary.pdf
[12] http://www.cmc.qld.gov.au/library/CMCWEBSITE/ProtectingChildren_Summary.pdf

professional ethics and do not become liable to civil or criminal process if the report is made in good faith and on reasonable grounds.

This focus on mandatory reporting should not be interpreted as diminished acknowledgment of the key role in child protection provided by Allied Health Professionals, especially Social Workers, and Indigenous Health Workers. Clearly the reporting requirement for this group as for all health professionals has existed within the common law principle of *Duty of Care*.



These links will allow you to access the legislation referred to in this section. You may wish to do some additional reading.

Public Health Act (2005)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf

Health Services Act (1991)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthServA91.pdf

Child Protection Act (1992)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf

Professional Standards and Child Safety

All health professionals within their own disciplines have their own professional competency standards and code of ethical behaviour and conduct. You should access these resources and consider the ways in which they influence and guide your professional behaviour in child protection.

Confidentiality and Disclosure

Under Section 1590 of the *Child Protection Act 1999*, all employees of QH are able to provide information directly to the DChS or a Queensland Police Officer if the information is relevant to the welfare or protection of a child or young person, or is given before a child is born and is relevant to the protection of the child after he or she is born.

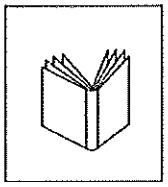
In providing this information, health professionals are afforded a number of protections under the *Public Health Act 2005* and the *Child Protection Act 1999.* They include:

- Professionals who make a mandatory report are deemed not to have breached any duties of confidentiality or privacy and are not liable to criminal, civil or disciplinary action for making the report (Section 186 *Public Health Act 2005).*
- Anyone who gives information to a professional about child harm is also protected (Sections 195 and 196 of the Public *Health Act 2005*). These protections enable, for example, a grandparent to give information to a doctor about harm to a child without fear of the doctor or the DChS revealing to the parents of the child that the information came from the grandparent.

- The provisions also enable a professional to discuss their suspicions with another professional. For example, a junior registered nurse may be uncertain about whether a particular presentation indicates child harm, so they would be able to discuss the presentation with a more senior registered nurse, social worker, or a medical officer.

- Section 22 of the *Child Protection Act 1999* provides protection from civil and criminal liability for making a notification or giving information about child harm to the DChS. For instance, a person who notifies the DChS of harm to a child or young person cannot be sued for defamation, charged with a breach of confidentiality or held to have breached any code of professional ethics.
- Section 186 of the *Child Protection Act 1999* prohibits an authorised officer from disclosing a notifier's identity except in the specified circumstances outlined in the Act (Section 186(2)). This includes when it is required to enable others to perform duties under the *Child Protection Act 1999* or under direction from a court or the Children's Services Tribunal.

These provisions also apply to a person who provides information about an unborn child who may be in need of protection after he or she is born.



WEB: http://www.legislation.qld.gov.au/OQPChome.html

Reporting Child Abuse and Neglect

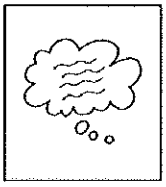
To fulfil the responsibilities as mandatory reporters, *Section 191 of the Public Health Act 2005* requires doctors and nurses to immediately notify the chief executive of the DChS of a ***reasonable suspicion*** that a child has been, is being, or is likely to be harmed. This threshold is also relevant to non-mandated health professionals whose duty of care obligation to report is equally compelling.

Whilst there is no legal definition of ***reasonable suspicion,*** a reasonable suspicion requires more than just an isolated fact that may or may not indicate harm. To reach this threshold for reporting means **forming a concern or well-founded suspicion that is based on the presence of signs, disclosures, injuries, symptoms and behaviours** that heighten concerns about the safety, health and well being of a child or young person.

Determining if Abuse and Neglect Has Occurred

Reasonable grounds are reached when:

- a child or young person tells you they have been abused or neglected
- your own observations of a particular child or young person's behaviour or injuries and your knowledge of children and young people generally leads you to suspect abuse or neglect is occurring
- a child or young person tells you that he/she knows someone who has been abused or neglected (the child or young person may be referring to themselves)
- someone who is in a position to provide information about a child or young person (parent, relative, friend, neighbour, sibling) expresses concern that the child/young person may be abused or neglected
- there is evidence such as injury or behaviour which is consistent with abuse or neglect and unlikely to be caused in any other way
- there is an injury or behaviour where there are corroborative indicators supporting the concern that it may be a case of abuse or neglect e.g. a pattern of injuries, an implausible explanation for the injuries, other indicators of abuse or neglect
- there is consistent indication, over a period of time, that a child is suffering from physical, sexual, emotional abuse or neglect



Reflecting on your previous experience ... (i) Did your suspicions reach the threshold to report? (ii) What was the evidence that you observed that allowed you to establish that your suspicions were reasonable?

Reflect on the scenario of your choice ... (i) Would your suspicions reach the threshold to report? (ii) What is the evidence that would suggest that your suspicions are reasonable?

Is your Suspicion Reasonable?

Additional actions to undertake when forming a reasonable suspicion include:

1. a review of the child's record to ascertain previous presentations / concerns
2. discussion with health colleagues who have had contact with the child and family
3. discussion and consultation with colleagues, social workers where available, line managers, team leaders, and the District's Child Protection Advisor or Child Protection Liaison Officer.

These processes of information collection, clinical assessment, analysis and documentation are the basis of sound clinical practice and form a substantive basis of a reasonable suspicion to report child abuse and neglect.

Reflecting on your previous experience ... (i) Did you utilise secondary data sources such as the child record? (ii) Did you consult with colleagues to assist in the formulation of reasonable suspicion?

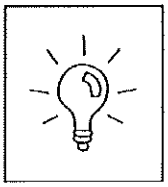
Reflect on the scenario of your choice ... (i) What secondary data sources are available? (ii) With whom would you consult to assist in the formulation of reasonable suspicion?

The Unborn Child

The CMC Inquiry identified that the existing child protection system had significant legislative limitations in its capacity to respond to unborn children who may be at risk of harm after birth. This meant that an unborn child who was suspected of being at harm or at risk of harm was not able to be the subject of a child protection notification and investigation by the DChS prior to birth. Subsequent amendments to existing legislation, namely Section 21A of the ***Child Protection Act 1999,*** have now enabled the DChS to take appropriate action where it suspects than an unborn child may be at risk of harm after birth.

The intent behind this change is not to interfere with the rights of the pregnant woman but to provide assistance and support that would reduce the likelihood that her child will be subject to abuse or neglect after birth.

The mandatory reporting by health professionals of child protection concerns related to an unborn child is not specifically prescribed in child protection legislation. However, this does not prevent health professionals from reporting their concerns about the potential risk of harm to a child following their birth to their local DChS service centre. Sections 22, 1590 and 186 of the *Child Protection Act 1999* provide protection for health professionals who report their concerns in these instances.



It is essential that all unborn child reports are discussed with the Districts' child protection advisor prior to the report being made to DChS.

Responding to an Unborn Child High Risk Alert

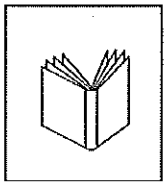
An ***Unborn Child High Risk Alert*** is an action that is ***initiated*** by the ***Department of Child Safety only***. It means that there are significant protective concerns about the unborn child and that the parent/s of the unborn child may have refused to participate or be engaged in an assessment of their circumstances.

Queensland Health policy indicates that it is the ***responsibility*** of the admitting midwife to undertake the relevant inquiries associated with these alerts and to facilitate advice to the DChS when the woman presents at hospital for delivery. (Please refer to your relevant

District policy and local facility procedures). This action then not only allows Child Safety Officers to fully assess the safety concerns regarding the child once born, but enables them, where appropriate, to initiate legal action to secure the protection and well-being of the child.

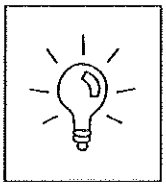
Unborn Child High Risk Alerts are only initiated after significant assessment and consideration by the DChS. The alert **must not** be disclosed to the woman who is the subject of the alert. They are made only in situations when the Child Safety Officer has assessed that the child will be in need of protection after he or she is born.

The existence of an ***Unborn Child High Risk Alert*** does not preclude health professionals from making further reports to the DChS if they suspect an unborn child will be in need of protection after birth.



WEB: http://qheps.health.qld.gov.au/csu/UCHRA_policy.htm

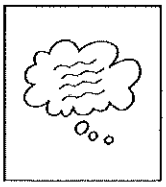
Assessment Principles



Working with children and families where child abuse and neglect may be present raises issues of values, rights and potentially conflicting interests[13]. It is therefore important to work within a set of principles that influence clinical practice when assessing the presence of a reasonable suspicion.

The core principles are:

- always consider child protection when assessing the health needs of ***every*** unborn, child and young person
- utilise a child centred approach where the safety and well being of the child is paramount
- consider the wider needs of the child, other children and family members



Reflecting on your previous experience ... Did your assessment of this child reflect these core principles of assessment?

Reflect on the scenario of your choice ... Is there evidence of these core principles in the assessment of this scenario?

[13] http://www.lincolnshire.gov.uk/section.asp?pageType=1&docId=28232

Responding to Children and Parents/Caregivers

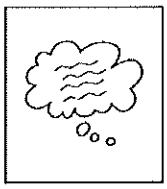
Communicating clearly and openly with children and their families facilitates the collection of information to support assessment. The following provides some guidelines for best practice.

The Child or Young Person

- stay calm
- communicate in a way that is appropriate to their age and understanding
- provide a private and child-friendly environment if possible
- respond in a caring and sensitive manner
- provide support without being judgemental
- listen to what the child wants to tell you.
- use open ended questions only
- do not probe for details by asking leading/direct questions of the child as this may prejudice any subsequent investigation by relevant officers
- do not promise **confidentiality**
- minimise the number of medical and nursing personnel examining and interviewing the child or young person
- avoid any emotional expression or response (anger, pity, outrage, taking sides)

Parents/caregivers

- communicate in a non-judgemental and helpful manner
- do not ask leading/direct questions as this may prejudice any subsequent investigation by relevant officers
- avoid any emotional expression or response (anger, pity, outrage, taking sides)
- empathise with any expressed coping problems the parents/caregivers may verbalise but do not support the abusive behaviour
- keep parents/caregivers informed about their child's medical condition and treatment needs



Reflecting on your previous experience ... (i) How did you respond to the parents or carers in this situation? (ii) How would you do it differently?

Reflect on the scenario of your choice ... (i) If you were in this situation how would you respond to the parents or carers?

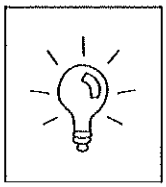
Report Don't Investigate

In forming a reasonable suspicion of abuse and neglect, it is **not** the responsibility of health professionals to prove abuse or neglect has occurred nor who might have caused it. Investigation of these matters remains the responsibilities of officers from the DChS and/or the QPS. Their combined roles are to :

- investigate allegations of harm or risk of harm;
- determine the immediate safety of a child

- continually reassess a child's safety throughout the investigation and assessment process;
- determine if a child has been harmed;
- determine if a criminal offence has occurred
- assess the risk to a child ie. estimate the likelihood that a child will suffer harm in the future; and
- assess if a child is in need of protection

It is important that the report to the DChS contains information that is relevant, accurate and reflective of a holistic clinical assessment.



An assessment of reasonable suspicion becomes an investigation when you exceed the boundaries, expectations and scope of your designated professional role and discipline.

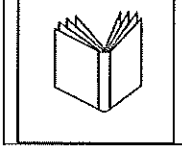
Client Record Documentation

Guidelines for documentation in the client record are available in all QH facilities. Specific child protection content needs to:

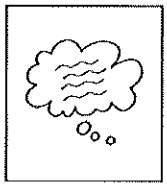
- include the date and time and reason for the presentation and who accompanied the child
- record the findings and outcomes of all interviews (child / parent / carer / person accompanying the child) and treatments and interventions (medical and psychosocial)
- record disclosures made by the child or caregiver. These should be recorded as verbatim quotations. For example; Mother said "I left him with his stepfather" or "mother states that she left him with his stepfather"
- be objective. For example, 'child presents with mother.....minimal interaction observed.....child withdrawn'. Do not include any documentation of feelings, judgemental reactions and intuitive responses . They play a role in care delivery however they do ***not*** belong in medical record documentation
- use precise anatomical descriptions. Describe each discreet injury separately and use a body map to document injuries
- be clear on the basis for your suspicion. Include specific indicators (refer to the recognition section)
- document discussions in determining if your suspicion is reasonable. Remember that there are experts in the District (medical, nursing and allied health) and they are there to assist you with determining if your suspicion is reasonable. Consultation is essential.
- consider clinical photography in relevant cases. You will need to refer to your local consent for medical photography policy to assist you through this process. QPS may initiate this if there is an investigation.
- Write legibly, sign the entry and print name for clarification

Accurate documentation is an important facet of child protection intervention. Your entries may form part of the assessment, treatment and ongoing care of this child or young person and in the determination if abuse and neglect has been perpetrated on this child. Mandatory

reporting requires the completion of the QH form ***Report of a Reasonable Suspicion of Child Abuse and Neglect.*** (Please refer to the Child Safety Unit website for this form)



WEB: http://qheps.health.qld.gov.au/csu



Reflecting on your previous experience ... (i) Did you document everything you needed to? (ii) Would you do it differently now?

Reflect on the scenario of your choice ... From this scenario – what exactly would you document?

Freedom of Information

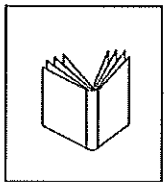
The Queensland *Freedom of Information Act 1992* provides the public with a legally enforceable right to obtain information about the operations of Queensland government, to gain access to documents held by government and to seek amendment to information held by government concerning their personal affairs if that information is inaccurate, incomplete, out-of-date or misleading.

The rights of access under the FOI Act are subject to certain exclusions and exemptions specified in the FOI Act which may, in certain circumstances, provide grounds for refusing to grant access to information held by government (eg. information contained in a patient's medical record).

It is not possible to give absolute assurances that information could not be released under FOI in any circumstances. However, in relation to child protection issues, there are very strong arguments in favour of exemption for:

- documents relating to suspected or actual child abuse, and
- documents revealing the involvement and deliberations of a SCAN Team in relation to a specific patient.

Further information on the FOI processes can be accessed though the District designated FOI officer or on the Legal and Administrative Law Unit QHEPS site.



WEB: http://qheps.health.qld.gov.au/ibm/css/lalu/contact.htm

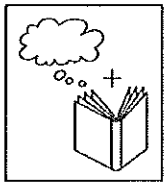
Section 3 – Recognition

Capability Statement Two – "Recognition"

The expectation is that you;

1. Utilise a child protection perspective in the assessment of the health needs and the provision of health care to the unborn, child and young person.

2. Make use of the common child protection indicator set in the identification when formulating a differential diagnosis that may include abuse and neglect.



The key points from the Responsibility Section are:

- You have a legislative and/or duty of care responsibility to report your suspicion of child abuse and neglect
- You are afforded a number of protections in the reporting of your suspicion
- You are bounded by the responsibilities and requirements of your own professional discipline to report child abuse and neglect

Defining Harm Abuse and Neglect

Within the area of child protection there are a number of definitions that are important to consider. These definitions can be categorised as legal or operational.

Legal Definitions

In Queensland, a *'child'* is defined in the *Acts Interpretation Act 1954* as an individual under 18 years. The *Child Protection Act 1999* supports this interpretation.

'Harm' is defined in the *Child Protection Act 1999:*

- As any detrimental effect of a ***significant*** nature on the child's physical, psychological or emotional wellbeing
- It can be caused by physical, psychological or emotional abuse or neglect, sexual abuse or exploitation
- It is immaterial how the '***harm***' is caused.

In the *Public Heath Act 2005, 'harm to a child'* is defined as meaning any detrimental effect on the child's physical, psychological or emotional wellbeing -

(a) that is of a significant nature: and
(b) that has been caused by -
    1. physical, psychological or emotional abuse or neglect; or
    2. sexual abuse or exploitation.

It is important to recognise the difference between these definitions of *'harm'*. Given the nature of health services, health professionals are confronted daily with children and young people who have suffered harm of some sort. It would therefore be unreasonable to report every sick or injured child that presents for care and treatment. The distinction for the health professional is that there has to be a reasonable suspicion that the harm may or has been caused by ***abuse or neglect***.

Significant harm means that the effect of the abuse or neglect "must have more than a minor impact upon a child's physical, psychological or emotional wellbeing. It must be substantial, serious and demonstrable - that is, measurable and observable on the child's body, in the child's functioning or behaviour"[14].

For officers from the Department of Child Safety to ***respond*** to a report of child abuse and neglect, they have to satisfy the legislative requirements of Section 10 of the *Child Protection Act 1999* which states that a child in need of protection is a child who:

- has suffered harm, is suffering harm, or is at unacceptable risk of suffering harm; *and*
- does not have a parent or carer able and willing to protect the child from harm.

The term ***'parent'*** of a child is defined in Section 11 of the *Child Protection Act 1999* as:

- the child's mother, father or someone else (other than the chief executive) having parental responsibility for the child.
- a person standing in the place of a parent of a child on a temporary basis is not the parent of the child.
- a parent of an Aboriginal or Torres Strait Islander child includes a person who, under Aboriginal tradition or Island custom, is regarded as parent of the child[15].

Operational Definitions

Harm

There are many definitions of child abuse and neglect found within contemporary literature. The common concept within these definitions is that child abuse includes ***harm*** arising from physical abuse and physical neglect, emotional abuse and neglect, and sexual abuse and exploitation.

The use of this term "harm" rather than "abuse" helps to focus on the *effects* on the child, rather than the *actions* of the adults. This distinction becomes important when assessing the child's ongoing safety and wellbeing and the parents' capacity to protect the child.

Physical abuse is any physical injury to a child that is not accidental[16]. It includes any injury caused by excessive discipline, severe beatings, punching, slapping, shaking, burning,

[14] Child Safety Practice Manual v1.0, page 43
[15] http://legislation.govnet.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf
[16] http://www.yesican.org/definitions/WHO.html)

biting, throwing, kicking, cutting, suffocation, drowning, strangulation or poisoning. Physical abuse can result in death.

Sexual abuse occurs when a male or female adult, or a more powerful child or adolescent (including a sibling), uses power to involve a child in sexual activity. It can be physical, verbal or emotional and includes any form of sexual touching, penetration, sexual suggestion, sexual exposure, exhibitionism, and child prostitution.[17]

Emotional abuse occurs when children are not provided with the necessary and developmentally appropriate supportive environment to develop mentally and/or emotionally. Emotional abuse includes constant criticism, restriction of movement, patterns of belittling, denigrating, scape-goating, threatening, scaring, discriminating, exposure to domestic violence, ridiculing or other non-physical forms of hostile or rejecting treatment[18] [19].

Neglect is depriving a child of their basic needs. These include food, clothing, warmth and shelter, emotional and physical security and protection, medical and dental care, cleanliness, education and supervision[20].

Presenting Characteristics of Physical, Sexual and Emotional Abuse and Neglect

Child abuse and neglect is *identified* within any community by the presence of signs, injuries, symptoms and behaviours that heighten concerns about the safety, health and well being of children and young people.

Some general characteristics of child abuse and neglect relevant to the everyday practice for health professionals are:

- The child or young person discloses abuse
- The child or young person gives some indication that the injury did not occur as stated
- The explanation provided by the parents/caregivers does not account for the injury/symptoms/behaviour
- There is an unreasonable delay in the child's presentation for the child's injury or condition.
- Parents' or caregivers' capacity to meet the child's care and protective needs is impaired.
- Parent or caregiver has unrealistic expectations/poor understanding of the child's developmental needs.
- Child related behaviours/triggers present at time of abuse.
- Abuse precipitated by family crisis.
- Parental history of abuse/violence.
- Child is dependent and unable to protect him/herself.
- Child is fearful of parent/caregiver or of going home.

[17] Department of Child Safety, Child Safety Practice Manual, Intake and Investigation and Assessment, V1.0, page 29
[18] http://www.yesican.org/definitions/WHO.html
[19] *World Health Organisation, Report of the Consultation on Child Abuse Prevention*, Geneva, 29-31 March 1999
[20] http://www.yesican.org/definitions/WHO.html

- Child has special needs which increase his/her vulnerability.

Indicators of Abuse

Indicators are clues or warning signs that suggest possible harm. They ***do not prove*** abuse or neglect as harm ***can occur in the absence of these indicators*** but they do require ***further assessment, interpretation and consultation***.

The following guidelines provide a framework for understanding and identifying the occurrence of child abuse and neglect. Relevant indicators/risk factors are specific to each abuse type and are described in terms of the way a child or young person presents and the behaviours of those who abuse and neglect children and young people[21]. The following lists are a guide for clinical practice only and ***are not considered to be comprehensive*** of all actions, harm, behaviours and presentations that may give rise to a concern or suspicion of abuse or neglect.

[21] New South Wales Interagency Guidelines fro Child Protection Intervention 2002

Indicators of Physical Abuse [22]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers:
• Facial, head and neck bruising • Ruptured internal organs without a history of trauma • Fractures of bones, especially in children under 3 years • Lacerations and welts from excessive discipline or physical restraint • Burns / scalds • Ingestion of poisonous substances, alcohol or other harmful drugs • Other bruising and marks which may show the shape of the object that caused it (eg. a hand print, buckle) • Bite marks and scratches where the bruise may show teeth patterns • Multiple injuries or bruises • Head injuries where the child may have indicators of drowsiness, vomiting, fitting, retinal haemorrhages, suggesting the possibility of the child having been shaken • Dislocations, sprains, twisting injuries / symptoms • Explanation offered by the child or young person that is not consistent with the injury or other minor complaints	• Direct admissions by parents or carers that they fear they may injure or have injured the child or young person • Family history of violence, including previous harm to the children • History of their own maltreatment as a child • Repeated presentation of the child to health or other services with injuries • Marked delay between injury and seeking appropriate medical assistance • Parental history of injury inconsistent with child's developmental stage and physical findings • Parental history of injury is vague, bizarre or variable • Parental reluctance or inability to adequately explain injury • History of domestic / family violence.
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances.	

[22] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework

Indicators of Emotional Abuse [23]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers:
• Feelings of worthlessness about life and themselves • Inability to value others • Lack of trust in people • Lack of interpersonal skills necessary for adequate functioning • Extreme attention seeking behaviours • Other behavioural disorders (eg. disruptiveness, aggressiveness, bullying).	• Constant criticism, belittling, teasing of a child, or ignoring or withholding praise and affection • Excessive or unreasonable demands • Persistent hostility and severe verbal abuse, rejection and scape-goating • Belief that a particular child is bad or 'evil' • Using inappropriate physical or social isolation as punishment • Situations where an adult's behaviour harms a child's wellbeing • Exposure to domestic violence
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances. *	

[23] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework

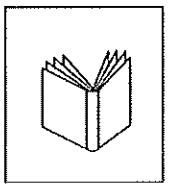
Indicators of Sexual Abuse [24]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers:
• Describes sexual acts • Direct or indirect disclosures • Age-inappropriate behaviour and/or persistent sexualised behaviour • Self-destructive behaviours: drug dependence, suicide attempts, self-harming • Unexplained changes in behaviour • Persistent running away from home • Poor concentration at school • Not wanting to go home from school • Anorexia or over-eating • Going to bed fully clothed • Regression in developmental achievements in younger children • Child being in contact with a known or suspected perpetrator of sexual assault • Unexplained accumulation of money or gifts • injuries such as tears or bruising to the genitalia, anus or perineal region • Bleeding from the vagina, external genitalia or anus • Sexually transmissible infections • Adolescent pregnancy • Traumas to buttocks, breasts, genitals, lower abdomen or thighs.	• Intentional exposure of child or young person to sexual behaviour of others • Committed / suspected of child sexual assault • Coercing child to engage in sexual behaviour with other children • Verbal threats of sexual abuse • Exposing child or young person to prostitution or child pornography or using a child for pornographic purposes • Inappropriate curtailing or jealousy regarding age-appropriate development of independence from the family • Denial of adolescent pregnancy by family • Perpetration of spouse abuse or physical abuse
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances.	

[24] NSW Interagency Guidelines for Child protection Intervention 2000 Paper Iii: Practice Framework

Indicators of Neglect [25]	
Indicators in Children and Young People:	Indicators in Parents or Caregivers
• Non-organic failure to thrive • Delay in developmental milestones • Loss of skin bloom • Poor hair texture • Untreated physical problems • Poor standards of hygiene leading to social isolation • Scavenging for or stealing food • Extended stays at school, public places, other homes • Self-comforting behaviour, eg. rocking, sucking • Being focused on basic survival • Extreme seeking of adult affection • A flat and superficial way of relating, lacking a sense of genuine interaction • Anxiety about being abandoned	• Failure to provide adequate food, shelter, clothing, medical attention, hygienic home conditions • Leaving the child inappropriately without supervision • Inability to respond emotionally to a child • Abandoning child or young person • Depriving or withholding physical contact or stimulation for prolonged periods
One indicator in isolation may not imply abuse or neglect. Each indicator needs to be considered in the context of other indicators and the child or young person's circumstances.	

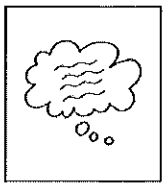
These indicators provide a guide for clinical practice and, as previously stated, are not considered to be comprehensive of all harm, behaviours or presentations. One indicator in isolation may not indicate abuse or neglect. Each indicator needs to be considered in the context of a child's personal circumstances. Furthermore, child abuse and neglect can occur in the absence of any of these demonstrable risk indicators. Their presence are merely clues or warning signs that require further assessment, interpretation and consultation.

Additional risk indicators or characteristics of child and family and examples of possible clinical findings of child abuse and neglect can be found in the fact sheets developed by the Child Safety Unit. These indicators are presented in a child developmental framework and have been compiled by a cross section of experienced clinicians. Please refer to the Child Safety Unit QHEPS site for this resource.



WEB: http://qheps.health.qld.gov.au/csu/

[25] NSW Interagency Guidelines for Child protection Intervention 2000 Paper iii: Practice Framework



Reflecting on your previous experience ... Utilising the "Indicators for Abuse and Neglect" – which specific indicator(s) were evident?

Reflect on the scenario of your choice ... Which specific indicators are you able to identify from the scenario?

Child Abuse and Neglect and Antenatal Care

The first indication of potential risk for an unborn child may be uncovered during antenatal care. All health professionals providing care to a mother during her pregnancy should be alert to the signs of abuse and neglect remembering also that the mother may not necessarily be the perpetrator of the abuse but a victim if she resides in an abusive relationship.

"Research and experience indicates that very young babies are extremely vulnerable to abuse and that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm"[26].

Antenatal assessment offers health professionals clues or indicators that point to the need for parental support and/or intervention to facilitate the adequate parenting, protection and well being of the unborn child. An awareness of those indicators [27]relevant to antenatal assessment is therefore critical.

[26] http://www.acpc.norfolk.gov.uk/right_frame(protocols23).html
[27] ibid.

Factors to be considered when undertaking an Antenatal Assessment of Risk:		
Unborn Baby	**Parenting Capacity**	**Family/Household/ Environmental**
• Unwanted/concealed pregnancy • Lack of awareness of baby's needs • Unattached to unborn baby • Unrealistic expectations • Inappropriate parenting plans • Premature birth • Different/abnormal perceptions about the baby • Inability to prioritise baby's needs • Poor/nil antenatal care • Special/extra needs • Stressful gender issue	• Negative childhood experience • Childhood abuse • Denial of past abuse • Multiple carers • Substance abuse • Family violence • Abuse/neglect of previous children • Age of parent - very young parent • Mental illness • Learning difficulties • Physical disabilities • Ill health • Inability/unwilling to work with professionals • Postnatal depression • Past antenatal/postnatal neglect	• Domestic violence • Violent network • Poor impulse control • Unsupportive partner • Isolation • High mobility/transience • No or little commitment to parenting • Relationship difficulties • Multiple relationships • Lack of community support • Poor engagement with professional services

Again, it must be remembered that these indicators are clues that suggest possible harm. They do not prove abuse or neglect as harm can occur in the absence of these indicators but they do require further assessment, interpretation and consultation.

"Antenatal assessment is a valuable opportunity to develop a proactive multi-agency approach to families where there is an identified risk. The aim is to provide support for families, to identify and protect vulnerable children and to plan effective care programmes, recognising long-term benefits of early intervention on the welfare of the child"[28].

[28] http://www.acpc.norfolk.gov.uk/right_frame(protocols23).html

Domestic Violence an Indicator for Potential Abuse and Neglect

Domestic and Family Violence (D&FV) occurs when one person in a relationship uses their power to control the other person, in any way, including physical, emotional, verbal, sexual, financial, social, cultural, and spiritual abuse.

Intimate Partner Violence (IPV) occurs when abuse and/or violence is used within an intimate partner relationship.

There is increasing evidence that there is a substantive correlation between domestic or intimate partner violence and the incidence of child abuse within the community, with one being an indicator of the other[29].

The Australia Women's Safety Survey reported that 61 per cent of women who experienced violence by a current partner had children in their care during the course of the violent relationship. The survey also revealed that 46 percent of women who experienced violence by a previous partner said that their children had witnessed the violence (ABS 1996). In the Victorian study, an estimated one in four Victorian children had witnessed intimate partner violence, increasing their risk of mental health problems, behavioural and learning difficulties[30]..

Children can be severely traumatised by witnessing domestic and family violence or intimate partner violence with possible persistent behavioural and psychological sequelae. They can also become victims of the abusive and/or violent behaviour. The type of violence is not always the primary factor determining the long term outcome but the more important predictors are the duration of the violence, its severity and frequency. However, physical violence is an overriding concern and as such should be carefully assessed with an appropriately prioritised response.

This evidence of possible co-existence of D&FV and child abuse necessitates the need for all health professionals to have a child protection perspective when confronted with D&FV or intimate partner violent situations. The recognition of indicators associated with domestic violence is a critical component of a supportive and protective response to ***all*** its victims.

[29] Astbury J., (2000) 'The impact of domestic violence on individuals' Medical Journal of Australia, Vol 173.
[30] NSW Health: Policy and Procedures for Identifying and Responding to Domestic Violence, page 51.

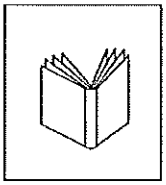
Indicators associated with domestic or intimate partner violence [31]	
Indicators in adult victims • Unexplained bruising and other injuries • Social isolation • Never making a decision without referring to partner • Low self esteem • Anxiety/depression/post-natal depression • No access to transport • Being submissive/withdrawn • Frequent absences from work or studies • 'Accidents' during pregnancy • Repeated presentations at emergency departments • Psychosomatic and emotional complaints • Sometimes there are no obvious indicators	**Indicators in young children** • Difficulties with eating • Difficulties in sleeping • Slow weight gain (in infants) • Regressive behaviour in toddlers • Delays or problems with language or other development **Indicators in school age children** • Behaviour which is clingy, dependent, sad and secretive • Academic achievement problems • Poor concentration • Poor school attendance • Withdrawal at school • Aggressive or violent behaviour • Defiance at school, particularly with female teachers • Over-protectiveness of or fear of leaving mother • Anxiety • Physical complaints • Sleeping difficulties

[31] Domestic Violence Interagency Guidelines, http://lawlink.nsw.gov.au/lawlink/vaw/dvguidelines

Indicators associated with domestic or intimate partner violence [32]	
Indicators of perpetrator behaviour in adults • Values/attitudes about 'ownership' of partner and/or children • Controlling behaviour • Always speaking for the partner (or child) • Describing the partner as 'incompetent' 'stupid' or other derogatory terms • Being overly concerned towards the suspected victim • Admitting to some violence, but minimising the frequency and severity • Holding rigidly to stereotyped sex roles • Not allowing partner or child to access service providers alone • Threatening and/or intimidating • Behaviour directed towards workers • Sometimes there are no obvious indicators	**Indicators in adolescents** • Physical/verbal abusiveness/violence • Social isolation • Abuse of siblings or parents • Eating disorders • Depression or suicide attempts • Over- or under-achievement • Alcohol or other drug abuse • Frequent absences from work or studies • Psychosomatic and emotional complaints • Exhibiting sexually abusive behaviour • Homelessness or prolonged staying away from home • Extreme risk taking behaviour
* **Please note: the indicators listed may also be indicators of other abuse or neglect issues and should be used as a guide only.**	

The QH Domestic Violence Initiative (DVI) is a screening tool that is used to identify women who are experiencing Domestic and Family Violence, particularly Intimate Partner Violence (IPV), and to provide referral options for further information, support, assistance and/or counselling.

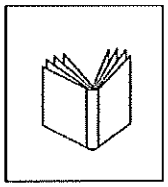
Queensland, and other Australian and international studies confirm that IPV often commences or escalates in pregnancy. Therefore, it is appropriate that women are asked about this possibility at the earliest opportunity during the pregnancy.



The DVI tool can be accessed at:
http://www.health.qld.gov.au/violence/domestic/dvpubs/DVIForm.PDF

[32] Domestic Violence Interagency Guidelines, http://lawlink.nsw.gov.au/lawlink/vaw/dvguidelines

The DVI tool offers the health professional an opportunity to recognise adult victims and children and young people who have been harmed or who are at risk of harm. It does not specifically ask about children and young people. However, if IPV is disclosed, midwives are encouraged to ask about the impact on children and young people. Identification or recognition of such harm facilitates the undertaking of health professionals' mandatory and duty of care responsibilities to report to the Department of Child Safety.



http://www.communities.qld.gov.au/violenceprevention/dv_legislation.html

http://www.health.qld.gov.au/violence/domestic/dvi/

Other useful starting points for relevant internet links are

- the Australian Domestic Violence Clearing House Links Page at: http://www.austdvclearinghouse.unsw.edu.au/Links.htm
- The Australian Government Partnership against Domestic Violence page at http://ofw.facs.gov.au/padv/index.htm

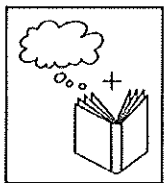
Section 4 – Reporting

Capability Statement – "Reporting"

The expectation is that you;

1. Are aware of, and know how to access the child protection support systems (District / State-wide) to determine if your suspicion is reasonable.

2. Are able to make a report to the Department of Child Safety utilising the standard QH child safety report form.



The key point from the Recognition Section is:

- That there are presenting characteristics and indicators that can alert health professionals to the presence of child abuse and neglect.

Reflecting on your previous experience ... did you report and did you know how to report?

Reflect on the scenario of your choice ... prior to completing this module, would you have reported this and to whom?

Support Systems

District

When reporting your suspicion of child abuse and neglect it is essential to determine if your suspicion is reasonable. To do this it is recommended that you ***consult*** with other health professionals. Remember that the provision of child protection involves many different professional groups and that your consultation does not have to be limited to your own specific professional group.

In a **metropolitan** or **larger regional centre** consultation may only need to occur locally. In this instance there are Paediatricians who fulfil the role of a Child Protection Advisor and Child Protection Liaison Officers (these positions may be either a nurse or a social worker).

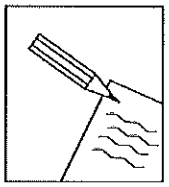
It may be that you choose to discuss your suspicion with your colleagues or line manager / team leader prior to a more formal consultation with the District's Child Protection Advisor and Child Protection Liaison Officer.

In **regional, rural** and **isolated** facilities the consultation may need to occur with colleagues and advisors in other facilities. For example, if you are a health professional in Cloncurry or Mornington Island then the flow of consultation may include colleagues locally and then with advisors in Mt Isa.

In isolated facilities where you may be a solo practitioner or a member of a very small team, then it is also acceptable to consult with the child's teachers and local police officer to determine if your suspicion is reasonable.

Remember as a health professional you are afforded legal protection in this consultation under Sections 159M,N,O,andQ the *Child Protection Act 1999.*

Information on supports that you are able to access should be available in your local facility. There is also a comprehensive list of child protection advisor positions available on the CSU QHEPS site.



It is important for you to know who the Child Protection Advisor or Child Protection Liaison Officers in your District are and how to contact them. Locate the contact details for these positions now.

Locate the contact details for those Child Protection Advisors in other Districts that you may need to contact.

Other

Other resources that could be of assistance to you in the formation of reasonable suspicion include;

1. Child Advocacy Service – Royal Children's Hospital
2. Mater Health Services, Child Protection Unit
3. Child Protection Unit – The Townsville Hospital
4. Your local DChS service centre staff (refer to the DChS internet site for contact information - http://www.childsafety.qld.gov.au
5. QH Child Safety Unit (QHEPS or telephone)

Department of Child Safety Officer (authorised officer)

The Chief Executive is the Director General and ***all Child Safety Officers*** from the DChS are *authorised officers* under Section 149 of the *Child Protection Act 1999.* They have the power to investigate allegations of alleged harm or alleged risk of harm to a child, and assess the child's need of protection or take appropriate action under Section 14 of the *Child Protection Act 1999.*

It is important to remember that you are not in breach of Section 62A of the *Health Services Act 1991* when you communicate confidential information to an *authorised officer,* **a Child Safety Officer,** *of the Chief Executive* of the DChS as long as the disclosure is relevant to the protection and welfare of a child.

Queensland Police Officers *are not authorised officers* but have legal provisions for involvement in child protection investigations and responses given the possibility of the commission of a criminal offence related to the alleged harm to a child[33].

However, under Section 159O of the *Child Protection Act 1999,* health professionals are also able to provide information directly to **Queensland Police Officers** if it is relevant to the protection or welfare of a child.

Written and Verbal Reporting

Making a Report

Given the sensitive nature of child abuse and neglect, and the serious potential outcomes for those involved, the need for objectivity and impartiality is important.
The types of report you are required to make to the DChS are;

- Written, and
- Verbal.

Verbal contact with an authorised officer of the DChS may be the first step you take when reporting. The DChS call this process an *"intake".* During this process the Child Safety Officer will ask a specific set of questions to assist them in determining the response level for the report.

The **QH "Report of a Reasonable Suspicion of Child Abuse and Neglect"** has been developed to mirror the *"intake"* questions you will be asked. It is anticipated that this will facilitate effective and efficient communication between QH and the DChS. You may find it prudent to work through the form prior to your telephone conversation with the Child Safety *"intake officer".*

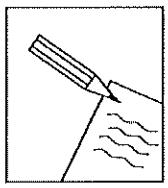
It is a legislative requirement that all verbal reports must be followed up with a written report. A written report must be forwarded to the DChS within seven days, even if you consider that your suspicion is no longer reasonable. This is mandated in Section 192 of the *Public Health Act 2005.*

Just remember - the ***contact*** with the Child Safety Officer is ***your responsibility*** if you have formed the reasonable suspicion, and cannot be undertaken by or delegated to another colleague, clinical team member or manager.

Other issues to consider when making a report are;

- Objectivity,
- Credibility, and
- Professional boundaries.

[33] Section 14(2) of the *Child Protection Act 1999*



Using your own scenario ...

Using the scenarios provided ...

Categorise the abuse type and complete the following extract from the QH "Report of a Reasonable Suspicion of Child Abuse and Neglect" form.

3. ABUSE TYPE BEING REPORTED (more than one may be ticked) - refer to Guide for assistance, if needed

Suspected:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect
At risk of:	☐ Physical abuse	☐ Emotional abuse	☐ Sexual abuse	☐ Neglect

Objectivity means having an awareness of any potential biases that may relate to a child, young person, parent or caregiver's age, gender, race, ethnicity, religion, sexual orientation, disability, cultural/community child rearing practices, or socio-economic status.

Credibility is reliant on the report being impartial and free of any possible interpretation/judgement of an individual's values, morals or religious or cultural beliefs.

Achieving credibility in reporting suspicions of child abuse and neglect is also important to maximising opportunities for the safety, well-being and development of children or young people who have been harmed or are at risk of harm. Credibility relates to the quality of the information you have collected and which forms the basis of your reasonable suspicion. Relevant, professionally sound, and accurate data are critical elements of a credible report.

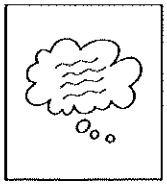
Professional boundaries are grounded within a clearly articulated ethical framework that is comprised of four central principles. These being;

- Beneficence (of always doing good for the patient)
- Non-maleficence (of avoiding doing harm)
- Respect for patient autonomy as a decision making individual
- Justice (treating everyone equally)[34].

These boundaries must be central to your practice when you are working with children and young people who have experienced or who are experiencing abuse and neglect. The involvement with and consideration of the family and/or their carers may present you with professional dilemmas and challenges in maintaining appropriate professional boundaries. It is important to know your District support systems and access them as required.

Despite your possible distress to a child or young person's abusive experience, it is important that your care, response, treatment and support remains within the parameters of your professional boundaries and responsibilities. Expressions of anger, pity, and outrage have no place in the provision of professional health care to the victims and possible perpetrators of child abuse and neglect.

[34] Bridges J., Hanson R., Little M., et.al. 'Ethical relationships in paediatric emergency medicine: Moving beyond the dyad' Paediatric Emergency Medicine (2001)13,pp344-350



Reflect on your professional boundaries and consider strategies you may utilise in your practice to ensure that these boundaries are not exceeded.

Department of Child Safety Intake Process

When ***reporting*** to the DChS, the minimal information requirements are contained in the prescribed QH reporting form. However in your discussion with the Child Safety officer/Intake Officer at the relevant service centre, additional information will be sought to assist them in their assessment and determination of the appropriate level of response.

You may be asked very specific questions related to:

- the harm which is the basis for the report eg. body location of an injury, severity, cause of reported/suspected injury
- child or young person's presentation, appearance, developmental and emotional capacity, attachment to parents/caregivers, behaviour.
- parents/caregivers presentation, their protective capacity of the child, attachment to child, relationship history, parenting capacity, behaviour during presentation.
- family characteristics such as their family/household type, (eg. step, single, blended), mobility, social isolation, cultural factors.
- child's environment such as type of housing, living conditions
- presence of any immediate safety concerns
- presence of any factors that may affect worker safety should a notification result.
- source of the information being provided eg. child/parental disclosure, hearsay from others, direct observation, deduction, other possible corroborative sources.

Your response to these queries needs to be objective and honest. If you are unable to answer the questions, state this and the reason you are unable to do so (that is you did not ask about that, you did not observe anything in relation to that etc). It is important to cooperate with the Child Safety Officer to provide as much information as possible as your report may be critical to the safety and wellbeing of the child. Remember though - you are a reporter not an investigator.

Your capacity and willingness to be recontacted by the Child Safety Officer may also be discussed.

Documenting the Report

Given that the information you may provide orally to the DChS may be more extensive than what you may have prepared for your written report, it is important that you document in the child's medical record, a summary of your discussion along with the name and details of the Child Safety Officer that you spoke with.

Maintaining an accurate, considered, objective and up to date account of your concerns, consultations, contacts, actions and plans will facilitate you and your colleagues' involvement in any subsequent response/intervention involving the child or young person. Good documentation not only clearly demonstrates your responsibility to reporting but reflects

professionalism and clinical skill and your commitment to the protection and wellbeing of the child or young person you have identified as being at risk.

Possible Report Outcomes by the DChS

After a report is made to the DChS, the Child Safety Officer must decide what action or response is required to the information you have provided. There are three possible outcomes:

1. An enquiry

This is a report that does not relate to child welfare issues of child protection concerns or there is insufficient information about a child's need for protection. This was previously known as an intake response.

2. A child concern report

A child concern report is a child protection concern that does not meet the threshold for recording for a child protection notification and so does not result in an investigation and assessment by the Department. This level was previously known as a protective advice.

Whilst there may be some concern for the child or young person's safety and wellbeing, it is not of a significant nature to warrant any statutory departmental intervention. Other services of assistance or support may be offered to the family.

3. Child protection notification

A matter is determined to be a child protection notification when the department receives information that a child is reasonably suspected to be in need of protection. That is, a child who:

- Has suffered harm or is at unacceptable risk of suffering harm, and does not have a parent able and willing to protect him/her from harm (*Child Protection Act 1999*, section 10); or
- Is unborn but is reasonably suspected to be in need of protection after he or she is born (*Child Protection Act 1999*, section 21A).

A notification response will result in an initial assessment by Child Safety Officers of the allegations of abuse and/or neglect and the family circumstances of the child or young person.

If the information received in the report indicates the commission of a criminal offence, the Queensland Police Service is immediately contacted for their response.

Involvement after Making a Report

In addition to the possible responses to the report by the DChS and the QPS, there are other child protection processes that may be initiated after a report which may include the involvement of health professionals. They include:

- a referral to the relevant Suspected Child Abuse and Neglect (SCAN) system
- a 'Care and Treatment Order for a Child'
- involvement in judicial proceedings
- provision of ongoing health and therapeutic care responsibilities

Referral to the SCAN System

As a result of the CMC Inquiry, Suspected Abuse and Neglect (SCAN) teams have been redeveloped with a legislative basis and a rejuvenated holistic 'whole of government' commitment to address and enhance their functioning.

The SCAN system now consists of a two-tiered model which provides a forum for inter-agency discussion and planning ensuring that the safety of the child is paramount.[35]

The **SCAN Assessment and Management Team (AM)** team is the first tier of the SCAN model and is the conduit for all matters to be referred to the SCAN System for deliberation. It is comprised of an authorised representative from these core departments:

- Department of Child Safety
- Queensland Police Service
- Queensland Health
- Department of Education and the Arts
- Recognised Aboriginal and Torres Strait Islander agencies

Referrals to the SCAN AM teams are made by the core member agency representatives based on specific criteria. Meetings are very regular and health professionals, in addition to the QH core member, may be required to attend to provide specific knowledge or expertise which will add value to the case discussion and resulting recommendations for action[36].

Their purpose is to ensure:

- the ongoing protection of the child or young person
- the provision of support to the child, young person and their family
- the intervention is effective and coordinated; through
- coordinated assessment of protective and support needs
- collaborative planning
- the implementation of recommendations for action[37].

The SCAN Community Implementation (CI) Team is the second tier of the SCAN model and is responsible for planning and implementation of the AM Team recommendations in association with the DChS case management plan. QH professionals may also be involved in service delivery at this level.

The DChS, as the lead child protection agency, has responsibility for the coordination of the 20 regionally based AM teams and the locally based CI teams.

[35] Suspected Child Abuse and Neglect (SCAN) System Interagency policy and procedures, July 2005, p9
[36] Suspected Child Abuse and Neglect (SCAN) System Interagency policy and procedures, July 2005, page 18
[37] Suspected Child Abuse and Neglect (SCAN) System Interagency policy and procedures, July 2005

Care and Treatment Order for a Child

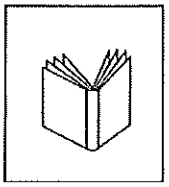
Under the *Public Health Act 2005*, Designated Medical Officers, have the power to order that a child be held at a health service facility for an initial period not exceeding 48 hours, if the Designated Medical Officer reasonably suspects that the child

- has been harmed, or is at risk of harm, AND
- the child is likely to be taken from the facility and suffer harm if immediate action is not taken.

The order may be extended for an additional 48 hours only with the agreement of a second Designated Medical Officer.

A Care and Treatment Order for a Child needs to be administered with the welfare and best interests of the child as paramount as it is a very powerful intrusion on the normal decision making rights of parents or guardians and can be invoked without judicial review. It is Queensland Health's policy position that a Care and Treatment Order only be invoked in circumstances where a child is likely suffer harm if immediate action is not taken and it is not possible to use the custody provisions of the *Child Protection Act 1999*, which in general is the preferred course of action.

This order makes it an offence to remove the child from the health service facility or to obstruct a Designated Medical Officer or another person involved in holding a child under the Order.



LINK TO 'Care and Treatment Order for a Child' Information Booklet
WEB
http://www.qheps.health.qld.gov.au/csu

LINK TO *Public Health Act 2005*
WEB:
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf

- Has been harmed or is at risk of harm:

And

- Is likely to leave or be taken from the facility and suffer harm if the designated medical officer does not take immediate action.

Judicial Proceedings

Involvement in a child protection case does not necessarily mean just completing a report of your concerns to the DChS. There may be occasions when you will be requested to provide an affidavit or statement to officers from the DChS and/or the Queensland Police Service about the delivery of your professional services to a child and/or family member who is subject to a subsequent court action. You may also be subpoenaed to give evidence in a court proceeding.

This will only occur in instances when a child or young person's safety can only be secured through the provision of a protection order and/or an alleged perpetrator of abuse or neglect to a child or young person has been charged with a criminal offence.

It is important to remember that on these occasions, this will not be about your role as the reporter of the alleged abuse. Your involvement in these instances will have most likely resulted from the performance of your clinical responsibilities involving a child or young person who has been harmed or who has been at risk of harm.

When confronted with these requests, seek support, direction and advice from your service supervisor/manager and remember that this is part of your professional responsibilities to the children and young people of Queensland who have been harmed or who are at risk of harm. You will be supported in your performance of these responsibilities. You should refer to your District policy for further information.

Other Possibilities

Other ongoing roles for health professionals can include:

- Provision of clinical services as an inpatient or outpatient
- Provision of clinical services to parent/s
- Participation in case planning
- Attendance at relevant case discussions/meetings
- Monitoring child's health and behaviour needs during the delivery of clinical services
- Advocating access to appropriate services to ensure good health outcomes
- Providing progress reports to the SCAN system, DChS, or other relevant agencies

As can be seen, your responsibilities do not cease with the completion of a report of a reasonable suspicion of abuse or neglect. Whilst the majority of these subsequent duties are not mandated, they fall within the charter of your health role. All children and young people have the right to access and receive adequate health care. The care they receive should reflect the holistic approach which underpins the Queensland's government commitment to children and young people who have been harmed.

Remember Yourself and Access Support

Recent evidence now reveals that practitioners who work with or help traumatised persons are indirectly or secondarily at risk of developing the same symptoms as persons directly affected by the trauma.

"The pain and helplessness of these children can be passed on to those around them. Listening to children talk about the trauma, trying to work in a complicated, frustrating and often "insensitive" system, feeling helpless when trying to heal these children - all can make the adults working with these children vulnerable to develop their own emotional or behavioural problems"[38].

There are many aspects of involvement in a child protection situation that can be very stressful for health professionals. Being confronted with a child with serious injuries or even their death is distressing and painful. Similarly, having regular contact with a child who is being constantly neglected by his parents can also result in feelings of frustration, powerlessness and anger.

Being mandated to report may not sit comfortably with you on a philosophical basis.

The very act of making a mandatory report about a child can also be demanding. You may worry about the implications of your action. Have I done the right thing? What will happen to the child now? Will the child be removed from his/her parents? Do I advise the parents that I am making a report? This decision depends on the relationship you have with the parent. Remember, you are obliged by law to report and this can be explained to the parents if appropriate. You are not obliged to advise parents of your report.

In addition, you may be exposed to situations that you can clearly identify with due to your own experiences as a child.

You can also expect to encounter high levels of distress, anger, and possible aggressive behaviour from parents whose child may have been harmed or is at risk of harm. Be aware of your own safety needs especially if you home visit, work alone or work in a rural or isolated centre. Seek appropriate advice and assistance if you are concerned.

It is important to ***recognise*** when you feel fearful, distraught or emotionally overwhelmed because of your involvement in a particularly difficult or series of difficult cases.

There are "individual indicators of distress" which can tell us all that we are at increased risk for developing secondary trauma[39].

Emotional Indicators		Physical Indicators	
Anger	Prolonged grief	Headaches	Lethargy
Sadness	Anxiety	Stomach aches	Depression
	Depression		

[38] Perry B D. "The Cost of Caring" Secondary traumatic Stress and the Impact of Working with High-Risk Children and Families, 2003 http://www.childtrauma.org/ctamaterials/Sec.Trma2_03_v2.pdf

[39] Perry B D. "The Cost of Caring" Secondary traumatic Stress and the Impact of Working with High-Risk Children and Families, 2003 http://www.childtrauma.org/ctamaterials/Sec.Trma2_03_v2.pdf

Personal Indicators		Workplace Indicators	
Self Isolation	Mood swings	Avoidance of certain	Missed appointments
Cynicism	Irritability with family / spouse	clients	Lack of motivation
		Tardiness	

It is important to ***acknowledge*** that you have been impacted by an incident or your participation in a situation of abuse and neglect.

It is important to ***seek*** appropriate assistance due to an incident or your participation in a situation of abuse and neglect.

As colleagues, supervisors, managers, you need to assist by:

- recognising that your colleague has been affected by their involvement
- providing encouragement and emotional support
- providing an opportunity to "talk" about how they have been impacted by the trauma
- assisting and encouraging your colleague to seek professional assistance and/or counseling

Checklist for Responding to Abuse and Neglect

Response	*Action*
Responsibility	• Recognise mandatory obligations • Fulfil mandatory responsibility
	• Recognise duty of care obligations • Undertake duty of care responsibility
Recognition	• Suspect abuse or neglect
	• Gather information
	• Assess information
	• Identify abuse type
	• Specify indicators/basis for concern
	• Consider if concern reaches 'reasonable suspicion' threshold.
	• Consult with colleagues/child protection advisor
	• Confirm concern as being a 'reasonable suspicion'
	• If no, still document your concerns with reasons for nil report.
	• Attempt case management of your concerns eg. refer to social work or community agency
	• If yes to reasonable suspicion, continue to **Reporting.**
Reporting	• Document concerns/suspicion in medical record
	• Obtain relevant information
	• Complete written documentation on prescribed QH Reporting form.
	• Contact your local DChS service centre during business hours or Crisis Care after hours.
	• Discuss your reasonable suspicion based on your observations and clinical assessment with an authorised officer from the DChS.
	• Document the officer's name, Service Centre, contact details and date and time of your contact on QH form and in the medical record.
	• Document any additional information discussed during reporting process to DChS in medical record.
	• Forward forms to DChS Service Centre and District Child Protection Advisor/Contact as per directions on the form
You have now done your part in protecting this child.	

Module Content Objectives

Section One

1. Discuss the concept of social justice and the role of Government in the provision of child safety policy and services.
2. Outline the basic principles of the "Ecological Model" and discuss its benefits as a conceptual model in the identification and reporting of suspected child abuse and neglect.

Section Two

3. Briefly outline findings and recommendations of the recent CMC report on "Children in Foster Care" and the impact of this report on current Government policy.
4. Briefly discuss the role of the DChS as the lead government agency for child safety.
5. Outline the recommendations that specifically relate to Queensland Health.
6. Discuss the role of the Queensland Health Child Safety Unit and differentiate its purpose from that of the DChS.
7. List the legislative changes that impact directly on clinical practice in the area of child safety.
8. Discuss the concept of mandatory versus discretionary reporting of suspected child abuse and neglect.
9. Outline the protections for health service employees with specific reference to section 62(a) of the Health Services Act.
10. Discuss the concept of reasonable suspicion
11. List the legislation that relates to the unborn child.
12. Briefly overview and describe the difference between;
    - reporting of an at risk unborn child
    - DChS unborn child high risk alert
13. Outline the guiding principles that should be considered when undertaking a health assessment of a child or young person that may have experienced abuse or neglect
14. Differentiate between the concept of assessment and investigation.
15. List the essential elements that need to included when documenting (in the clients medical record) an assessment of a child or young person that may have experienced child abuse and neglect.
16. Outline the "FOI" protections and limitations specifically relating to staff confidentiality when documenting in the medical record.

Section Three

17. Define the concepts of harm, neglect and abuse.
18. Outline the common presenting characteristics of physical, sexual and emotional abuse and neglect.
19. List the common risk indicators to be considered when assessing a child or

young person that may have experienced abuse and neglect.

20. Relate the concepts of harm, neglect and abuse to different scenarios and the role of the QH Health Professional
21. Provide information on where more detailed information on child protection indicators can be accessed.
22. Outline the role of the health professional in the antenatal assessment of child abuse and neglect
23. Briefly overview the relevance of Domestic and Family Violence (D&FV), including intimate partner violence (IPV), as an indicator when considering the possibility of child abuse and neglect in a family unit
24. Discuss the use of Queensland Health Domestic Violence Initiative (DVI) assessment tool and its benefit in determining the presence of D&FV or intimate partner violence.

Section Four

25. Outline the support systems (Corporate and District) that can be accessed by individuals to assist them in determining if their suspicion is reasonable.
26. Discuss the concept of an *authorised person*.
27. Overview the two mechanisms (written and verbal) of reporting suspected child abuse and neglect.
28. Discuss the importance of credibility and objectivity when reporting any suspicion of abuse and neglect.
29. List the common questions that may be asked when making a verbal report to the DChS.
30. Discuss the importance of recording the DChS Officer's name together with the content of the information disclosed during the verbal reporting process in the client medical record.
31. Overview the possible responses by the DChS following a report of suspected child abuse or neglect to the DChS
32. Overview the common outcomes likely to occur following a report of suspected child abuse or neglect to the DChS eg. Referral to the SCAN system, care and treatment order, DChS specific actions, affidavit
33. Define SCAN
34. List the core members agencies of the SCAN System.
35. Describe the two-tiered models of SCAN System and their basic activities.
36. Overview possible subsequent involvement in judicial proceedings
37. Overview the circumstances of a Care and Treatment Order for a Child.
38. Discuss the importance of obtaining support in the event that the reporting process causes personal distress.

Appendix One

Scenario 1:

James Brown, DOB 24.3.05, is brought to hospital by mother and her partner with very recent history of difficulty in feeding, vomiting, constant crying and irritability.

Upon examination, child has red marks around neck and shoulders (they have an outline of a handprint). The child is difficult to arouse and starts to fit during the triage process. Child is subsequently admitted to hospital and a CT scan reveals multiple cerebral haemorrhages.

Mother, Mary Brown is 17 years old and has previously been in the care of the Department of Families as a result of her mother's failure to protect her from being sexually abused by her stepfather. She lives with her boyfriend, Bill Burr who is 19 years old and a friend of the partner, Matt Blinco, aged 18 years. Mary tells you that she and her partner had a fight last night and she left the unit at around 11PM and stayed with a friend for a few hours as she was scared that she would be hurt by Bill as he was drunk and had beaten her in the past. She is not breastfeeding and the baby is not yet sleeping through the night. Despite this she was so scared she just left the unit and left the child asleep in the unit. Bill is not the father of the baby but Mary tells you that he has cared for the baby by himself on previous occasions. The basis of the argument was that Bill had accused her of having sex with Matt while he was at the hotel. Matt and Bill also were violent with each other during the argument.

Mary receives Supporting Parent's benefits, and Bill lost his job yesterday, came home and started drinking with a mate. Bill drinks regularly and heavily according to Mary.

Bill tells you that the baby started crying after Mary left. He went to change him and give him a bottle. He and the baby then went off to sleep and didn't awake until Mary returned at around 7am. Mary states that when she returned home, the baby was crying and had vomited on his clothes and bedding. She tried to comfort the baby but was unsuccessful and that the baby periodically shook. She became worried as the baby looked very unwell and decided to take him to the hospital.

Mary also tells you that she has been visited at home by the Child Health nurse over the last few weeks since the birth of the baby and that she has had contact with her local GP. The baby is on the 10th percentile for weight.

Address: 12 Harris Lane, Highwood. There is no landline telephone in the house and the mobile phone has no credit and has been disconnected.

Scenario 2:

Mother, Jo Black, presents with 5 year old daughter, Jenna, who has discomfort when urinating and is complaining of general pelvic soreness. Mother quietly tells you that she is concerned as her daughter has not been sleeping for the past six months, has been becomes very clingy, has frequent nightmares and that the teacher at her preschool has mentioned that her behaviour there has recently deteriorated – not socialising as well as she has, and refusing to have afternoon rests.

Her parents are separated. The mother lives with Jenna and her 9 year old son, John, from a previous relationship. Jenna's father has overnight contact visits every second weekend. These visits have been happening for the last 6 months since the separation. Jenna cries for hours before she goes on these visits and tells her mother that she doesn't want to go and that she doesn't like the staying with her dad. When her mother asks why, she says nothing and cries more vigorously but still sends the child on the visit each fortnight as they are court ordered. Jenna has stayed with her father the previous weekend.

Dad, Walter Black, is 32 years old and lives alone.
During examination, child is very distressed and even her mother is unable to comfort her. She does not want people to look at her lower abdominal, pelvic and genital areas and refuses to give a urine sample.

Address: 32 Blaxland Ave, Ample Hill 4997. Tel: 90986523

5.4 Reporting sexual acts involving children and/or young people

Sexual activity involving children and young people

In circumstances when a health professional becomes aware and reasonably suspects the sexual abuse of a child or young person, there is an obligation to report the suspicion immediately to the Department of Communities (Child Safety Services).

In Queensland the age of consent for any person participating in a sexual act with another consenting person, is 16 years of age, or 18 years of age for anal intercourse (*Criminal Code Act 1899*).

However, under the Criminal Code, no person is required to report a crime except where there is a specific legal requirement to do so. (Refer to fact sheet series 5.6 Reporting criminal matters to the Queensland Police Service). Therefore, in some circumstances when a health professional becomes aware of sexual activity between **young** people, they are under no legal obligation to report these acts to the Queensland Police Service. There is however, an obligation on the part of the health professional to assess the relative harm or risk of harm, and to report to the Department of Communities (Child Safety Services).

Threshold for reporting suspicions of child abuse and neglect to the Department of Communities (Child Safety Services)

In determining whether a young person has been sexually harmed or is at risk of sexual harm, Queensland Health staff is required to apply the following criteria:

(a) In the case of a person **under 14 years** participating in a sexual act, the young person's circumstances are deemed to have reached the threshold for harm or risk of harm and must be reported to an authorised officer of the Department of Communities (Child Safety Services). (Please refer to *Protecting Queensland Children: Policy Statement and Guidelines for the Management of Child Abuse and Neglect of Children and Young People (0 – 18 years)).*

(b) When considering a young person **14 years and over**, circumstances are considered to have met the statutory definition of significant harm or risk of harm, and should be reported when a staff member suspects that a sexual relationship involving a young person:

- is non-consensual
- is not fully comprehended by the young person
- suggests an inappropriate power differential
- constitutes a significant age-gap (5 years or more) between the young person and partner
- involves coercion to engage in any unlawful sexual activity including prostitution
- exposes them to, or uses them in, pornographic performances or materials
- occurs between family members.

(c) In the case of a person **14 years and over** participating in a sexual act, and staff have clearly identified that the sexual acts have occurred consensually between similarly aged (i.e. peer), developmentally normal young people (including intercourse), these acts need not be considered harmful or place the young person at risk of harm. To meet legal, policy and ethical requirements, staff must comprehensively document the basis of their decision which deems it unnecessary to report the case to Department of Communities (Child Safety Services).

(d) There will be circumstances when the criteria above (section c) may not be met and staff are concerned the young person may be at risk. In these circumstances, the absence of the above specific indicators is not intended to restrict reporting to the Department of Communities (Child Safety Services) and/or the Queensland Police Service.

(e) In relation to age, specific consideration must be given to the presence of developmental (especially intellectual) delays and/or disabilities, which may reduce the young person's ability to identify report and/or consent to, the sexual acts in question.

In all other cases involving sexual activity amongst young people, staff must apply a high level of suspicion. Circumstances that should trigger suspicion of sexual abuse are listed in fact sheet 4.5 'Sexual Abuse – Clinical risk factors and indicators.

Who reports?

Any Queensland Health staff member may report these matters directly to the Department of Communities (Child Safety Services) under the *Child Protection Act 1999.* However, all registered nurses and doctors are required by law to report reasonable suspicion of harm or risk of harm to children and young people under the age of 18 years under the *Public Health Act 2005.*

Further information

Please refer to the Protecting Queensland Children: *Policy Statement and Guidelines for the Management of Child Abuse and Neglect of Children and Young People (0 – 18 years).* Information is available by visiting the Child Health and Safety Unit website at http://qheps.health.qld.gov.au/csu or emailing CSU@health.qld.gov.au.

Queensland Government
Queensland Health

Appropriately skilled staff shall perform medical examinations or treatments on children who are victims of sexual assault

Standard # QH-IMP-078-5:2012

Protecting Children and Young People Policy

Implementation Standard for conducting child sexual assault examinations

1. Purpose

This Implementation Standard identifies the minimum requirements that evidence the implementation of the conducting sexual assault examinations component of the Protecting Children and Young People policy and identifies individual positions accountabilities and responsibilities in relation to consent in child protection.

2. Scope

This Implementation Standard applies to all Queensland Health employees (permanent, temporary and casual) and all organisations and individuals acting as its agents (including Visiting Medical Officers and other partners, contractors, consultants and volunteers).

3. Supporting documents

Authorising Policy:

- Protecting Children and Young People Policy

Related Standards:

- Implementation Standard 'Information sharing in child protection'
- Implementation Standard 'Information Coordination Meeting (ICM) and Suspected Child Abuse and Neglect (SCAN) team'
- Implementation Standard 'Reporting and responding to a reasonable suspicion of child abuse and neglect'
- Implementation Standard 'Care and Treatment Order for a Child'
- Implementation Standard 'Consent in child protection and management of complex care cases and end of life decision making'

4. Related documents

- Queensland Health Informed Decision-making in healthcare policy and Implementation Standard
- *Child Protection Act 1999*
- *Public Health Act 2005*
- *Coroners Act 2003*

5. Requirements

5.1 Conducting sexual assault examinations

5.1.1 All medical practitioners shall comply with the informed consent requirements detailed in the Queensland Health Informed Decision-making in healthcare policy and Implementation Standard prior to conducting sexual assault examinations in children and young people.

5.1.2 For child victims of sexual assault **under** the age of 14 years, medical examinations shall be performed by a medical officer with appropriate paediatric skills including child protection and/or sexual assault medical examination training or skills.

5.1.3 For child victims of sexual assault 14 years of age **and over**, medical examinations shall be performed by a Forensic Medical Officer, Government Medical Officer or a medical officer trained in sexual assault medical examinations.

6. Review

This Standard is due for review on: 24/08/2013

Date of Last Review: N/A

Supersedes: N/A

7. Business Area Contact

Child Health and Safety Unit, Primary Community and Extended Care Branch

8. Responsibilities

Position	Responsibility	Audit criteria
Forensic Medical Officer/ Government Medical Officer	Medical officers who are specially trained to provide forensic medical services.	Record sexual assault examination.
Medical Practitioners	Performing medical examinations and treatment.	Local level audit of responsibilities.

9. Definitions of terms used in this policy and supporting documents

Term	Definition / Explanation / Details	Source
Child	For the purposes of this document, a child is 'an individual under 18 years of age'.	S8 *Child Protection Act 1999*
Clinical assessment	This procedure refers to a physical, psychiatric, psychological or dental examination that result in a judgment being made about the patient. It can include forensic examination and an examination or assessment carried out by a nursing or other appropriately qualified health practitioner. This term also refers to a bio-psychosocial assessment undertaken by a multidisciplinary mental health team.	
Custody	A person who has, or is granted, custody of a child has the right to uphold a child's daily care and the right and responsibility to make decisions about the child's daily care.	*S12 Child protection Act 1999*
Informed Consent	Agreement to a proposed procedure, given after proper and sufficient explanation of the condition, the procedure, the general and specific risks, the benefits and anticipated outcomes, alternative treatment available, the risk of not having the procedure. True consent to what happens to oneself provides an opportunity to evaluate comprehensively the options available and their associated risks. Questions must be answered truthfully and the patient, not the Medical Practitioner makes the final decision. To assist a patient to make an informed choice, it is essential that the Medical Officer has knowledge of therapeutic alternatives and their associated risks. In addition there are other pre-conditions for the consent to be valid, including the requirement that the patient has the capacity to give that consent.	Lord R.S.A. Informed Consent in Australia. Australian, *New Zealand Journal of Surgery* (1995) 65.224-228.
Gillick competence	A particular level of understanding and maturity on the part of person under 18 years of age that is required for them to personally consent to medical treatment (or disclosure of their information). It is not age specific and is based on the capacity of the young person to understand the nature and extent of treatment and side effects of treatment.	*Gillick v West Norfolk and Wisbech Area Health Authority.* [1986] 1 AC 112 (HL)
Government medical officer	A medical officer employed as a government medical officer has the ability to perform procedures under the *Coroners Act 2003*	Queensland Health Human Resources Policy C3
Guardianship	In accordance with the *Child Protection Act 1999*, a person who has, or is granted, guardianship of a child has the powers, rights and responsibilities to attend to: • a child's daily care • make decisions that relate to day-to-day matters concerning the child's daily care • make decisions about the long-term care, welfare and development of the child in the same way a person has parental responsibility under the *Family*	*Child Protection Act 1999*

	Law Act 1975.	
Medical Examination	A medical examination is a physical, psychiatric, psychological or dental examination, assessment or procedure and includes forensic examination and an examination or assessment carried out by a health practitioner.	*Child Protection Act 1999*
Parent	A parent of a child is – 1. The child's mother, father or someone else having or exercising parental responsibility for the child; or 2. The Chief Executive Child Safety Services, for a child who is in the custody or guardianship of the Chief Executive Child Safety Services under the *Child Protection Act 1999* The following also applies: 1. A parent of an Aboriginal child includes a person who, under Aboriginal tradition, is regarded as a parent of the child. 2. A parent of a Torres Strait Islander child includes a person who, under Island custom, is regarded as a parent of the child. 3. A reference in this part to the parents of a child or to one of the parents of a child is, if the child has only one parent a reference to the parent.	*Child Protection Act 1999*
Treatment	The care and management of a patient to combat, ameliorate, or prevent a disease, disorder, or injury.	http://medical-dictionary.thefreedictionary.com/treatment

10. Approval and Implementation

Policy Custodian

Executive Director, Primary, Community and Extended Care Branch

Responsible Executive Team Member:

Deputy Director-General, Policy Strategy and Resourcing Division

Approving Officer:

Michael Cleary, Deputy Director-General,

Policy, Strategy and Resourcing Division

Approval date: 16 May 2012

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