IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT FD-17 TO STATEMENT OF FRANCES MARIE DIVER

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This is the attachment marked '**FD-17**' produced and shown to **FRANCES MARIE DIVER** at the time of signing her Statement on 3 August 2015.

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Attachment FD-17

Vulnerable babies, children and young people at risk of harm

Best practice framework for acute health services

A Victorian Government initiative

Victoria
The Place To Be

Vulnerable babies, children and young people at risk of harm

Best practice framework for acute health services

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Foreword

All of us are vitally interested in ensuring that children have the best chance in life. While most children living in Victoria enjoy physical, mental and emotional wellbeing, up to one in 11 children are affected by issues of child abuse or neglect, often as a result of long term poverty, social isolation, family violence, parental substance misuse, and parental mental health or disability issues. More than 50 per cent of children and young people at risk of serious harm come from families that experience domestic violence, and more than 30 per cent of vulnerable families have substance abuse problems (Department of Human Services 2005a). It is predicted that the numbers of children who cannot live at home with their birth parents will grow by more than 20 per cent by 2015–16.

The *Vulnerable babies, children and young persons at risk of harm: best practice framework for acute health services,* has been developed as a resource for health services to assist them in providing an effective health service response to vulnerable children. The framework takes into account the provision for increased information sharing, a focus on early intervention, and the need to consider cumulative harm when assessing concerns about the safety, health and wellbeing of vulnerable children.

The 'every child every chance' reforms aim to create a more integrated system of child development, youth and family services that focuses more directly on children's safety, health, learning and wellbeing. The legislative framework provided by the Children, Youth and Families Act 2005 (to be enacted in early 2007) is based on the fundamental principles of promoting the best interests of the child and supporting a more integrated system of effective and accessible child and family services with a focus on prevention and early intervention.

Victoria's acute health services have a key role to play in the care and protection of these vulnerable children through the early identification of child abuse and neglect. It is critical that our acute health services respond quickly and appropriately to meet the needs of these children, working together with community services, Child Protection and the justice system to achieve the best possible outcomes in what are often difficult and complex situations.

We know that the needs of these children and their families are often multiple and complex. We also know that we can more effectively assess a child's needs and the capacity of the parents to respond to those needs by working together to share information, professional knowledge and experience to improve decision-making and service delivery to ensure the child's safety and wellbeing.

I trust that health services will find this a useful tool in working together to provide the best possible response for vulnerable children and their families.

P.M. Faulkner

P M Faulkner
Secretary
Department of Human Services

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- Victorian Child Protection staff
- Vulnerable Children within the Health Sector Advisory Group:

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Contents

The framework

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Chapter 1: Introduction

Vulnerable babies, children and young people at risk of harm: best practice framework for acute health services, has been developed to document the vital role performed by public hospitals in identifying and protecting babies, children, and young people at risk of harm from abuse and neglect.

The framework comprises a suite of information and resources to enable hospitals as a whole, and individual health professionals who deliver acute health care, to:

- identify babies, children and young people at risk of harm from abuse or neglect
- respond rapidly and effectively to ensure the child's immediate safety and to set in train a multi-agency response that ensures that safety in the long term and supports the wellbeing of the child and family.

Protecting vulnerable babies, children and young people is everyone's business.

The framework is part of a broad, multi-pronged approach by the Department of Human Services to improve responses to these vulnerable children and the coordination and consistency of responses across the service system, with the aim of providing the best and most appropriate range of services for each child at risk and their family.

This approach includes tools to assist in identifying vulnerable babies, children and young people, the development of enhanced Victorian Forensic Paediatric Medical Services, education and training for acute health staff and increased liaison with regional Child Protection services both within the department and between health services and other agencies providing services for vulnerable children.

Child abuse and neglect in our community

'The long lasting and pervasive nature of the effects warrants a strong approach to early identification and intervention by the health sector.' [9]

Child abuse and neglect is a social and health phenomenon which effects up to one in 11 children.[11, 36] More than 30 per cent of vulnerable families have substance abuse problems. Family violence is a factor in more than half of substantiated child protection cases and children are present at more than half of police attendances for family violence in Victoria.[6, 9]

Babies, children and young people who are victims of abuse and neglect experience detrimental effects in their physical, cognitive, emotional, behavioural and social development. The fundamental damage caused by abuse and neglect can undermine the child's developing capacities for trust, intimacy, agency and sexuality.[15, 26]

As well as the personal impact of abuse and neglect on babies, children, young people, their families and carers, sequelae of child abuse and neglect include significant drains on the economic and social resources of health, education, community and justice sectors in responding to the victims and perpetrators. These costs are often life-long, as adult victims of childhood abuse are over represented in mental health services, drug and alcohol services and the prison population.

In Victoria 37,004 reports of child abuse and neglect were made to protective services in 2003–04. Of these, 12,424 cases (34 per cent) were investigated and 7,474 cases of abuse (20 per cent) were substantiated. Reports arising from hospital staff accounted for 1,337 cases: 736 cases (55 per cent) were investigated by Child Protection services and abuse was substantiated in 511 cases (38 per cent).

There is no record of the number of referrals made to social support agencies where there were concerns related to the child's safety and wellbeing which did not require a report to Child Protection.

Using the framework

The framework is relevant to all those who deliver and are responsible for the provision of acute health care, including health care executives, boards, administrators and managers, and clinicians. It provides clear direction on the critical role performed by Public Hospitals in ensuring the safety, health and wellbeing of all Victorian babies, children, young people, their families and carers. Information is provided to assist clinicians to identify children at risk and to take the appropriate steps to ensure their safety and wellbeing.

While the resource is designed primarily for public acute hospitals, much of the content is relevant for all health care service providers and can be easily adapted for other health care environments.

Scope

The focus of the framework is on those babies, children and young people who have experienced or are at risk of harm resulting from physical, sexual or emotional abuse or neglect. This includes those children who present at hospital for care, as well as siblings at home or children in the care of adult patients who may also be at risk of harm. The risk of harm may also stem from the child's or young person's own behaviour. Health professionals in acute hospitals need to be alert to any child or young person at risk of harm, be it self-harm or harm resulting from abuse or neglect by a parent or carer.

Terminology

The *Babies, children and young persons at risk of harm best practice framework for acute health services* is concerned with babies, children and young people under the age of 17 years or 18 years if under a protection order. Where the term 'child' on its own is used for brevity, it should be understood to refer to all babies, children and young people in this age group.

The terms 'harm' and 'abuse and neglect' are used in different contexts. In some contexts, it is preferable to focus on the harm to the baby, child or young person rather than the actions of the adult; at other times it is appropriate to focus on the abuse and neglect that is causing harm. Where the term 'harm' is used, it should be understood to mean harm resulting from abuse or neglect (unless otherwise qualified).

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The framework content

Chapters 2 and 5 contain information on different types of harm and factors that may indicate non-accidental injury or risk of harm from physical or sexual abuse or neglect to consider when assessing a baby, child or young person; specific issues for particular program areas are outlined in Chapter 6; and what actions to take if you form the belief that a child is at risk are detailed in Chapter 5.

The Appendices include:

- contact information for key agencies with expertise in the area of vulnerable babies, children and young people, child abuse and neglect, including a section where local referral agency contact information can be inserted
- standard proformas for reporting to Child Protection or Child FIRST and for exchange of information with Child Protection or Child FIRST
- extracts from the relevant legislation.

The *Vulnerable babies, children and young people at risk of harm: intervention guide*, available as a separate booklet, provides a summary of the seven steps for taking actions detailed in Chapter 5.

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Chapter 2: Patterns of risk and harm

Risk and significant harm

A baby, child or young person is at risk of harm when it is considered likely he or she may suffer physical, psychological or emotional harm as a result of what is done (physical, sexual or emotional abuse) or not done (neglect) by another person, often an adult responsible for the child's care. Young people may also be at risk of physical, psychological, sexual or emotional harm as a result of environmental factors (for example, homelessness) or self-harming behaviours.[28] Child abuse and neglect are not usually single incidents, but take place over time.

'There are many clinical situations where good practice demands that we ask ourselves the basic question: "Is this a situation where the baby, child or young person may have been abused or neglected or is at risk of harm?"'[28]

Forming a belief that a child is at risk of harm and in need of protection is a matter of professional judgement by the health professional; however, factors contributing to the 'significance' of harm include how acute or longstanding in nature the abuse or neglect is and the degree to which it is likely to interrupt or impair the child's development. Assessing significance entails considering the likely degree of harm, taking in to account the child's age, development and vulnerability.

Abuse affects children from all cultural and socioeconomic backgrounds. Children are vulnerable to abuse because:

- they are dependent on adults, with the power dynamics inherent in this
- they are not able, or may not have the opportunity, to stand up to adults and speak for themselves
- they are placed in the care of various people at different times (for example, parents, teachers, sports coaches, babysitters, family) where there is the potential for abuse to occur
- society generally promotes the notion that children 'belong' to their parents and therefore parents' rights outweigh children's rights.[15]

Types of harm

Physical harm

Physical harm refers to harm from an injury inflicted by a parent or caregiver. It can be life-threatening, and failure to adequately ensure the safety of a baby, child or young person may expose the child to extreme danger.

The injury may be inflicted intentionally or may be the inadvertent consequence of physical punishment, beating, or physically aggressive treatment (for example, shaking). A child may also be injured in trying to protect another person in a situation of family violence.

Injuries may include bruising, lacerations or welts, burns, fractures or dislocation, female genital mutilation, attempted suffocation or strangulation. Physical injury and significant harm to a baby, child or young person may also result from neglect by a parent or caregiver or from failure to adequately ensure the safety of a child.

Sexual harm

Sexual harm refers to a situation in which a person uses power or authority over a baby, child or young person to involve them in sexual activity, and the parent or caregiver has not protected the baby, child or young person. Physical and/or psychological coercion is intrinsic to child sexual assault and differentiates it from consensual sex with a peer. Adults, adolescents or older children who sexually assault children or young people exploit their dependency and immaturity. Child sexual abuse involves a wide range of sexual activity, including fondling of the genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or other object, or exposing the child or young person to pornography.

'Professionals who come into contact with children, particularly those involved in child health and welfare, must consider the needs of each and every child – regardless of the child's background and socioeconomic status.' [15]

The apparent consent of the child or young person may not mean that abuse did not occur. Although a child or young person may perceive sexual activity as consensual because of the way the other person involved has promoted it, the situation may be one of sexual abuse and exploitation.

It is important to report sexual assault to a child that happened in the past, as the alleged perpetrator may still have contact with babies, children and young people (for example, in a family setting or as a teacher or other worker involved with children or young people).

A child or young person who is exhibiting sexually problematic or abusive behaviour should be considered at risk of harm. If health service staff have reasonable grounds to suspect that a child or young person is exhibiting such behaviour, they should make a report to Child Protection or a sexual assault treatment service. There is provision under s. 185 of the Children, Youth and Families Act for a report to be made to Child Protection based on a belief that a child aged ten to 14 years is in need of therapeutic treatment as a result of exhibiting sexually abusive behaviours.

Research shows that the potentially profound effects of serious sexual assault on a child or young person are not always obvious and disclosure of the abuse is often delayed. A child or young person who has experienced past serious abuse, including sexual abuse, should be considered at risk of harm even if no obvious concerns are apparent. Reporting such abuse enables follow-up by employers if the alleged perpetrator still works with or cares for babies, children and young people.

All sexual assault of children is a crime and must be reported. In the case of young people, however, it is essential to engage with the young person and ensure they are involved in the decision making about their care.

Emotional harm

Emotional harm refers to a situation in which a parent or caregiver (who might be an older child or another person) repeatedly rejects the baby, child or young person or uses threats to frighten him or her. Such behaviour can damage the child's confidence and self-esteem and result in serious emotional deprivation or trauma. It may involve name-calling, put-downs or continual coldness from the parent or caregiver to the extent that it significantly damages the child's physical, social, intellectual or emotional development.

A child or young person may also experience emotional harm when living in a situation of ongoing family violence.

Neglect

Neglect refers to a situation in which a parent or caregiver fails to provide a baby, child or young person with the basic physical necessities of life, such as food, clothing, shelter, medical attention or supervision, to the extent that the child's health and development is, or is likely to be, significantly harmed.

Neglect of basic psychological needs can occur when the baby, child or young person does not receive sufficient or appropriate interaction, encouragement, nurturing or stimulation from their parent or carer. Neglect also refers to the persistent ignoring of a child's signals of distress, such as pleas for help, attention, comfort, reassurance, encouragement and acceptance. This may include lack of interest by the parent or carer in all aspects of a young person's life.

Situations of neglect may also arise in relation to the care of babies, children or young people with medical needs where the parent or caregiver is unable or unwilling to provide the medical care required to maintain the child's wellbeing, health and development (see 'Children with medical needs', page 13). These children often require complex medical care to maintain their health or palliative care during terminal illness. Situations may also arise where a parent's refusal to allow medical intervention that could impact on a child's long-term wellbeing.

Cumulative harm

Cumulative harm refers to the effects of patterns of harm over time that may impact on a child's safety and development. There is a focus on the accumulation of risk factors rather than seeing each in isolation.[12] Under s.10 of the Children, Youth and Families Act the effects of cumulative harm are specifically referred to as requiring consideration in determining decisions or actions to take in the best interests of the child. s162 also states 'harm may be constituted by a single act, omission or circumstance or accumulate through a series of continuing acts, omissions or circumstances'.

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Patterns of risk at different ages

Babies

Abuse and neglect in the first two years of life can have significant long-term neuro-developmental consequences. Risk in this age group may relate to a number of factors, many of which may be identified by health service staff working with pregnant women. Risk factors include:

- use of hazardous drugs or alcohol during pregnancy
- a family violence situation
- mental health problems or intellectual disability, which can compromise a woman's ability to care for her child
- poor attachment to the infant
- absence of social supports or isolation
- unstable housing or financial situation.
- history of own abuse or neglect or that of another child in the family

The baby's health needs may compound these difficulties.

Early supportive intervention, particularly during the antenatal period, provides an opportunity to identify special needs and to assist pregnant women to plan for the care of their baby. In some cases this may include making a referral to a Child, family information, referral and support team (Child FIRST) or other appropriate agency or making a report to Child Protection on an unborn child because of significant concerns for the wellbeing of the child once it is born. This may reduce the likelihood of the baby suffering the effects of harm or of being placed in out-of-home care.

Children

Once children become more mobile they are at an increased risk of accidental trauma and they therefore require close supervision while they explore and learn about their environment. Factors such as parental drug and alcohol addiction, mental illness and intellectual disability negatively impact on an adult's capacity to provide appropriate supervision, nurturing and care. All professionals working with adults who require treatment and intervention services for addiction, mental illness and intellectual disability should remain vigilant about the needs of the index patient's children.

Inadequate supervision and environmental neglect can predispose toddlers and young children to significant risks of physical harm and can be fatal. The lack of a secure relationship with a primary carer and inadequate stimulation negatively impacts on children's development, including the development of a coherent positive self-concept and the capacity to form intimate relationships. The importance of adequate nurturing in early life cannot be over-stated.

Because it may be difficult to differentiate deliberately inflicted injuries from injuries that occur as a result of an accident, professionals working in areas where injured children are treated should remain alert to the possibility of child abuse. This is particularly pertinent for younger, pre-verbal children who are vulnerable to significant physical harm from deliberately inflicted trauma.

Primary school children are at risk of physical and sexual abuse. Punitive disciplinary practices, an authoritarian parenting style and sub-cultural tolerance for aggression can place some children at increased risk for physical harm.

Neglect of children's educational, dental and health needs as well as social relationships can also impact on their capacity to successfully transition to adolescence.

Young people

The transition through adolescence can be a time of risk-taking, with young people placing themselves at an increased risk of harm through experimentation with drugs and alcohol. Factors that reduce the quality of a young person's relationship with adult family members can further increase the risk of harm from a variety of causes. The 2006 annual report of inquiries into the deaths of children known to Child Protection reported that seven of the 20 deaths reviewed by the Victorian Child Death Review Committee (2006) were of young people aged 13–18 years, stating, 'All presented with extremely challenging and high risk behaviours and had a multiplicity of needs relating to mental illness, substance use and transience'.

Adolescence is also a time of increased risk of unwanted sexual experience. All professionals working with adolescents should remain sensitive to the needs of young people who might require medical intervention and treatment following an unplanned and/or unwanted sexual experience. At times there is a need to balance the young person's need for protection and care with the mature minor's right to self-determination.

The safety and emotional development of young people is also likely to be negatively impacted where they are functioning without adequate guidance, limit setting or opportunities for reflection and learning about strategies for resolving conflict.

Issues related to a mature minor's right to consent to medical treatment, in the absence of parental consent, is complex and health professionals are advised to seek advice on individual case management.

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Vulnerable populations

Children from all cultural and socioeconomic backgrounds are vulnerable to adversity, child abuse and neglect; however, evidence suggests that some, due to their age, genetic predisposition or psychosocial situation, are at higher risk of some forms of harm.

Aboriginal babies, children and young people

The issue of child abuse and neglect in Australian Indigenous communities is considered to be particularly serious and is one that needs to be understood and addressed from a broad perspective that includes both historical and present day issues.[34]

A number of prominent Indigenous spokespersons believe many of the problems presenting in some Indigenous communities today are the result of the experiences of the past where Aboriginal people were subjected to racism and violence from the early days of European settlement.[34]

Government policies of dispossession, segregation and assimilation contributed to the present disadvantage through the dislocation of indigenous communities from their land and the forced separation of children from their families and communities. These children, the 'stolen generations' were deprived of the nurturing of family and community. This has contributed to loss of identity, and other problems for the children, their families and communities and is reflected in contemporary social problems including alcohol, poverty, drug addiction and family violence, which are creating present day stresses for Indigenous people.

The Australian Institute of Health and Welfare 10th biennial report noted that 'data from a number of sources indicate that the Indigenous population is disadvantaged across a range of socioeconomic factors that affect health' these include lower incomes than other Australians, higher rates of unemployment, poorer education achievements and lower rates of home ownership. The report also highlighted that the death rate for Indigenous infants and children (under 15 years) generally remains about three times those of other Australian infants and children. (p.278).[3]

Aboriginal children and young people continue to be overly represented in Child Protection and, for many adults, the experience of the 'Stolen Generation' is still a live issue.

Further information is available in Chapter 8: Working with Indigenous babies, children, young people and their families' on page 69.

Children with health related needs

Children with a disability

Children with a disability are more vulnerable to abuse and neglect than other children.[13, 25] Prolonged dependency and a high incidence of communication problems increase their vulnerability. Deaf children and those with severe physical disability have been identified as being at particular risk.[30] This is particularly problematic if the child's 'interpreter' or carer is also the abuser.[15]

Children with medical needs

Situations of neglect may arise in relation to the care of babies, children or young people with acute or chronic health needs where the parent or caregiver is unable or unwilling to provide the medical care required, sometimes over long periods, to maintain the child's health and development or to provide palliative care during a terminal illness.

Acute health staff need to consider whether risk of harm is likely to arise from a failure to arrange for medical care for an acute or chronic illness or injury. For very young children, the risk of harm may be high. Failure to seek medical care does not always pose a risk of harm to the child, depending on the type and severity of the illness or injury, but some conditions (for example, burns) may require urgent medical attention and failure to provide this can be life threatening.

Some forms of medical intervention, such as immunisation, are widely debated in the community and would not for these purposes be included within the definition of 'necessary medical care'. Similarly, cultural or parental beliefs may lead a parent or carer to decide on a particular course of treatment for a condition. If these decisions do not result in a baby, child or young person being deprived of necessary medical care, then no abuse has occurred.

Acute health services are often the key care providers for medically fragile babies, children and young people and those requiring palliative care. The day-to-day medical needs of these children are complex, and they and their families require additional support and services to care for their specific needs. Health service staff can assist through early identification of risk and instigating support services and review processes. The potential harm to a child through the neglect of medical needs is best understood by health service professionals and should be made clear to others responsible for the child's care.

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Children with Munchausen syndrome by proxy (fabricated or induced illness by carers)

Munchausen syndrome by proxy (also known as 'fabricated or induced illness by carers' is defined as 'the deliberate production or fabrication of physical or psychological symptoms in a child by a parent or carer'. Typically, suspicion of this situation arises when children are repeatedly presented to medical practitioners or hospitals with symptoms that are difficult to explain. Such children may present with symptoms that are induced (breathlessness or choking caused by suffocation) or fabricated (for example, fictitious seizures).[10]

The outcomes for children range from mild to severe harm and, in extreme cases, death. The child may be at risk of physical or psychological harm as a consequence of either:

- the carer's behaviour (for example, poisoning) and failure to provide a nurturing environment to meet the child's emotional and developmental needs
- unnecessary medical intervention (for example, unnecessary surgery, psychological assessment, medication or hospitalisation).[10]

Children at risk because of social or family context

Vulnerable children and families very often have issues and problems that span a number of different program areas at different times, including (but not limited to) child protection, mental health, drug and alcohol, disability services, housing, education, financial support, family support and health services. While some of these professionals may pick up some of the warning signs, it is unlikely any one professional will be aware of the whole picture. For this reason it is important that professionals share information. Within Victoria there have been many initiatives aimed at enhancing cooperation, coordination and collaboration between services across these sectors, and it is vital that services and programs continue to work together and develop strategies that are consistent in their approach.[41]

Children in out-of-home care

Many children placed in out-of-home care have experienced extreme family dysfunction over a long period of time, as well as episodes of abuse. They frequently have significant emotional and behavioural problems[16] as well as developmental delays and neglected health needs.[31] These children are mainly cared for by extended family and foster carers, although a small proportion are cared for in residential establishments. Their health, developmental and behavioural needs may not be met because of instability in their care arrangements, limited assessment, and various barriers to accessing appropriate medical, allied health and mental health services. The children and young people's experiences can make them challenging to care for and they may remain vulnerable to inadequate care and further abuse unless caregivers are well supported and appropriate services provided.

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Children in a situation of family violence

'There is nothing new about violence within families. What is new is to treat it as a health issue and to develop policy and interventions to prevent it'.[23]

Exposure to family violence can constitute a form of child abuse. A baby, child or young person may be harmed directly or indirectly by physical violence when they are attempting to protect another person. The child may also experience emotional and psychological trauma by living in a climate of fear and intimidation in a home where violence occurs.[27]

Child abuse frequently co-exists with family violence.[39] One in five Victorian women are directly affected by family violence over the course of their lifetime, and it is the leading contributor to preventable death, disability and illness in Victorian women aged 15 to 44 years.

Family violence is a factor in more than half of all substantiated child protection cases and children are present at more than half of police attendances for family violence.[6, 9] Pregnant women are particularly vulnerable to family violence, with 42 per cent of women responding to the Australian Women's Safety Survey reporting they experienced violence during pregnancy.[1]

Family violence, whether witnessed or experienced, has harmful effects on children's and young people's physical, cognitive, emotional, behavioural and social development. Effects may include depression, withdrawal, low self-esteem, poor performance at school, truancy, aggression, tantrums and anxiety[21, 35] The severity of the problems increases with the severity of the violence.[9]

The estimated cost to the Australian economy is $8.1 billion a year, including around $2 billion lost to the Victorian economy.[35] The economic costs to the health sector include costs relating to general practitioner subsidies, psychiatric and psychological services, community health and welfare, social worker and group services, child guidance clinics, and hospitalisation, including accident and emergency, outpatients and admissions, and dental treatment.[9]

Children of parents with a drug or alcohol problem

Many studies have reported the co-occurrence of parental substance abuse and child abuse.[38] Substances involved include alcohol, marijuana, heroin, ecstasy, amphetamines and inhalants. Women using illicit drugs are reported to be less likely to access prenatal and postnatal care and more likely to avoid seeking help for parent-child problems, fearing that their drug use will be exposed and this may lead to intervention by child protection authorities. They may perceive that nothing is wrong, lack interest in parenting, be isolated or marginalised from traditional health services, or lack access to relevant services, particularly in rural regions and urban areas of poverty.[15, 37]

A thorough assessment of a woman's family, risk factors and strengths during pregnancy and in the postnatal period will help identify the supports that may be needed to make sure that an infant will be nurtured and protected and families are linked to a network of services. The Children, Youth and Families Act, which comes into effect in October 2006, enables an unborn child report to be made to Child Protection

or referral to community-based child and family services where there are significant concerns for the wellbeing of the baby after he or she is born. This has the potential to provide the catalyst for early assistance (see 'Maternity and neonatal departments', page 50).

Children of parents with a mental illness

Mental illness can jeopardise a parent's capacity to function adequately[32] and drug or alcohol use often compounds the problem. Depression, substance dependence and personality disorders are the most frequently reported psychiatric conditions affecting parents who abuse their children. Parents with mental illness might experience difficulty relating to their child, display impulsive physical discipline or fail to meet the child's emotional and developmental needs. Parents with psychotic illnesses comprise a significant proportion of parents who kill their children. All professionals working with parents with a mental illness are encouraged to enquire about the children and take action to ensure the children's safety and wellbeing.[2, 15]

A thorough assessment of a woman's family, risk factors and strengths during pregnancy and in the postnatal period will help identify the supports that may be needed to make sure an infant will be nurtured and protected and the family is linked to a network of services (see 'Maternity and neonatal departments', page 50).

Children of a parent with an intellectual disability

Many people with an intellectual disability have little understanding of the complexities of pregnancy and it is not uncommon for pregnancy to be confirmed later than is usual with non-intellectually disabled mothers. A number of women with an intellectual disability may have difficulty in discussing their pregnancy and be less likely to attend antenatal classes or regular antenatal checks.[7]

Parenting is also more difficult for people with an intellectual disability. The needs of people with an intellectual disability will vary from person to person and over time as their circumstances and the needs of their child or children change. It is necessary to assess the individual needs of a parent to provide a well structured plan to assist in skill development. Collaboration between services such as disability and protective services and maternal and child health is important to ensure appropriate assessment and care planning.

It should be remembered that the child is the most vulnerable member of the family; the highest priority is to ensure that the child is safe and their physical, emotional and developmental needs are met.

Chapter 3:
The service system for vulnerable children

A shared responsibility

Responsibility for ensuring that the needs of babies, children and young people are met and that they are safe within their families is shared between the family, the community and the government. When adults who care for children do not meet their responsibilities or are abusive, then the wider child protection system is responsible for taking action to ensure children are safe and well cared for.

Acute hospitals have a special role in ensuring children's safety, in that they come into contact with a large number of babies, children, young people and their families or carers. They are in a position to identify those at risk of harm from abuse and neglect and to intervene early to reduce that risk, prevent harm, and support the wellbeing of both child and family. At times they may need to weigh concerns about the wellbeing and risk of harm to a child against considerations of client or patient privacy or therapeutic relationships. When determining the most appropriate course of action, it is important that health professionals consider the possible harmful effects of not reporting concerns about the child's safety or development.

Hospitals do not act alone in ensuring children are protected and safe from harm. The most effective response involves collaboration and coordination of care across all relevant agencies to provide the most appropriate combination of services for each child at risk and their family.

The reforms associated with the implementation of the Children, Youth and Families Act 2005 seek to establish a range of responses based on close cooperation between Child Protection and family services aimed at supporting and assisting children and their families in a timely way, that responds to the complexity of family needs, the level of risk to children and the capacity of the family to support their children. These responses promote early intervention and provision of sustained supports and services, which reflect a family's changing needs and focus on a child's wellbeing and development.

This chapter provides an overview of the service system for children at risk, which spans universal services, secondary and specialist services, and tertiary child protection and out-of-home care services.

In all interventions, the safety and wellbeing of the child is paramount, and the emphasis is always on early intervention to support families, promote healthy development and prevent harm.

A continuum of services

Health, community and early childhood education services play a critical role in promoting and monitoring the health and development of babies, children and young people, and supporting families. Families have a variety of complex needs and the network of child and family services reflects this diversity. These services fall into three broad categories, although these categories often overlap in their roles and responsibilities. The categories are:

- **universal services.** Services that are offered to everyone. They include antenatal services, maternal and child health services, preschool and school education services, and general practitioners. They provide the critical foundations for health and learning for all children, including vulnerable babies, children and young people, and their families. In many cases, universal services help to prevent abuse and neglect occurring, and they may be the first to identify vulnerable children. Acute hospitals, while offering specialist care, also offer a universal service, particularly through their accident and emergency departments
- **secondary and specialist services.** These services provide more intensive and targeted support where a problem has been identified and offer programs that identify and reduce the personal and social stresses on parents that lead to family breakdown and/or child abuse. Services include in-home family support, financial and family counselling, respite care, drug and alcohol services, health and mental health services, disability services and housing services. Under the Children, Youth and Families Act referrals can be made to community-based child and families services that are registered under s. 47b of the Act where there are 'significant concerns for a child's wellbeing'
- **tertiary child protection services.** These services include the statutory Child Protection services, and out-of-home care services for children who are unable to live at home because of the risk of harm. A strengthening of the secondary service sector, in line with current government policy on the broader service system support, means that the Child Protection service's role is a service of last resort. Where there is a 'belief that a child may be in need of protection', a report should be made to Child Protection.

The responsibility for ensuring babies, children and young people are protected lies with all services that provide care for babies, children and young people. The best outcomes will be achieved when agencies work together to provide the best combination of services. Optimal care requires:

- a shared commitment to promoting healthy development, wellbeing and protecting children from harm a shared understanding of the aims of intervention and of what is good practice
- a shared understanding of the context in which agencies work and acknowledgement of their strengths and constraints
- a shared appreciation of and respect for different roles and different contributions of practitioners.[28]

Acute health

Hospitals

Public hospitals are an integral part of improving the health and wellbeing of our children. Acute paediatric health care services are provided throughout Victoria. More than 167,000 children (0–17 years of age) were admitted for inpatient care across metropolitan, regional and rural acute health services, and emergency departments provided care for almost 290,000 paediatric presentations in Victorian hospitals in 2003–04. More than 6,000 of those children presented to emergency departments with injuries noted to be associated with assault, maltreatment or neglect, although in many cases insufficient information was available to determine how the assault was sustained.

'Child abuse is a serious health problem affecting a significant proportion of the paediatric population and we have a responsibility as health professionals to ensure the diagnosis is made and children protected'.[8]

Acute health services are often the first point of contact for babies, children and young people at suspected risk of harm from child abuse and neglect. This places a special responsibility on hospital staff to identify this risk and reduce it by offering crisis support, ongoing care, and referral to specialist intervention services and by working with other agencies to provide the best combination of services for a particular child and family.

Acute services also see adult patients whose health status or lifestyle (such as physical or mental health problems or disabilities, and substance abuse) may place their children at risk of harm. In such situations, health care staff have a responsibility to intervene early to ensure the child's safety, as well as to care for and support the parent and family.

The specific roles and responsibilities of acute hospitals and their professional staff are discussed in Chapter 4: Acute hospital roles and responsibilities'.

Specialist services within the acute health sector

Where abuse or neglect is suspected, the baby, child or young person may need referral to a paediatric forensic medical service. The Victorian Institute of Forensic Medicine defines Paediatric forensic medicine as encompassing 'the areas of suspected non-accidental injury of children, sexual abuse and physical and emotional neglect. The examination of children for forensic reasons is a specialised area in which both appropriately trained paediatricians and forensic physicians have expertise. Such examinations are usually performed as part of a comprehensive, integrated, forensic and child health service'.[43]

In Victoria, specialist services for physically and sexually abused children are coordinated through the Victorian Forensic Paediatric Medical Service. Provider partners include the Monash Medical Centre, Royal Children's Hospital, and the Victorian Institute of Forensic Medicine. Metropolitan services are located at the Gatehouse Centre, the Royal Children's Hospital and the Angela Taylor Child Protection Unit, located at Monash Medical Centre. The service provides a multidisciplinary response, which may include social workers, psychologists, psychotherapists, paediatricians and forensic physicians providing a range of assessment and treatment services.

Forensic paediatric medical services in Victoria are currently being strengthened to improve services for vulnerable children in rural and regional Victoria. In addition to providing forensic paediatric medical assessments, the service will be a source of expertise, advice and referral for all Victorian health service staff, Child Protection and Victoria Police. Other components of the service include providing education on child abuse and neglect to Child Protection, Victoria Police and health service staff and undertaking research to improve the evidence base for identifying and caring for children who have suffered abuse or neglect.

The Victorian Forensic Paediatric Medical Service works closely with Child Protection services to assist in the assessment and treatment of children who have experienced harm through abuse and neglect.

The South Eastern Centre Against Sexual Assault provides services within the department's Southern Metropolitan Region to female and male children and adults who have been sexually assaulted. The centre also works with non-offending family members, partners, caregivers and support workers.

Other Centres Against Sexual Assault (known as CASAs), which are sometimes co-located with public hospitals, provide support and assessment to children and adolescents for suspected sexual abuse (see www.casa.org.au for a complete listing of centres and their locations). The Children's Protection Society's sexual abuse counselling and prevention program provides specialist intensive therapeutic services to children who have been sexually abused, children under ten displaying sexualised behaviour and young people with sexually abusive behaviour who have been reported to the police.

The Office for Children

The Office for Children, within the Department of Human Services, was established to ensure a consistent approach across Victorian Government policies, programs and services for Victorian children and their families, with greater coordination and sharing of resources between related programs and improved outcomes for babies, children, young people and families.

The Office for Children brings together:

- universal early childhood care, education, health and disability programs
- programs to assure the safety and wellbeing of vulnerable children
- juvenile justice services and other programs to support vulnerable young people
- state concessions programs targeted at lower income families and individuals.

The Child Protection and Family Services Branch, within the Office for Children, works to ensure the safety and wellbeing of adolescents and children at risk of harm, abuse or neglect. Services are provided through a network of Department of Human Services

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regional offices and funded agencies to provide children and young people at risk of significant harm with safety, stability and assistance to develop skills necessary for their future. These services include:

- Victoria's Child Protection service
- accommodation and support services for children and adolescents in care
- adoption and permanent care
- family services
- sexual assault services
- family violence services
- the victims' assistance and counselling program.

Service functions include:

- investigation of child abuse
- support services for families
- case management and support services for children and young people who have experienced abuse or neglect
- placement prevention and support
- home-based and residential care
- provision of advice to court.

'A basic understanding by medical professionals of child protection and the legislation is crucial if they are to provide appropriate advice to assist in formulating risk assessments and guide risk analysis.'[42]

The type of service provided by the Child Protection service is determined by the seriousness of the risk of harm to the child's safety and wellbeing. Currently, Child Protection refers many families to child, youth and family services however the safety of children and young people at risk of significant harm cannot always be addressed through the less intrusive support offered by secondary services. The implementation of the Children, Youth and Families Act 2005 will result in new options for professionals and others referring and reporting situations where a child's safety or wellbeing may be at risk.

Family services

Under the new system, currently being established, professionals and others are able to refer situations where there is a significant concern regarding a child's wellbeing, or an unborn child where there is concern for the child's wellbeing at their birth, to a child, family information, referral and support team (Child FIRST). Child FIRST will operate on a sub-regional basis and provide entry to secondary child and family services in a local area.

Child FIRST will receive referrals about families where it is considered that a family is facing severe stresses that are impacting on a child's wellbeing and where there are concerns about the parents' capacity to deal with those stresses. Child FIRST will seek to engage families in appropriate services, often involving intensive family support services. It will provide a preliminary assessment of the range of services a family may need, and help the family to access those services. A family's involvement in assessment and ongoing services will be voluntary.

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This builds on the approach developed through the Family Service Innovation Projects (FSIP). Families requiring services provided through Family Service Innovation Projects generally have multiple and complex needs that are likely to impede the child's development.

The FSIP's service approach includes:

- actively linking and engaging families with broader health, community and early years services
- provision of interventions in a timely manner to minimise the need for Child Protection involvement where appropriate
- a continuum of services tailored to meet the family's individual needs delivered in ways that cater for changing needs
- sustained longer term individual support for families using a child/youth centred, family focused approach that ensures the needs of children are at the centre of assessment, planning and interventions
- collaboration and consultation with Child Protection to develop effective diversionary responses and assess risk and cumulative harm.

Child Protection has a role only when services in the primary and secondary system are unable to sufficiently ensure the safety and wellbeing of the child in collaboration with the family. However, in situations where a child may be at risk of significant harm reports should still be made directly to Child Protection.

Child Protection services

Under the Children, Youth and Families Act 2005, the Victorian Child Protection service has responsibility for receiving reports and where necessary, undertaking investigation of children who may be harmed (or at risk of harm) and in need of protection.

Specifically, Child Protection:

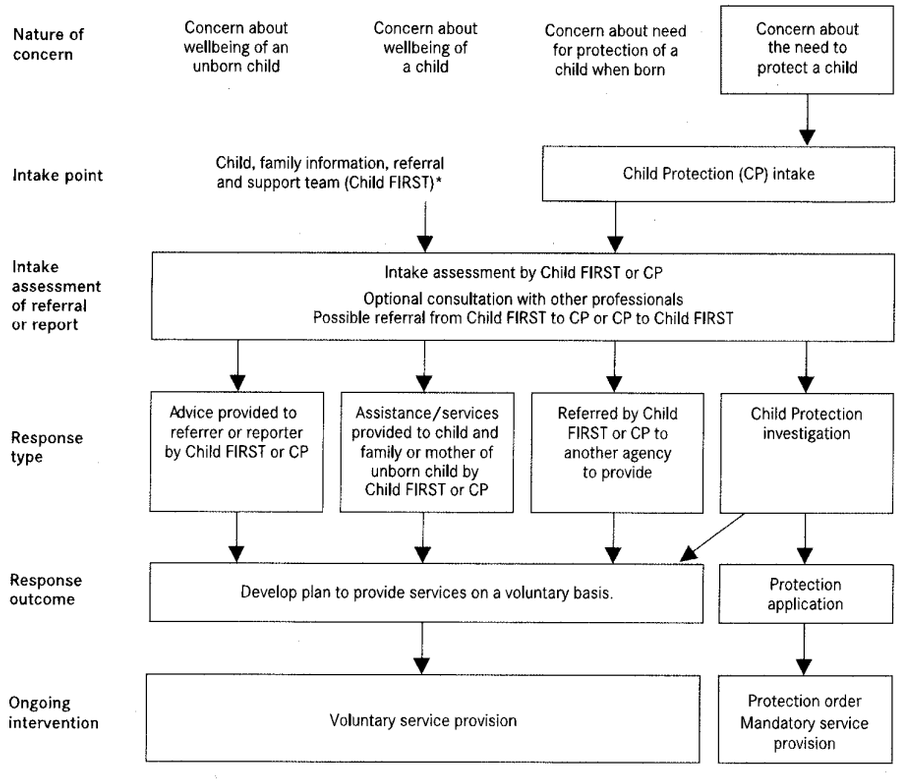
- receives reports from people who believe on reasonable grounds that a baby, child or young person is in need of protection
- undertakes risk and wellbeing assessment of the baby, child or young person and the family, in order to determine whether they are in need of protection as specified in the Children, Youth and Families Act 2005
- investigates matters where it is believed that a child is at risk of significant harm
- refers babies, children, young people and families to universal and secondary services that assist in providing the children's ongoing safety and wellbeing
- determines whether a baby, child or young person is in need of care and protection
- takes matters before the Children's Court if the child's safety and wellbeing cannot be assured within the family with the support of community based services

- provides ongoing case management and casework to babies, children, young people and their families during protective intervention (including children on court orders)
- works with babies, children and young people and their families who are subject to legal orders granted by the Children's Court

Diagram 1 shows the types of reports that can be made and how they might be responded to, depending on the information available on which to base an assessment.

Diagram 1. Child Protection and family services referrals, reports and response pathways

Those reports or processes, which appear in grey, relate to changes associated with the Children's Youth and Families Act to be in enacted in early 2007.



**referred to in the Children's, Young persons and Family Act as community-based child and family services.*

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Victoria Police

In relation to the protection of vulnerable children, Victoria Police:

- deals with criminal matters that arise in child abuse and neglect investigations
- investigates and enforces intervention orders under the *Crimes (Family Violence) Act 1987*. Intervention orders may remove abusers from the home, which allows children to remain safely at home
- assists Child Protection workers where there are concerns about the safety of workers and family members
- activates a criminal investigation whenever reasonable grounds exist for believing that a child has been physically or sexually abused, suffered serious neglect or left unsupervised.

Chapter 4:
Acute hospital roles and responsibilities

Acute health services, as discussed earlier, have a special role in ensuring children's safety, in that they see large numbers of babies, children and young people and are in a position to identify those at risk of harm from abuse and neglect and to intervene early to reduce that risk, prevent harm, and support the wellbeing of both child and family.

This section sets out the organisational roles and responsibilities for acute hospitals in relation to vulnerable babies, children and young people. Health care managers and administrators need to read this section in conjunction with Chapter 5, which sets out specific individual responsibilities and actions for health care staff.

Action is needed across the state to achieve best practice in this area. A recent audit of Victorian public hospitals revealed diverse and inconsistent approaches to responding to vulnerable children and a need to improve the understanding of the role hospitals and health staff play in protecting babies, children and young people from harm. Of the 15 metropolitan heath services surveyed, 11 had some type of documentation related to vulnerable children ranging from mission statements and directives to comprehensive protocols. When asked about staff awareness of child abuse and neglect indicators and general issues, seven out of 15 stated staff awareness was generally poor. Results from the 18 regional and rural services that responded to the survey were similar, with slightly fewer, ten of the 18, having some type of documentation relating to vulnerable children. This ranged from formal protocols and procedures to information on mandatory reporting. In response to the question of staff awareness, 11 didn't consider they were able to comment, three thought staff awareness was poor, and four respondents believed their staff had a good awareness of general child protection issues.

The majority of respondents commented that greater opportunities for staff training in the identification and management of children at risk of abuse or neglect would be welcomed.

This best practice framework provides health services with the key elements of an effective response to vulnerable children which can be adapted to fit with organisational structure, patient population and local community.

Principles

Four basic principles underpin this framework and provide a basis for local policy and procedure development and external interagency practice and cooperation:

1. **Child protection is everyone's business.** All services that work with families will share responsibility for and contribute to the wellbeing and safety of babies, children and young people
2. **The best interest of babies, children and young people** will be at the heart of all decision making and service delivery across the service system
3. **Health and other services will act together** to form an integrated, cohesive and coordinated service system so that babies, children, young people and their families receive the best combination of services to meet their needs
4. **Health services will deliver services that are appropriate and sensitive** to the culture, disability, gender, language, religion and sexuality of the baby, child or young person, their family and caregivers.

Key elements of an effective health service response

These elements comprise the essential components of an effective health service response to vulnerable babies, children and young people. They should be incorporated into each health service's program, modified to the organisation's environment, population and resources.

1. **A core responsibility**: Protecting babies, children and young people from child abuse and neglect needs to be seen as integral to the provision of health services to babies, children, young people and their families, and a core responsibility for all health service staff.
2. **Protocols, policies and programs**: Health services should have in place specific protocols, policies and programs that detail the service's response to child abuse and neglect. Services should be consumer-focused and designed with consumer and community input and collaboration.
3. **Early identification**: Health service staff should be able to recognise child protection issues at all entry points to health services.
4. **Staff support and consultation**: All health service staff should have access to support and consultation regarding child abuse and neglect.
5. **Appropriate referral**: Health service staff should be aware of and able to competently refer to appropriate services within and external to the health service, including reporting to Child Protection services if required.
6. **A comprehensive, holistic response**: Relationships should be developed with internal and external services to ensure services delivered to vulnerable babies, children, young people and their families are managed and coordinated both internally and externally to provide a comprehensive and holistic response.

7. **Staff training and education**: Training and education programs in child protection issues are essential for health service staff and should be developed and delivered according to the ongoing needs of the unit and the health service.
8. **Evidence-based care**: Research and emerging good practice should inform service delivery and health services should contribute to the evidence base.
9. **Continuous improvement**: Policies, programs, processes and outcomes for vulnerable babies, children and young people should be regularly reviewed and evaluated to enhance practice and improve the organisational response to babies, children and young people at risk of abuse and neglect.

Everyone's business

Protecting vulnerable babies, children and young people is everyone's business, and everyone within the health service shares this responsibility, including the board, managers and administrative staff, and individual health professionals. Commitment and leadership are therefore needed at all levels of the health service to ensure the service as a whole, and individual health professionals, respond effectively to children at risk.

These responsibilities sit within the clinical governance framework that is required to be in place in all public health services. Clinical governance refers to boards' accountability for ensuring a framework and rigorous systems are established so health care safety and quality is monitored and supported, evaluated and continuously improved.[22]

Under this framework, all levels of the organisation share responsibility and accountability for the pursuit of clinical excellence, providing best practice and high quality patient care and continuously monitoring and improving the quality of that care.

The responsibility for identifying and caring for vulnerable babies, children and young people does not rest with clinical staff alone. Non-clinical staff need to be involved in awareness raising campaigns and educated around their responsibilities as part of the broader community.

The clinical governance framework provides for clear accountabilities for all roles in health care improvement. This includes health care consumers. Their involvement, with health care providers, in bringing about improvements in the clinical, social, emotional and cultural aspects of care and services will help to ensure service improvement is truly consumer-focused, rather than biased towards provider concerns. 'Consumers' in this context can be taken to include advocates, carers, clients, parents, patients, representatives, volunteers and other social service providers such as child protection services. Effective consumer collaboration requires that health services have a high level of awareness of and active liaison with community and social support agency resources.

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Acute health services for vulnerable children and their families

Acute public hospitals provide emergency, general and specialised medical care, crisis support and ongoing counselling to Victorian babies, children, young people and their families and carers through a range services and programs. These include:

- medical treatment for babies, children and young people where abuse or neglect is suspected or has been identified
- medical examinations, including a developmental assessment for babies, children and young people where there is an allegation of physical or sexual abuse or neglect
- forensic medical examinations and reports for legal proceedings, through the specialist paediatric forensic medical services (see page 19)
- psychosocial/psychiatric and developmental assessment of children and young people where psychological abuse or neglect has been suspected, including the preparation of court reports where appropriate
- crisis and ongoing counselling and advocacy services for children, young people and their families who have been sexually abused
- counselling for children and young people exhibiting sexually problematic or abusive behaviours
- referral to early intervention and support to prevent abuse or neglect
- drug and alcohol services
- mental health services for children and adolescents
- mental health services for adults
- maternity services.

Hospital responsibilities: actions and elements of a holistic response

In working with vulnerable babies, children and young people and their families, the aim is, wherever possible, to prevent harm occurring and to recognise not only abuse, but risk of abuse. Acute health services therefore need to offer a hierarchy of responses, from prevention and early intervention to crisis intervention, and work with community-based child and family services as well as Child Protection.

Hospitals also need to support staff in what can be a very stressful process, and one in which inadequacies in management may have disastrous consequences. Clinicians may, for example, have concerns relating to the consequences of challenging parents, inadequate training, confidentiality, a deep-seated inability to acknowledge abuse or a view that child protection is somebody else's business.[4]

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'It is vital that formally agreed guidelines are adhered to and that senior and appropriately trained medical and nursing staff are involved.'[20]

Hospitals need to have in place:

- **internal protocols and processes** which:
  - clearly identify the protection of vulnerable babies, children and young people as core business for hospitals and as the responsibility of all health staff
  - reflect best practice for early intervention and prevention of child abuse and neglect
  - ensure a coordinated and consistent approach and response to vulnerable children and their families
  - are readily available and familiar to all professional staff
  - facilitate appropriate referral to specialist services for children, young people and their families where abuse or neglect have occurred
- **clear, agreed and documented referral and communication protocols and processes** that support:
  - interagency collaboration
  - the exchange of relevant information to progress case management, investigations and assessments as permitted by law (refer to the Office for Children's web site for guidelines for professionals on sharing information under the Children, Youth and Families Act)
  - case planning for, and delivery of, the best combination of services for each vulnerable child and to strengthen and support families
  - regular ongoing liaison between health services, local Child Protection services and community-based child and families services. Existing relationships with local organisations helps facilitate communication and improve coordination of care for vulnerable babies, children and young people
- **consistent policy in relation to other areas of practice** (both within and outside the hospital) which provide psychosocial support for vulnerable children and their families, including family violence
- **mechanisms to ensure ready access** to information and referral for other agencies working with vulnerable children and their families, particularly those that manage community intake, such as Child FIRST
- explicit and clear recognition that in delivering adult services, such as mental health, drug and alcohol, and maternity services, where children of adult patients are at risk, **the protection of the child is paramount**
- **staff education, training and support** to enable health professionals to undertake their responsibilities in relation to vulnerable children, ensuring that they clearly understand their responsibilities, have adequate knowledge and skills to carry them out, and have appropriate professional support and debriefing when necessary. The Forensic Paediatric Medical Service can provide information about available training and/or training resources

Any person has the capacity to harm and neglect a baby, child or young person if the circumstances are adverse and stressful (especially if there are no models of positive, non-violent parenting available), and there is substantial evidence that early intervention to improve parenting skills works, especially if the underlying causes can be addressed.

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- **readily available resources** to support:
  - identification of vulnerable babies, children and young people (for example, posters and pamphlets on recognising risk and the indicators of harm, and clinical screening tools)
  - patient information on child abuse and neglect and family violence
- **regular audit** to monitor knowledge of and compliance with policies and protocols as well as to identify areas for improvement.

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Chapter 5: A guide for health professionals

'... a key message is that suspected abuse or neglect should be treated with the same level of urgency as other potentially fatal childhood disorders'.[42]

This chapter addresses clinicians and health professionals who work at any time with babies, children, young people, parents, those about to become parents, and others who care for children. It has been designed primarily for professionals in acute health, but will also be of value to those working in child protection, community services, and any other health care setting. It will also inform health managers and administrators responsible for implementing the framework. For those in acute hospitals, it should be read in conjunction with Chapter 2, 'Patterns of risk and harm' and Chapter 6, Issues for specific program areas'.

Health professionals see many victims of abuse and neglect, often during the early stages of their victimisation or before it is reported to justice or child protection agencies. They also see adults whose children may be at risk because of the parent's health or social problems.

Babies, children and young people are usually powerless to stop abuse; they require adult assistance and intervention.

The aim of this guide is to help you identify vulnerable babies, children and young people in your professional care, and to respond in ways that reduce the risk of harm from child abuse and neglect, prevent any further harm, and improve health and wellbeing outcomes for these children.

The following principles and key elements also appear in Chapter 4: Acute hospital roles and responsibilities', but are repeated here because they form the basis for action for both health organisations and individual health professionals.

Principles

Four basic principles underpin this framework and provide a basis for local policy and procedure development and external interagency practice and cooperation:

The best strategy to protect children is to prevent child abuse from occurring however, when a child is at risk of or is being abused, action must be taken quickly and intensively.[15]

1. **Child protection is everyone's business**. All services that work with families will share responsibility for and contribute to the wellbeing and safety of babies, children and young people
2. **The best interest of babies, children and young people** will be at the heart of all decision making and service delivery across the service system
3. **Health and other services will act together** to form an integrated, cohesive and coordinated service system so that babies, children, young people and their families receive the best combination of services to meet their needs
4. **Health services will deliver services that are sensitive and appropriate** to the baby, child or young person, their family and caregivers. Consideration should be given to culture, disability, gender, sexuality, language and religion.

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Key elements of an effective response

These elements comprise the essential components of an effective health service response to vulnerable babies, children and young people. They should be incorporated into each health service's program, modified to the organisation's environment, population and resources.

1. **A core responsibility**: Protecting babies, children and young people from child abuse and neglect needs to be seen as integral to the provision of health services to babies, children, young people and their families, and a core responsibility for all health service staff.
2. **Protocols, policies and programs**: Health services should have in place specific protocols, policies and programs that detail the service's response to child abuse and neglect. Services should be consumer-focused and designed with consumer and community input and collaboration.
3. **Early identification**: Health service staff should be able to recognise child protection issues at all entry points to health services.
4. **Staff support and consultation**: All health service staff should have access to support and consultation regarding child abuse and neglect.
5. **Appropriate referral**: Health service staff should be aware of and able to competently refer to appropriate services within and external to the health service, including report to Child Protection services if required
6. **A comprehensive, holistic response**: Relationships should be developed with internal and external services to ensure services delivered to vulnerable babies, children, young people and their families are managed and coordinated both internally and externally to provide a comprehensive and holistic response.
7. **Staff training and education**: Training and education programs in child protection issues are essential for health service staff and should be developed and delivered according to the ongoing needs of the unit and the health service.
8. **Evidence-based care**: Research and emerging good practice should inform service delivery and health services should contribute to the evidence base.
9. **Continuous improvement**: Policies, programs, processes and outcomes for vulnerable babies, children and young people should be regularly reviewed and evaluated to enhance practice and improve the organisational response to babies, children and young people at risk of abuse and neglect.

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Health professional responsibilities and expectations

Your primary responsibility, in working with potentially vulnerable children and their families, is to care for the child's health, safety and wellbeing. This entails:

- **recognition**. You must be able to identify factors that suggest that babies, children and young people are at risk of harm from abuse or neglect
- **prompt investigation** to accurately diagnose or exclude a diagnosis of abuse or neglect. Harm may befall a child if the diagnosis is missed or professionals fail to act decisively when there is a risk of harm. Similarly, harm may result if abuse or neglect is wrongly diagnosed or there are long delays in excluding such a diagnosis. When child abuse or neglect is first considered, professionals should act decisively, promptly, and thoughtfully, consulting others with appropriate specialist knowledge.
- **early response**. If you have concerns about the child's safety and risk of harm, you have a responsibility to ensure that both child and family receive the most appropriate combination of support services. This means referring the child to, and working with, appropriate social and welfare support services within the hospital and the community. Where you have concerns for the immediate safety of the child, then a report to **Child Protection** services is required (see below). You should consider the possibility of cumulative harm when considering the wellbeing of the child.
- **alertness to adults whose children may be at risk**. While working with adult patients, you should also be aware of any children for whom the adult may be responsible. If you believe the adult is not capable of caring for their children at that time (for example, because of physical or mental health problems, disabilities, intoxication, or distress), early, supportive intervention is indicated to reduce any risk of harm to the child or children. If an adult discloses abuse or neglect of a baby, child or young person, you are not required to actually see the child before making a report to Child Protection.

Child abuse can masquerade as, and be mistaken for, a wide range of disorders. Missing the diagnosis, or deliberately ignoring it to avoid 'getting involved', can spell tragedy for the child. The opposite error, attributing clinical findings to abuse when they are in fact a manifestation of serious disease, is distressing for all concerned.[14]

You have a duty to be informed about:

- the clinical presentations of child abuse and neglect
- the principles of management and referral within your organisation if child abuse or neglect is suspected
- your responsibilities as a mandated professional (see page 34).

You can expect your health service to:

- foster a culture and working environment where the safety of babies, children and young people, and their protection from harm, is paramount
- ensure protocols and procedures are in place to manage vulnerable babies, children and young people
- provide staff with education and training on the identification and management of child abuse and neglect
- support staff in undertaking their duties as a mandated professional.

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If you are a mandated professional:

- Doctors, nurses, teachers and police are required by law to report to Child Protection if, in the course of their professional practice, they form a belief, based on reasonable grounds, that a baby, child or young person is at risk of significant harm and is in need of protection from physical injury or sexual abuse. This covers children up to the age of 17 years (unless in relation to a protective order, which may continue up to the age of 18 years).
- You must make the report without delay, when the belief is first formed.
- You must report each time you become aware of any further reasonable grounds for this belief.
- You do not have to be able to prove that the abuse has occurred or investigate the alleged abuse. This is the responsibility of Child Protection services. Victoria Police investigates criminal aspects of abuse and neglect. You may, however, be able to provide valuable information which can inform the assessment of risk of harm.

'Every health worker should have a clear understanding of the main points of the law that apply to the safety, welfare and wellbeing of babies, children and young people and the implications these points of law have for the discharge of their responsibilities.' [28]

Reporting is discussed in detail in Chapter 7: Working with Child Protection and community-based child and family services: reports, referrals and information.

Even if you are not a mandated professional, every member of the community, including every health worker, has an ethical obligation to report concerns about the safety and wellbeing of babies, children and young people.

The 'significance' of harm is a matter of professional judgement by the health professional; however, factors contributing to 'significance' include how acute or longstanding in nature the abuse or neglect is and the degree to which it is likely to interrupt or impair the child's development. Assessing significance entails considering the likely degree of harm, taking in to account the child's age, development and vulnerability.

Within the current legal and policy framework, if a child who is injecting drugs is deemed to be at risk, they can be the subject of a report to Child Protection in addition to a referral to drug and alcohol services. If the child's name is not known, health professionals must provide Child Protection with a description and any other identifying information.

A child wellbeing referral

In cases where you do not consider there is imminent harm but you have significant concerns about a child's wellbeing you may also make a referral to Child FIRST or a community-based child and family service or other community services. If these services are unavailable then you should contact Child Protection.

When you make a child protection report to Child Protection of your concerns about the safety of a baby, child or young person, you can expect:

- your call to be treated as a priority call and to speak with an intake worker without delay
- where the situation is critical (for example, imminent risk of harm, or of a parent absconding with a child), prompt feedback on Child Protection's intended actions, particularly where this information is relevant to the ongoing provision of health care
- in non-critical cases, routine written information on the outcome of reports, undertaken by Child Protection on a monthly basis
- where you are providing ongoing care for the child or family, your involvement in the decision making with other service providers. This may be coordinated by Child Protection or a community-based child and family service.

Taking action

The following flowchart sets out the steps for health professionals in considering and acting on the suspicion of non-accidental harm of a baby, child or young person.

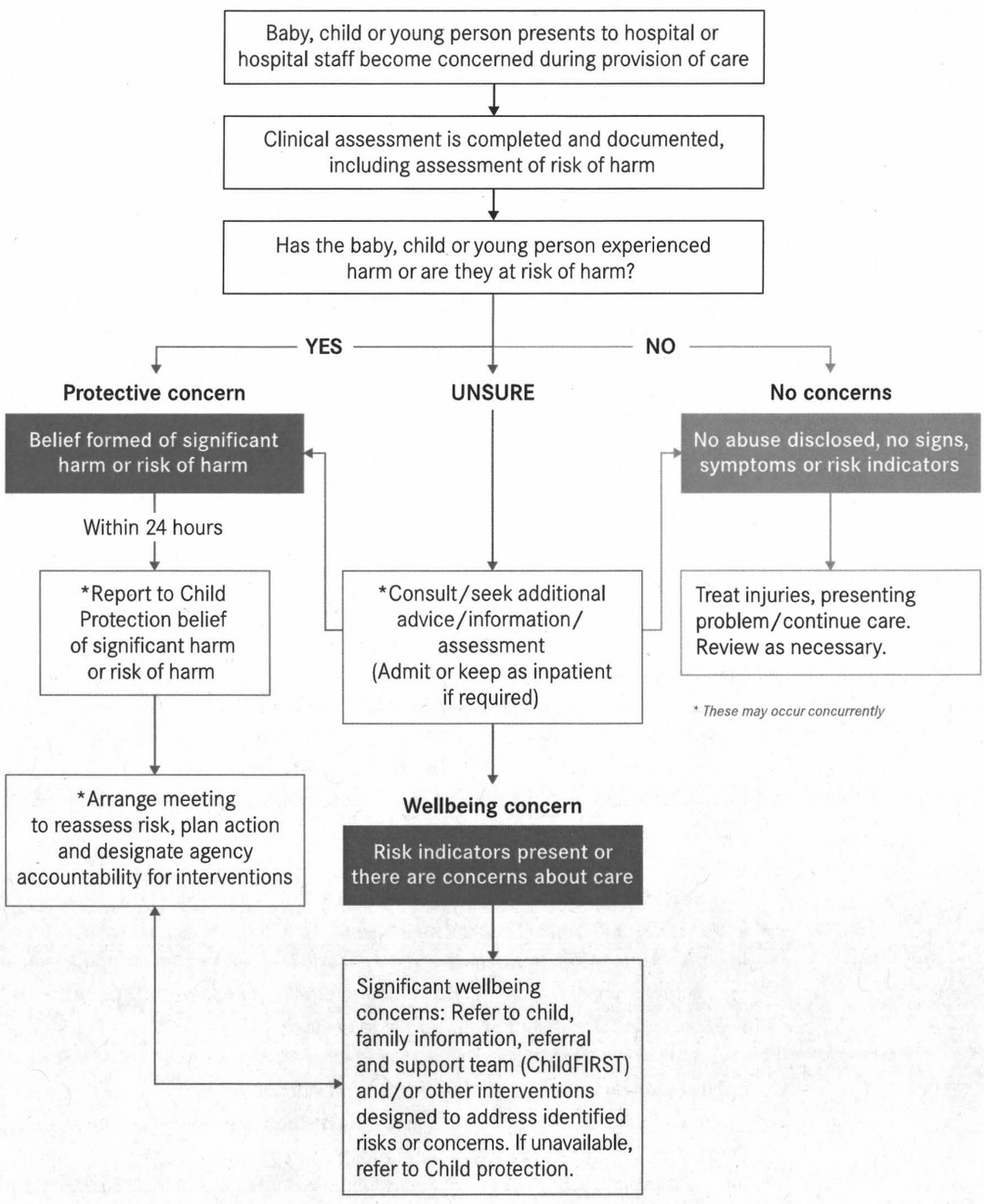
Acute health services should use the steps described to develop processes for their own organisation (or adapt existing processes).

The steps in this chart may take only minutes or occur over days or weeks, depending on the level of urgency or assessed risk.

The range of measures involved in intervention will depend on the severity of the situation, the risk of harm to the baby, child or young person, and the parent's capability and willingness to protect the child from harm.

Regular ongoing liaison between health services, local Child Protection offices, Child FIRST and other community-based child and family services is encouraged to facilitate communication and improve coordination of care for vulnerable babies, children and young people.

Intervention flowchart



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STEP 1: Consider the possibility of non-accidental harm in:

- **high risk groups**
- **those with signs and symptoms suggestive of abuse or neglect (see below)**

Note

- **Always consider the possibility** that harm to a baby, child or young person may be non-accidental (see next table for signs and symptoms):
  - Is the child at risk of or subject to physical or sexual abuse or ill treatment?
  - Have the parents/caregivers behaved in such a way that the child is at risk of or subject to serious psychological harm?
  - Are the child's basic physical and psychological needs not being met, or at risk of not being met? Does the parent or carer have the capacity to met the child's daily needs?
  - Does the child live in a household where there is family violence? Does this place them at risk of serious physical or psychological harm?
  - If the child requires medical care, have the parents failed to arrange for this care? Are they unable or unwilling to do so?
- **Act promptly and decisively** to investigate any suspicions, and **diagnose accurately** to confirm or exclude abuse or neglect. A child may suffer harm if child abuse is not recognised or professionals fail to act decisively when a child is at risk or when a diagnosis of child abuse is wrongly made or there are long delays in excluding such a diagnosis.

Action

- Treat any presenting medical problems.
- Complete and document a thorough physical, developmental and psychosocial history (may require referral to a paediatrician, senior colleague or other health professional experienced in child abuse and neglect).
- Identify any immediate concerns about safety and activate appropriate internal and external processes. **The child's safety is paramount.**
- Review any old notes and previous presentations or admissions. Multiple presentations for illnesses may indicate risk.
- Consider the risk of self-harm or suicide.
- Assess for family violence and risk to siblings.
- If uncertain, or if clinical findings are unusual or puzzling, consult a senior colleague, paediatrician or other health professional experienced in child abuse and neglect.
- Provide appropriate clinical treatment and referral for the presenting problem.
- Seek multidisciplinary input or expertise to ensure:
  - evidence of child abuse and neglect is not lost (expert medical assessment may be required with collection of forensic evidence)
  - trauma to the child from multiple assessments and questions is minimised.
- When doctors offer an opinion about the likelihood that a child's condition might be due to child abuse or neglect, a comprehensive appraisal of the uncertainties must be included.
- Refer all vulnerable children to the hospital social worker, or suitably experienced staff member, for a psychosocial assessment.

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Assessing for signs and symptoms associated with harm

The presence of one of these signs does not always mean that abuse or neglect is occurring and the absence of signs does not necessarily rule out abuse or neglect. Child abuse may present in many different ways, and may be mimicked by accidental trauma or some medical conditions.

A belief that harm has occurred, or may occur, may be based on a number of signs or a single sign. Consider each sign or combination of signs in the context of the child's circumstances. Take into account the possible cumulative nature of signs/incidents.

Signs in the history	Physical signs	Behavioural and developmental signs
• History inconsistent with the injury presented • Parental delay in seeking help • Past abuse or family violence • Disclosure by the child • Exposure of the child to family violence, pornography, alcohol or drug abuse • Severe social stress for the family or parents • Parental isolation and lack of support • Parent (or parents) abused as child • Mental illness in a parent, including postnatal depression • Unrealistic expectations of the child • Inappropriate or inconsistent discipline (especially thrashings or any physical punishment of babies) • Terrorising, humiliating or oppressing the child • Neglecting the child • Promoting excessive dependency in the child • Actively avoiding seeking care or shopping around for care (frequent changes of address)	• Multiple injuries, especially of different ages: bruises, welts, cuts, abrasions • Scalds and burns, especially in unusual distributions, such as glove and sock patterns • Pregnancy • Genital injuries • Sexually transmitted diseases • Unexplained failure to thrive • Poor hygiene • Dehydration or malnutrition • Fractures, especially in infants or in specific patterns • Poisoning, especially if recurrent • Apnoeic spells, especially if recurrent • Retinal haemorrhage • Rapid improvement in hospital	• Aggression • Anxiety and regression • Obsessions • Overly responsible behaviour • Frozen watchfulness • Sexualised behaviour • Fear • Sadness • Defiance • Self-mutilation • Suicidal thoughts/plans • Withdrawal from family • Substance abuse • Overall developmental delay, especially if failure to thrive is also present • Patchy or specific developmental delay: motor, emotional, speech and language, social, cognitive, vision and hearing[24]

STEP 2: If harm is suspected, ask careful and sensitive questions

Asking children about possible harm

Talk to children at an age-appropriate level. If children are asked directly about abuse or neglect, observe the same conditions of privacy as when asking adults about possible victimisation. Questions might include:

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

Questions for the parent or carer

Use open-ended non-judgemental questions about parenting and discipline, for example:

- Do you ever fear for your children's safety?
- Have you ever been worried that someone was going to hurt your children?
- Who looks after your children when you are not home?

Questions if you suspect the parent or carer may be the abuser

- Do you ever worry about your children's safety when they are with you?
- What methods of discipline do you use with your children?
- What do you do when your child misbehaves?
- Are you ever afraid that you might hurt your child?
- Have you ever hurt your child?
- Do you know what practical help is available to assist you?

Asking young people about possible harm

Causes of harm include family, peer violence/bullying, and dating violence. Be alert to the possibility of self-harm. Where harm is suspected, a thorough psychosocial assessment is indicated. To determine the most appropriate action or referral, it may be relevant to ask questions about the following (offer the option to 'pass' on a sensitive topic):

- **Home (family, culture, connections)**. For example: Where do you live? Who with? Extended family links and culture? Is home life stable? Who makes the rules and what happens if rules are broken? What happens when you fight at your house? Is there any violence? Who in the family do you get on well with and not so well with? Who do you talk to most?
- **Education**. For example: Do you go to school/training/work? Which, for how long? If not, how long have you been out of work? Do you have good friends at school/work? Is there a teacher you get on well with? What do you do in and outside classes? Are you bullied?
- **Activities (eating, sleeping, exercise, risk behaviour)**. For example: What do you do out of school? How do you get money? How do you get around? What do you do for a thrill? Do you go to parties? Do you sleep well?
- **Drugs and alcohol**. For example: Do you/your friends/people at your school smoke? Do your friends/parents/you ever drink alcohol? Have you ever used marijuana? What other drugs are people using now? What do you think about it? What have you tried? How much are you using? In what circumstances? What risks are involved?
- **Sexuality**. For example: Do your friends have sexual relations? Do you? What do you know about safe sex? Has anybody ever touched you in a way you don't like or made you feel uncomfortable or afraid? If this happened, is there anyone you could tell or ask for advice about sex/relationships? Do you want to talk about anything else about sex/relationships?

STEP 3: Provide emotional support for the child or young person

If the child or young person discloses abuse:

- **Be aware** that:
  - the child may be feeling scared, guilty, ashamed, angry, powerless, and have been told by the perpetrators the child is responsible for the abuse
  - you may feel outrage, disgust, sadness, anger, disbelief, but need to remain calm and in control of your feelings
- **Reassure** the child. Ensure they know they are not at fault and that something will be done to keep them safe. This reassurance is one of the most powerful interventions you can provide
- **Show your care and concern** by:
  - listening carefully to what they are saying
  - telling them that you believe them
  - telling them it is not their fault, no one deserves to be hurt or neglected and that they are not responsible for the abuse
  - telling them you will seek help for them
  - letting the child know that you will make a report to the appropriate authorities so that they can help stop the abuse
  - telling the child you are pleased they told you.

When there is no disclosure

- If you suspect abuse, but the child has not told anyone, be aware of the emotional distress the child may be experiencing. Be sensitive and caring, and assure the child that you are willing to listen and to help if there is a problem.
- **Do not**:
  - make promises you cannot keep, such as promising that you will not tell anyone
  - push the child into giving details of the abuse. Your role is to listen to what the child wants to tell you, not conduct an investigation
  - indiscriminately discuss the child's circumstances with others not directly involved with helping the child
  - communicate with the parents or carers about your concerns, except where it may place the baby, child or young person or you in danger and/or the family may seek to avoid child protection staff.

STEP 4: Consult, seek additional advice, information and/or assessment

Be aware that:

- Early multidisciplinary input and case conferencing is the key to providing an appropriate, comprehensive and coordinated response
- Consultation may be brief, such as a telephone call or, if time and safety permit, more extensive, with multiple referrals and investigations
- Referral to an experienced paediatrician helps to ensure an adequate investigation of suspected abuse, and an accurate diagnosis regarding suspected abuse.[45]

Seek the advice of:

- your manager or a senior colleague or clinician experienced in child abuse or neglect to discuss your grounds for concerns and how to proceed with the most appropriate support and intervention
- a senior medical officer, nurse manager, paediatrician, social worker or Child Protection worker to advise on additional assessment or investigations
- Where experienced staff are not available (for example, in some rural settings), consider seeking advice from a general practitioner or staff from a community health service with experience in child abuse and neglect
- If expertise or experience is limited internally or locally, seek external specialist advice from the Victorian Forensic Paediatric Medical Service
- In addition, consult **an Indigenous liaison officer** if the baby, child or young person identifies as Aboriginal or Torres Strait Islander.

Admit or keep the baby, child or young person as an inpatient if required to complete the assessment or provide a safe environment.

Seek information from any other agencies currently working with the baby, child, young person, their family or carer.

Forensic paediatric medical assessment:

- Consult the Victorian Forensic Paediatric Medical Service to arrange forensic paediatric medical advice and assistance
- Proformas for forensic paediatric medical assessments are available in the resources section of this document and from the Victorian Forensic Paediatric Medical Service web site.

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STEP 5: Notify Child Protection services of concerns

Making the decision to report

- If you believe the baby, child or young person has suffered, or may suffer, significant harm as a result of abuse or neglect and are in need of protection you must notify Child Protection.
- This may be clear immediately or only after monitoring a situation over time (for example, initial warning signs in the child's behaviour may not warrant report, but later information– such as a crisis event–may clarify the situation).
- You do not have to prove that abuse or neglect has occurred. Following a report, the Child Protection worker does a risk assessment based on the information from the reporter, and other information, and determines whether significant harm has occurred or may occur. Data and evidence provided by acute health staff can critically inform this risk assessment.

Making the report

- Depending on the urgency of your concerns, you may call Child Protection before you consult or meet with any other staff or agency.
- Gather the information required to complete a *Protective Intervention Report Form* (see Appendix E for health forms).
- Contact your regional Child Protection service (see Appendix C for contact information).
- Arrange a multidisciplinary, multi-agency case conference within 24 hours (see step 6).
- Initiate internal reporting/communication processes related to the report, for example:
  - Notify your manager/supervisor of the report
  - Refer the child to a general or forensic paediatrician for additional examination or investigations
  - Refer the child to a social worker or other health professional for assessment of existing social supports, relevant support and welfare services, preventative and early intervention programs.

After making the report

- When Child Protection becomes involved, a family is usually thrown into crisis, and you may also feel guilty about making matters worse. Focus on the child's situation and remember that you have acted correctly.
- Your ongoing roles and responsibilities may include:
  - acting as a support person in interviews with the child or young person
  - attending a case conference relating to the investigation
  - participating in case planning meetings about a child or young person
  - continuing to monitor a child or young person's behaviour in relation to ongoing harm
  - observing/monitoring the conditions on a protective court order that may relate to access or contact with a parent
  - liaising with other professionals and Child Protection workers in relation to a child or young person's wellbeing
  - providing written reports for case planning meetings or court proceedings in relation to a child or young person's wellbeing or progress.
- The child or young person may feel distressed, guilty, ashamed, confused, frightened, and will need support throughout the protective intervention. Professionals involved with the family may be in a position to offer ongoing support by:
  - liaising with Child Protection workers to ensure they are giving appropriate support to the child or young person
  - providing support to the family where appropriate
  - dealing sympathetically and effectively with changes to the child's behaviour that may occur in response to intervention.

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STEP 6: Arrange/participate in meetings of relevant agencies and professionals to reassess risk, plan action and assign accountability for interventions

Reasons for a meeting

A multidisciplinary, multi-agency meeting may be held to:

- **help in making the decision** about whether to report
- **plan and manage care following report**. This is sometimes referred to as a **SCAN** (Suspected Child Abuse and Neglect) meeting. Case planning will be led by Child Protection with responsibility shared between Child Protection and hospital staff. SCAN meetings bring together three main professional groups–health staff, Victoria Police, and Child Protection–to coordinate and exchange information in order to provide early supportive intervention in cases of suspected child abuse and neglect. Health staff provide medical input with forensic and psychosocial assessments, Victoria Police evaluates whether a criminal offence has been committed and whether charges should be laid, and Child Protection investigates the suspected child abuse and neglect
- **plan and manage care where report is not required**. If you do not report as a protective matter, case planning with other agencies led by hospital staff may still be appropriate. Consider referral to Child FIRST or other community agency if you have significant concerns for the child's wellbeing. Under these circumstances community-based child and family services will lead case planning

'Case planning' relates to the safety, welfare and wellbeing of a child and/or family, and should ensure there are no misunderstandings for clients and practitioners about goals or responsibilities. If health professionals are asked by Child Protection services or a registered community-based child and family service to attend a case planning meeting they should do so.

Organising the meeting

Bring together an appropriate multidisciplinary and multi-agency group to provide information and input to planning any intervention, including:

- relevant hospital staff
  - medical
  - nursing
  - social work
  - other allied health
  - other relevant specialties (for example, mental health service staff)
  - patient liaison
- other agencies or services involved with the family, such as disability services.

- If Child Protection is involved, include:
  - Child Protection services staff
  - Victoria Police (generally notified by Child Protection staff as appropriate)
  - If age-appropriate, involve the child or young person
  - Involve parents or carers unless it will jeopardise the safety or wellbeing of the baby, child or young person.

At the meeting

- Document planned interventions and agency or staff accountability for all actions. Generally the hospital will not be the lead agency for ongoing safety and protective concerns, but will play a key role in providing health care and information to other agencies
- Agree any need and timeline for future communication or meeting
- Agree on any interagency feedback required for future management of the baby, child or young person's case.

STEP 7: Follow up, and complete additional assessments, investigations, interventions

- **Complete any additional investigations** and assessments related to the risk of harm, as agreed in the consultation process (steps 4 and 5).
- **Complete and follow up any interventions** required to continue clinical care.
- **Document** steps taken:
  - referrals made
  - support/information provided
  - meetings convened
  - investigations and results
  - plan for care, including discharge and return visits or admissions.

Note

- **Meticulous documentation** is of critical importance where there is suspected or actual harm, for a number of reasons:
  - Medical notes may be used as evidence in protective legal proceedings (which may occur at a time distant from the time of the report)
  - The need to report may not be clear initially, but result from evidence accumulated over time. This enables a presentation to hospital to be considered in light of other presentations rather than as an isolated incident
  - Documentation is critical to future interventions.
- **External referral agencies** are vital in providing support to actual or suspected victims of harm. It is strongly recommended that appropriate hospital staff meet and develop referral relationships with staff from local Child FIRST, community-based child and family services, other agencies and community health services.

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Chapter 6: Issues for specific program areas

Emergency departments

Hospital emergency departments are often the first service accessed by families or caregivers with babies, children or young people at risk of harm.[28] Staffing includes medical, nursing, social work and allied health, administration and support services staff.

- **Consider the possibility of harm.** Emergency department staff should always be alert to indicators of abuse when providing care for babies, children, young people and their families or carers. A baby, child or young person may present for a variety of reasons that might suggest abuse and may have previously attended other emergency departments because of other injuries. See page 38 for indicators of abuse and neglect.
- **Fractures of bones and soft tissue injuries** should be considered an indicator of risk of harm when in the context of other indicators. Be alert to inconsistencies in the explanation of an injury. If fractures are detected in a non-ambulatory infant, consider investigations such as a full skeletal survey to check for previous fractures. If you have reasonable grounds to suspect risk of harm, you must make a report to Child Protection.
- **Referral to social work** for psychosocial assessment should be made where there are concerns about risk of harm to a baby, child or young person. This should include young people who attend an emergency department without an adult carer, because the young person may be at risk of harm.
- **Family violence.** Adults who present to emergency departments with injuries following family violence may be the parents or caregivers of babies, children and young people who are at risk of harm as a result of the violence. Concern about risk of serious physical or psychological harm as a result of exposure to family violence is grounds for making a report to Child Protection.
- **Parental refusal to permit admission, treatment or tests.** On occasion, a parent or caregiver may refuse permission for a baby, child or young person to be admitted to hospital or to have relevant investigations, such as x-rays or blood tests. If you have reasonable grounds to suspect risk of harm as a result of 'failure to provide necessary medical care', you should make a report to Child Protection services.

  If you treat a baby, child or young person without consent in an emergency situation–that is, to save the child's life or avert immediate risk or serious injury–you are not acting unlawfully.
- **If uncertain, consult.** If you are unsure whether a report should be made to Child Protection, consult your manager, a senior colleague, paediatrician or social worker with experience in child abuse or neglect. Expert advice or consultation on vulnerable babies, children and young people is also available from Victorian forensic paediatric medical services which provide a 24 hour service through the Gatehouse Centre at Royal Children's Hospital and the Angela Taylor Child Protection Unit at Monash Medical Centre. Regional Child Protection services are also available for

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consultation. If sexual assault is suspected, consultation and/or referral to a Centre Against Sexual Assault service or Child Protection must occur. Contact details for agencies listed here and other social support services can be found in Appendix C: Contact Information.

- **Examine and treat**. If medical practitioners have concerns about injuries to a baby, child or young person, they should continue their routine examination of the baby, child or young person to ensure that appropriate medical care is provided.
- **History taking** is important to take a full history to establish an understanding of the situation which has lead to the presentation, any previous presentations and other underlying factors that may be relevant.

Maternity and neonatal departments

Maternity care encompasses the entire episode of care for a woman (antenatal, intrapartum and postnatal) and can involve general practitioners and community providers as well as hospital staff. Comprehensive antenatal assessment will enable appropriate and timely assistance and support to be arranged for the woman and family as needed. Assessment and care planning during pregnancy and postnatally should include physical, medical, mental health and psychosocial elements, as well as collection of information relating to parenting capacity.

- **Pre-natal report or referral**. Currently, there is no legal means for reporting before the birth about risk of harm to the baby after birth. However, under the Children, Youth and Families Act (effective early 2007), a report or referral can be made to Child Protection or Child FIRST prior to birth where there is significant concern for the wellbeing of the child after he or she is born. Pre-natal reporting offers the opportunity for early support and assistance to a pregnant woman whose child may be at risk of harm after birth. It also helps to reduce the likelihood of need for out-of-home care. It is anticipated that such a report or referral would not be made before the third trimester.

  Pre-natal reports or referrals may be particularly helpful for pregnant women in family violence situations or with mental health or drug issues during pregnancy, because reporting can provide the catalyst for assistance. Such reports should be used only if there are clear indications of risk of harm to the baby once he or she is born. Reporting is not intended to be used as a punitive measure against women under stress. Maternity staff need to involve and consult with other relevant health and social services to assist with the care of the mother and her child.
- **Assessment**. A thorough assessment of a woman's family, risk factors and strengths both during pregnancy and in the postnatal period will help identify the supports that may be needed to make sure that an infant will be nurtured and protected and families are linked to a network of services. Staff should have the opportunity to attend training to obtain the skills and confidence to engage with women and discuss with them any difficulties they may be experiencing.

- **Family violence** often begins or escalates during a woman's pregnancy. All pregnant women and girls should be routinely asked about the possibility of violence in their relationship. When responding to women suffering family violence, refer to local family violence protocols.
- **Mother's mental health**. Be aware of significant changes in the mental state of a mother. In particular, look for signs of postnatal depression or post-partum psychosis. If there is concern about the mother's mental health or behaviour, arrange an assessment of the child's care and safety needs as well as of the mother's mental health and safety.
- **Substance use.** Drug and alcohol use is not isolated from other psychosocial and cultural factors. Women with drug or alcohol issues can be difficult to engage, and skilled and consistent case management is important. It is recommended that women who are using drugs or alcohol during pregnancy be referred for specialist assessment and help. National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn provide more comprehensive information (See Appendix C: Contact Information).
- **Other risk factors** include previous involvement with Child Protection, unstable living arrangements, isolation, late or infrequent attendance at antenatal care, intellectual disability and concerns about parenting practices.

  The timing of consultations with social work, Child Protection high risk infant managers, maternal and child health and other community services, should take into consideration the limited time women remain in hospital following the birth and the limited capacity of neonatal units to keep babies in hospital for non-medical reasons.

  Determining the best response to meet the needs of a mother and her baby is not easy. Multidisciplinary case meetings provide an opportunity to bring together the different perspectives and share information to strengthen decision-making and should be encouraged.

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Paediatric departments

Child and adolescent units offer care and treatment to babies, children and young people across an age spectrum from day one of life to 18 years in the model of family-centred care. Staffing includes medical, nursing, allied health, play therapy, administration and support staff. In many country and metropolitan hospitals within Victoria, children and young people are cared for in adult units. It is therefore of upmost importance that education and resources are provided to support staff in this environment.

Always believe a child; listen to what they are telling you.

- **Consider the possibility of harm.** Child and adolescent unit staff should be always alert to indicators of abuse when providing care for babies, children, and young people and their families or carers. A baby, child or young person may present for a variety of reasons that might suggest abuse and may have previously attended emergency departments, other hospitals or a general practitioner because of other injuries or the parents' inability to care for a child with non-life threatening illness (for example, a crying or unsettled baby).
- **Fractures of bones and soft tissue injuries** should be considered an indicator of risk of harm when in the context of other indicators. Be alert to inconsistencies in the explanation of an injury. If fractures are detected in a non-ambulatory infant, consider investigations such as a full skeletal survey to check for previous fractures. If you have reasonable grounds to suspect risk of harm, you must make a report to Child Protection.
- **Parental capacity**. When caring for children consider parents' or carers' capacity to care for the child and the supports that may be needed to ensure they are able to safely care for their child. Parental capacity may be affected by a range of health or social issues, such as mental disability or illness, substance abuse, family violence and social isolation. A number of these issues are discussed further in Chapter 2: Patterns of risk at different ages.
- **Siblings**. In child and adolescent units, most parents stay with their child during the hospital stay. Many families have minimal support or extended families and staff need to be alerted to the needs of the other children and ensure they are safe.
- **Children and young people** may place their lives at risk through self-harm (for example, using alcohol or drugs, chroming, showing risk-taking behaviours, having an eating disorder or inflicting injury to themself). Refer to Chapter 2.
- **Consultation and decision-making.** Determining whether a child is at risk is not always straightforward where abuse or neglect needs to be considered among an array of medical or developmental conditions. In addition, there is often a number of staff involved in the care of children and their families, ranging from nursing staff, junior medical officers, paediatric or general practitioner trainees, and consultants. Often these professionals will have different experiences with the child and their family and varying knowledge about particular conditions. It is important in these circumstances that multidisciplinary meetings are used to strengthen decision

making and gain consensus to ensure the best outcomes for the child or young person. Where possible, it is recommended that the advice of those with specialised knowledge in child abuse and neglect is sought. This can be particularly important if medical evidence is to be provided in court.

Child and adolescent mental health services

Child and adolescent mental health services provide specialist assessment and treatment for children and young people (up to 18 years of age) affected by severe and complex mental health problems and disorders. Consultation and liaison with other services and agencies is an important part of their role.

Child and adolescent mental health services play an important role in the early identification of abuse or neglect and in the provision of timely responses. These responses include assessment and treatment of children and young people with a range of mental health problems associated with or arising from their experiences of abuse and neglect. Child and adolescent mental health services work closely with Take Two, the therapeutic intervention service for children who have been abused and/or neglected who are on protection orders.

- **Child and adolescent mental health services' role with children and adolescents at risk of harm** entails responding to requests for service, assessment and treatment and clinical case management. They can be asked to provide court assessments or reports and be referred to in court orders (although not in terms of direction to participate in or comply with treatment). They may also provide services to parents, families or other caregivers and respond to requests for information.
- **Clinical assessments conducted by either child and adolescent mental health services or adult mental health services** may identify a range of problems in the child and/or the family that raise concerns about the safety of the child or young person. These may include unexplained physical injuries, direct revelations by the child or young person of abuse or neglect (which must be reported to Child Protection) or questions over the capacity of a child's parents or caregivers to provide safe and supportive care (which may include revelations of family violence). In such instances, child and adolescent mental health service staff need to liaise and consult with other services and agencies to ensure the child or adolescent receives appropriate care and support.
- **Report**. If during assessment, care planning or treatment a child and adolescent mental health service clinician has reasonable grounds to suspect a child or young person is at risk of harm of abuse or neglect, they are responsible for reporting their concerns to Child Protection services consistent with the Children, Youth and Families Act. The safety, health and wellbeing of children and young people are paramount.

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Adult mental health services

Adult mental health services provide specialist clinical mental health care for people aged 16–64 years with severe and complex mental health problems and disorders, and psychiatric disability rehabilitation and support services. Consultation and liaison with other services and agencies is an important part of their role. On entry to adult mental health services, all clients who are parents are provided with written information about the supports and resources available to assist them in their parenting role.

- **Children's safety is paramount.** All staff working with adult clients who have a mental illness or problem need to be aware that the safety, welfare and wellbeing of any children in the care of their clients is paramount. Family-sensitive practice underpins good clinical care. Information collected as part of a mental health assessment should include the needs of any dependent children in the client's care. Where a clinician working with a person who has care of a baby, child or young person has reasonable grounds to suspect that the child is at risk of harm, he or she must report their concerns to Child Protection.
- **Assessment and support of parenting**. Comprehensive assessment and care planning for adult clients includes collecting information on their family status and assessing the formal and informal support systems available to them. Clients' role as parents or caregivers should be considered as part of mental health assessment and care planning.

  Consistent with family-sensitive practice, staff of adult mental health services and psychiatric disability rehabilitation and support services should periodically review with clients their capacity to cope with providing care to their children. Management plans should be revised to take into account the actions and supports required if and when a parent is unable to care for their children.
- **Mental health crises**. If a parent or caregiver is experiencing an acute mental health crisis, mental health workers must consider the needs and circumstances of any babies, children and young people. Liaison and consultation with other services and agencies may be necessary to ensure appropriate care and support.
- **Pre-natal risk**. Family-sensitive practice requires staff to consider the safety of all children, including the risk of harm to an unborn child of a client or a client's partner, so that adequate assistance and support can be offered before problems eventuate. A thorough assessment of a family's risks and strengths will help identify the supports that may be needed to ensure that an infant will be nurtured and protected and that families are linked to an appropriate network of services.
- **Working with young people**. Both child and adolescent mental health services and adult mental health services have important roles to play in providing assessment and treatment for children and young people who have been found to be at risk of harm. These roles may include responding to requests for a service, involvement in case planning, providing assessments, and providing services that may be linked to a court order. You may also need to provide services to parents, caregivers and families and to respond to requests for information.

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Dental health services

General dentists, paediatric dentists, dental hygienists, and dental therapists, with the support of dental assistants and dental technicians, provide dental health services to the community. Children and young people can receive public dental care, which includes health education, assessment and clinical care, through the school dental service, community health agencies and the Royal Dental Hospital of Melbourne.

- **Orofacial trauma**. When children or young people present with orofacial trauma, harm and abuse should be considered as part of your assessment. The head and orofacial region (including intraoral structures) are common sites of trauma from all forms of child abuse. Clinical experience indicates that around 40–50 per cent of cases of child abuse include orofacial trauma.[19] Many of these injuries, such as bruising, lacerations, burns and bites, are outside the mouth and are obvious without an intraoral examination. Injuries within the mouth tend to be reported less often than orofacial injuries: it may be that they are overlooked compared with more obvious injuries or that medical practitioners are not familiar with intraoral examinations. Intraoral injuries include fractured teeth, oral bruises, oral lacerations, jaw fractures and oral burns.
- **Neglect** could be considered in children or young people with untreated, rampant caries, pain or infection, and children who have a history of poor dental attendance.[29] You may be in a position to recognise whether a child or young person could be currently at risk of harm.
- **Responding to risk**. Dental health professionals have an important role to play in assessing and treating children and young people who have been found to be at risk of harm. This may include responding to a request for information, being involved in case planning, providing assessments, and providing services that may be linked to a court order. You may also need to provide services to parents, carers and families in response to their requests for information.

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Chapter 7: Working with Child Protection and community-based child and family services: reports, referrals and information

As outlined in Section Three, the Children Youth and Families Act 2005 provides for professionals and others in the community who hold concerns for the safety and/or wellbeing of children to refer and report these concerns to the appropriate agency, via the following means:

A child wellbeing referral made under section 31 of the Children, Youth and Families Act.

An unborn child referral or report made under section 29 and 31 of the Act.

A child protection report made under section 183 and 184 of the Act.

Under Victorian law, a child is regarded as being under 17 years of age.

Child wellbeing referral

New pathways to ensure that prevention and early intervention services are provided to vulnerable children and families are available through child wellbeing referrals and community-based intake. A person who has a significant concern for the wellbeing of a child can refer the matter to a child, family information, referral, and support team (Child FIRST). These teams will operate in sub-regional areas, their contact numbers will be publicised and well known in the community.

It is planned to phase in Child FIRST locations during late 2006 and 2007. In areas where a Child FIRST is not yet established, a significant concern about the wellbeing of a child can be reported to Child Protection. (Section 28 Child, Youth and Families Act).

Child FIRST will undertake an initial assessment. Following an assessment they can provide advice to the referrer, provide advice and/or assistance to the family or refer the family to a service agency. They may also assess that the child is at risk of significant risk of harm and make a report to Child Protection.

Unborn child referral or report

Sections 29 and 31 of the Children, Youth and Families Act enable professionals and others in the community with concerns regarding an unborn child, (who is likely to be in need of protection when born) to report these concerns. Such concerns can be either referred to child FIRST or reported to Child Protection. For example, a hospital may contact Child Protection with information that an expectant mother has a serious drug problem, which is likely to place a newborn infant at risk, or the mother has an intellectual disability and does not appear to have sufficient supports.

When responding to unborn child referrals/reports the community based service or Child Protection can provide advice to the referrer/reporter, provide advice and/or assistance to the mother or refer to a service agency to work with the mother and plan appropriate services and supports, both prior to and after the child's birth.

All work with the mother of the unborn child prior to the birth of child is subject to her consent. The Child Protection worker is required to record the report, but as is the case now, none of Child Protection's statutory powers (for example to issue a Protection Application) will apply until after the child's birth.

Child Protection Report

Section 183 of the Children, Youth and Families Act provides that any person who believes, on reasonable grounds, that a child is in need of protection may report to a protective intervener that belief and the reasonable grounds for it. This means that any person is voluntarily able to make a report to the Child Protection service when they believe a child is in need of protection. (Some health professionals have a legal obligation to report in particular circumstances, refer to Chapter 5, A guide for health professionals).

Under s.162 of the Children, Youth and Families Act, a key aspect for Child Protection in assessing the need for protection is that the child has suffered or is likely suffer significant harm, and that the child's parents have not protected them or are unlikely to protect them from harm.

Legally mandated reporters

While any person can make a Child Protection Report under Section 183, Section 184 of the Children, Youth and Families Act requires that certain professionals must make a Child Protection Report when in the course of their professional duty:

[the professional] forms the belief on reasonable grounds that a child is in need of protection [because] the child has suffered, or is likely to suffer, significant harm. These grounds include:

(1) physical injury and the child's parents have not protected or are unlikely to protect, the child from harm of that type or the child has suffered, or is likely to suffer, significant harm as a result of

(2) sexual abuse and the child's parents have not or are unlikely to protect, the child from harm of that type.

The professionals which are mandated to report are:

- nurses
- doctors
- primary and secondary school principals and teachers
- police.

Under s.184 the test for forming a belief is based on that of a reasonable person; that is a reasonable person practicing the profession would have formed the belief on those grounds.

Reasonable grounds for a child protection report

There may be reasonable grounds when:

- a child states that they have been physically or sexually abused
- a child states that they know someone who has been physically or sexually abused (sometimes the child may be talking about themself)
- a relative, friend, acquaintance or sibling of the child states that the child has been physically or sexually abused
- professional observations of the child's behaviour or development lead the mandated professional to form a belief that the child has been abused
- signs of physical or sexual abuse lead to a belief the child has been abused.

Forming a belief

The concept of forming a belief is a thinking process, where a person is more likely to accept rather than reject the notion that there is significant harm for the child or young person. You may ask yourself, 'Am I more likely to believe there is significant harm for the child, or less likely to believe there is significant harm for the child?' If you are more likely to believe, then you have formed a belief.

It is the Child Protection worker's job to investigate and determine significant harm; other professionals need only have reasonable grounds for belief.

Responsibilities of a mandated professional

- Mandated professionals are required to make a report to Child Protection when *in the course of practising their profession* they form a belief on reasonable grounds that a child is in need of protection from physical or sexual abuse. If you are a mandated professional, you are not legally obliged to report if you encounter abuse in your private life or when working in a capacity that is not directly related to the professional affiliation under which you are mandated. However, in such situations you have a moral or ethical obligation to report your concerns if you have reasonable grounds to believe that a child is at risk of harm.
- You must make a report without delay.
- You are required to make a report *each time* you become aware of any further grounds for your belief.
- You do not have to prove that the abuse has occurred. You only need reasonable grounds for your belief.
- It is your responsibility to report your belief; it is not the responsibility of your supervisor, principal, senior or manager. If you are one of a group of mandated professionals who share the belief, based on reasonable grounds, then only one mandated professional needs to make the report. However, you must be satisfied that the report was made promptly and that all of the reasonable grounds were included in the report.

- If a mandated professional (supervisor, principal, manager) directs another mandated professional not to make a report, and that professional continues to hold the belief that a child is in need of protection, then that person is legally required to make a report to Child Protection.
- Mandatory reporting requirements take precedence over professional codes of practice where confidentiality or client privilege is claimed. You do not need permission from parents or caregivers to make a report, nor do they need to be informed that a report is being made.
- If you make a report in good faith, you cannot be held legally liable, regardless of the outcome of the report.

The identity of professionals making a report is protected

The identity of a professional making a report will remain confidential under the Children, Youth and Families Act unless:

- you choose to inform the child or family of the report yourself
- you consent in writing to your identity as the reporter being disclosed or, in the case of a referral to a community-based child and family service, give written or oral consent to the service for your identity to be disclosed
- the court decides it needs this information in order to ensure the safety and wellbeing of the child
- the court decides in the interests of justice, it requires that the evidence be given.

It is not general practice for the Children's Court to seek information about the identity of the person who has made the report.

How to make a report to Child Protection

To make a report of child abuse contact your regional Child Protection office as soon as possible. You will find a list of these offices under contacts in Appendix C: Contact information. Proformas detailing the information to be provided when making a report can also be found in Appendix E: Health forms.

The After Hours Child Protection Emergency Service is available to accept Child Protection Reports at any time outside normal business hours including evenings and weekends. This service can be contacted on telephone 131 278 (Victoria only, toll free). This service is a crisis service only, and if the matter is assessed as not requiring immediate action, it will be referred to the region in which the child lives for follow up in business hours.

Information required by Child Protection intake staff

The Child Protection intake worker will need to gather a range of information to decide whether to investigate the report and to prioritise the urgency of the response. Assemble the relevant information (depending on the urgency) prior to making the report and allow sufficient time to discuss the concerns in detail with the Child Protection intake worker when you call. Appendix E: Health forms contains the protective intervention report proforma for suspected child abuse and neglect.

The Child Protection intake worker at the regional office will initially ask the person making the report for certain information, including the following.

About the baby, child or young person

- Name, age, gender, cultural background, address
- Who currently has custody of the baby, child or young person?
- What is the baby, child or young person's present location?
- Is the baby, child or young person safe now?

About the alleged abuse

- Description of injuries and behaviours observed
- Presence of risk indicators of harm
- What are the safety and risk of harm concerns held for the baby, child or young person?
- What response/intervention has been initiated by the hospital?

About the family

- Composition, name, age of siblings, parents, carers
- Parents' marital status
- Other adults in the home
- Extended family
- Patterns of interaction
- History of violence, abuse
- Are other agencies involved?
- Likely reaction to Child Protection

About the person making the report and contact details

- Identification of hospital, name and position of person making the report
- What are the reasonable grounds (how did you form your belief)?
- Your relationship to the child
- Are the child, young person and family aware of the report?

A report should still be made even if you do not have all the necessary information.

See Appendix E: Health forms for the protective intervention report and the wellbeing referral proformas.

What happens following report to Child Protection?

Intake

Intake refers to the period when a report is first received and assessed by Child Protection. In the majority of instances Child Protection receives the report by telephone. A small percentage of reports are received by mail, fax or in person.

The intake worker will then ascertain if the child or siblings have previously had contact with the Child Protection service. If the child is currently a client, then the information obtained from the caller will be recorded on the existing client file and the allocated protective worker for the child will be notified. If the child has never been involved with the Child Protection service or if there has been past involvement but the case has been closed, a new intake will be created and the report details recorded.

Upon receipt of a Child Protection report, a Child Protection worker will undertake a preliminary risk assessment of the information provided by the reporter. Where there is an identified professional, agency or support service involved with the child, young person or family they may be contacted to provide information to assist in the initial assessment.

A case conference may be held at the intake stage to assist in determining whether or not a report requires further action and who should take this action.

Child Protection will then complete an initial assessment of risk and make a decision regarding whether further action is required. This may include further investigation and intervention by Child Protection, advice or consultation with the reporter, a referral to Child FIRST or alternatively if no further action is required the case is closed at this point.

No further action by Child Protection

Child Protection may decide, as a result of the intake assessment, that no further action is required. If the case is closed the Child Protection worker will need to give reasons and provide written advice to the person who made the report.

Child Protection Reports which require investigation

Where the Child Protection Intake Unit assesses that sufficient concerns exist to require investigation of a Child Protection report by direct contact with the child and family, a decision will be made regarding the urgency of the situation and the required response.

Further investigation becomes necessary when:

- The child's described circumstances fall within the legal definition of a child in need of protection; and
- The protective concerns cannot be adequately addressed without direct Child Protection involvement
- Where a case is deemed urgent, initial visits to the family will occur within 48 hours. If a case is deemed non-urgent, the visit must occur within 14 days.

Once a decision to investigate has been taken, the report is passed from the intake area to a team, which will coordinate the subsequent investigation and any required referral or intervention. The Child Protection service will inform the professional who made the report of this decision as soon as is practical. All mandated professionals who make a report to Child Protection should receive written advice about the status of that report no later than a month following the report.

Child Protection, in accordance with their Protocol with Victoria Police, are required to contact the Victoria Police Sexual Offences and Child Abuse Unit regarding notifications involving physical and sexual abuse and in cases of serious neglect to determine if a criminal investigation is required.

Direct contact is then made with the child and family to assess the child's safety, the validity of the allegations and the child's needs and will lead to a decision as to the most appropriate course of action to ensure the child's safety and well being. During the investigation, Child Protection needs to determine whether abuse or neglect has occurred or is likely to occur, whether the child's parent or caregiver is able and or willing to protect the child and whether there is a need for continuing Child Protection involvement.

Completion of the Investigation and Substantiation

At the end of the investigation, a decision is made about the outcome of the investigation. If abuse or neglect has not occurred as defined in Children, Youth and Families Act, or if it has occurred in the past but the child is now safe from recurrence, the case will be closed at this point.

A protective plan meeting is generally held when abuse or neglect has occurred and Child Protection is to remain involved without immediate Court action. The purpose of the meeting is for family members and professionals to collaborate in the development of a protective plan to ensure the child's safety.

Protective Intervention

The purpose of the protective intervention phase is to manage the implementation of a protective plan formulated at the protective plan meeting. The Child Protection worker continues to work with the client and others relevant to the case. Part of the protective plan may be to refer the case to a community service organisation to provide further support and monitoring of the child's circumstances. Child Protection may subsequently withdraw from the family when the case can be managed within the available family and community support network.

In some instances, the continuing risk to the child can result in the Child Protection service having to initiate court proceedings because the implementation of the protective plan has been unable to establish sufficient safety for the child. If court action is not taken, and the protective plan has been successfully implemented, the case will be closed.

Court activity

At any stage in the protective investigation, it may be assessed that the risk of harm to a child or young person cannot be safely managed via a protective plan with the voluntary cooperation of parents. In these situations Child Protection issues a Protection Application and the matter is brought before the children's court. This can occur in either of two ways:

- **By taking the child into safe custody**. In cases of extreme and immediate risk, the child protection worker removes the child from the parent's care and attends the Children's Court (office hours) or a Bail Justice (after hours) to apply for an interim accommodation order. Children and young people over six years of age who are subject to a protection application are required to speak with a legal aid solicitor independent of their parent legal advocate and attend court. If the child is an inpatient, and over six years of age, they may not be required to attend court if their medical situation precludes this. This may require confirmation by the relevant hospital medical officer, and alternate arrangements made for consultation by the child with legal aid.
- **By notice**. The application is lodged at the Children's Court and the Court advises of the date for the Court hearing. The worker then serves the notice to appear on the child and parents. At the first hearing of the application an interim accommodation order is made which states where and with whom the child must live until the next hearing and any conditions that the child, parents and Child Protection must abide by. A further date is set for a full hearing at which the magistrate will decide whether the grounds for the protection application have been proven. If so, they will decide on the most appropriate disposition following review of a disposition report from Child Protection. At each hearing all parties are entitled to independent legal representation, including the child, family members and the Department.

Feedback to health staff making a report

It is good practice for Child Protection to provide feedback to professionals who make Child Protection Reports. This enables health care staff that may continue to see families and hold concerns for the child to be aware of the current status of Child Protection involvement.

Response time for feedback to health staff will depend on the urgency of the report. If a report is to be investigated by Child Protection, exchange of information and feedback will also take place through case planning meetings and telephone calls. The Child Protection caseworker will coordinate communication with agencies involved in the case. The hospital will nominate a single person to act as the contact point for coordinating the information exchange. This contact person will then keep all hospital parties informed of the progress or status of the report.

Child Protection will contact professional reporters nominated person in writing, informing them of the outcome of the Intake Assessment. This process will be undertaken on a monthly basis for all hospital-based reports. In cases where the professional who made the report has not had feedback within an agreed time period, or after 28 days, they should contact the Child Protection intake manager in their region.

Child Protection cannot provide information about the outcome of the investigation, or whether the family have engaged with the referral agency, without the consent of the family.

Providing information to Child Protection

Health service medical records provide documented evidence of a baby, child or young person's health including illness, injuries and management for each visit to or stay in a health facility. All clinical findings must be recorded accurately and objectively. Reports must be up to date and include a full disclosure of all the facts. Health records can be used as evidence in court. Health records must be kept confidential, current, complete and readily available for patient care. Any disclosure of health records must be made in accordance with Principle 2 of the *Health Records Act 2000, which relate to the use and disclosure of information*. Principle 2.2c of the HRA enables Health Professionals to disclose the health records of an individual, in accordance with the requirements of the Children, Youth and Families Act.

Disclosure of information at intake

Health professionals (and other information holders) under the Children, Youth and Families Act are able to disclose information to Child Protection or Child FIRST (community based) intake when an initial risk assessment is being conducted and the most appropriate response is being determined in regard to a child protection report or family service referral.

Disclosure of Information during or following an investigation

Under the Children, Youth and Families Act, acute health services may be required to provide information to Child Protection services. Information should be provided on the response to request for information form provided in Appendix E: Health forms.

The information requested can only relate to the safety, welfare and wellbeing of a particular child or young person or a class of children or young people. The request cannot require health services to collect or obtain new information. The request only applies to information already held by the health service.

Child Protection services may request information about:

- the baby, child or young person's history, current circumstances and their views
- the parent or family
- other relationships
- the agency's role and relationship with the baby, child, young person and family
- the capacity of the parent to adequately care for the baby, child or young person. This could include information on family violence, drug and alcohol or mental health concerns.

Child Protection investigating a protective intervention report can request information under s.205 of the Children, Youth and Families Act.

Child Protection services will clearly outline:

- the subject of the information request and, if this is an adult, their relationship to the baby, child or young person
- how the request for information relates to safety, welfare and wellbeing and risk of harm issues
- identifying information so health workers can check they are talking about the appropriate person
- the timeframe for providing the information (this may be subject to negotiation depending on the timing of the request).

Child Protection services should make the request for information through the staff member nominated by the health service as the contact person for the particular baby, child or young person, when the report was made.

If the information required is not related to a hospital-initiated report, the request should be directed to the clinician, if known, with the understanding that they may need to consult further within their health service prior to releasing information. Where the clinician is not known or unable to be contacted, requests should be made through the chief executive officer's office. Health services will need to have protocols relating to the release of information and all health professionals will need to ensure they are familiar with their health service's internal policy about the release of health information.

A health professional as an information holder may also be requested to provide information as part of the decision making process to develop a case plan for the care and protection of a child and family.

Urgent requests

Where information is requested urgently as part of an investigation of a report:

- If it is known which service site within the health service the person has had contact with, health services should respond to Child Protection services as soon as practicable (and within 24 hours). Information that can reasonably be expected to be supplied within this timeframe includes whether the client has made contact with a health service, the name of the service, the last date of contact, and the nature of the contact.
- If the identity of the service site is not known, health services should make reasonable efforts to establish whether the person has had contact with any site within the health service. If this is established, the health service should provide Child Protection services with the name of the service site, the last date of contact with the client, and the nature of the contact.

Standard requests

Health services should make efforts to provide Child Protection services with the requested information within five to ten days.

After hours and weekend requests

Where requests for information are received from Child Protection services after business hours and on weekends, health services are only required to provide information on whether the nominated person has attended a hospital or after-hours crisis service. They should, nevertheless, make reasonable efforts to respond to such requests. The information you can be reasonably expected to provide includes whether a client has made contact with a health service, the name of the service, the date of last contact and nature of the contact.

Requests for written reports

Where written reports are requested from Child Protection health services should provide these to Child Protection services within three weeks. In urgent situations a health service may provide information to Child Protection services by telephone. This information should then be confirmed in writing using the appropriate proforma as soon as possible and a copy attached to the patient record.

Compulsory Disclosure of Information

Under s.200 of the Children, Youth and Families Act, where a child is subject to a Protection Order, the Secretary of the Department of Human Services has the legal authority to compel health professionals (and other Information Holders) to disclose information relevant to the protection and development of a child. Medical professional privilege does not apply in this circumstance.

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Requesting information from Child Protection

While Child Protection is not obliged to respond to requests from other agencies it is good practice to do so where it is assessed to be in the best interests of the child and is appropriate under the circumstances.

Protection under legislation for health staff providing health information to Child Protection

Under s.208 of the Children, Youth and Family Act the giving of information to a protective intervener during the course of the investigation of the report:

- does not for any purpose constitute unprofessional conduct or a breach of professional ethics on the part of the person by whom it is given
- if given in good faith, does not make the person by whom it is given subject to any liability in respect of it
- does not constitute a contravention of s.141 of the *Health Services Act 1988* or s.120A of the *Mental Health Act 1986*.

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Chapter 8: Working with Indigenous babies, children, young people and their families

This chapter expands on the issues discussed in Chapter 2: Patterns of risk and harm.

The decision making process for health service staff regarding harm or risk of harm is the same regardless of the culture, disability, gender, language, religion and sexuality of the baby, child, young person and their family or carer. Nevertheless, if hospital staff are to provide culturally appropriate services to vulnerable babies, children and young people from Indigenous families and understand the context for the current health problems many Indigenous people experience, they require an awareness of some of the problems Indigenous families are facing and of why those problems exist.[5]

The Victorian Aboriginal population is approximately 0.6 per cent of the total Victorian population. Aboriginal Australian have a younger age structure than that of the non-Aboriginal population, with 57 per cent under 25 years of age, compared with 34.1 per cent of the total population (Australian Bureau of Statistics 2001a).

Aboriginal Victorians in every age group are more likely than other people to be hospitalised because of a range of diseases and conditions. These illnesses include high levels of injury and poisoning, drug and alcohol disorders, kidney disease, digestive diseases, diabetes and social, emotional and behavioural disorders (Victorian Department of Human Services 2005).

From the Indigenous perspective

For the most part, the next section is taken from *Lookin' after our own: supporting Aboriginal families through the hospital experience* (2000). This report was written by Angela Clarke, Shawana Andrews and Neville Austin, Koori workers at the Royal Children's Hospital, as part of a project funded by the Victorian Health Promotion Foundation.

As well as detailing the development of the Aboriginal Liaison Program at the Royal Children's Hospital, the book describes the background to the root of some of the health problems and the difficulty many Aboriginal people today have in accessing mainstream medical services. Written from an Aboriginal perspective, it argues that the present circumstances of many Aboriginal Australians can be understood only by understanding the impact of colonisation on Aboriginal life. This view is also expressed in the report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families (1997) which states 'most significantly the actions of the past resonate in the present and will continue to do so in the future. The laws, policies and practices which separated Indigenous children from their families have contributed directly to the alienation of Indigenous societies today'.

While bringing a child to hospital can be a traumatic experience for any family, Aboriginal families often have additional worries. In the words of Clarke et al, 'The cultural shock of being a minority within what can often seem like a big, cold and foreign place is very real and poses genuine barriers to health care. Fears associated with past government policies resulting in the forced removal of Aboriginal children from their families and communities also impinge on access. These barriers, which are unseen, and are often not understood, can significantly impact on receiving equitable treatment and do contribute to the poor health status of Aboriginal Australians'.

The following provides a summary from chapter 1 of *Lookin' after our own: supporting Aboriginal families through the hospital experience* (2000), which looks at the impact of white colonisation on Aboriginal Australians.

Invasion

The atrocities that occurred throughout the colonisation period and the policies that have been implemented since had a devastating impact on Aboriginal people's health and wellbeing.

The arrival of the British began a series of government policies, which continue to impact on the lives of Aboriginal people and their communities today. These government policies can be loosely categorised into three eras:

- dispossession 1788–1880s
- segregation 1890s–1950s
- assimilation 1930s–1970s.

Dispossession

In the words of Clarke and colleagues (2000), 'The history of dispossession of land for Aboriginal people through white settlement is heart breaking. The taking of land shattered the very basis and fabric of Aboriginal society. As more land was 'cleared' for incoming settlers, many Aboriginal families were shot and slaughtered, others were deliberately poisoned, and many died from starvation. The violence even extended to the abduction and rape of Aboriginal women'.

The era of dispossession saw Aboriginal people 'camped on the margins of European settlements, increasingly dependent on their colonisers for their survival', with malnutrition and endemic disease manifest and access to hospitals or proper medical treatment denied as a basic right.

Segregation

By the beginning of the 20th century relations between Aboriginal and non-Aboriginal men and women had led to a population increase of children with one Aboriginal parent or grandparent. During the segregation era, Aboriginal people were systematically removed from traditional lands and placed on reserves. Aboriginal people were reliant on limited government rations (flour, sugar, tea and tobacco) for survival. The segregation era was also known as the 'protection era' with 'Aborigines protection boards,' being appointed in all states and territories to watch over what they considered to be the interests of Aboriginal people. The extensive powers held by these boards included the power to remove children from their families.

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Assimilation

Towards the middle of the twentieth century, assimilation policy ushered in a new wave of policy making. Under assimilation, Aboriginal people were to adopt the same manner of living as white Australians and be absorbed into the mainstream population. The assimilation policy continued with the forcible removal of Aboriginal children from their families and communities and placeing them in white institutions and foster homes to be raised away from their families and communities.

These policies were often implemented in the name of child welfare. Clarke and colleagues (2000) note, 'The rich knowledge, culture, language, belief systems, laws – not to mention the love and nurturing – they would have received in their own families and communities were simply not given validity. These policies had a devastating impact on Aboriginal people. They tore Aboriginal families apart all over Australia, and continue to impact on families today'.

The child removal policies were practised in this country until the 1970s. In 1995, the Commonwealth Government set up a national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. Under this inquiry, the Human Rights and Equal Opportunity Commission was asked (among other things) to trace the past laws, practices and policies that resulted in the separation of Aboriginal and Torres Strait Islander children from their families.

The inquiry's report, *Bringing them home,*[17] reinforced and highlighted the atrocities that were inflicted on Aboriginal people which resulted in physical and psychological harm that is still prevalent today. The many problems associated with the emotional development of Aboriginal children separated from their families are only beginning to be understood. Many generations of Aboriginal people have been denied normal childhood development, bonding to their families, or any form of consistent, positive relationship or love. The inquiry found that:

> *Indigenous children have been forcibly removed from their families and communities since the very first days of European settlement. In that time, not one Indigenous family has escaped the effects. Most families have been affected in one or more generations by the removal of one or more children. Nationally, the inquiry concludes that between one in three and one in ten Indigenous children were forcibly removed from their families and communities between 1910 and 1970.*

The role of hospitals

The many submissions and evidence provided to the inquiry strongly suggest that hospitals throughout Australia, over decades, were involved in the systematic removal of Aboriginal children from their families. Many Aboriginal parents, knowing that taking their children to hospital presented a huge risk, nevertheless took this risk when their children needed health care, only to have the children taken from them. The legacy of fear and distrust remains.

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Post-assimilation era

Aboriginal people were included in the national census with equal rights to vote in 1967 but there were few changes to the assimilation and integration policies until the Labor (Whitlam) government was elected in 1972 and introduced the policy concept of self-determination. This was later modified to self-management and, though such policy changes were positive, access to services for Aboriginal people remained restricted. Carriage of the *Racial Discrimination Act 1975* followed–a further positive step. But past experiences of shame and humiliation and the persistent racist attitude of many non-Aboriginal hospital staff were responsible for a near- impenetrable barrier between Aboriginal people and medical attention, and hospitals and mainstream services remained largely unattainable for Aboriginal people.

The 1980s saw the emergence of a realisation that there was a crucial need for culturally sensitive services within mainstream medical institutions. A positive example is the Wronski report.[44] It was a recommendation from this report that led to the Aboriginal Liaison Officer Program in Victorian hospitals, initiated in 1982. Other recommendations included establishing a network of Aboriginal community-controlled health services, an Aboriginal health resources consultative group to advise the State Minister for Health, and an Aboriginal Health Unit.

The Aboriginal Liaison Officer Program has been the subject of recent review and additional funding and has now become Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP), which encourages an outcome focus through cultural change in health services leading to improved identification and health care for Aboriginal patients, responses proportional to the number of Aboriginal and Torres Strait Islander patients, whole-of-health service responsibility, and relationships with Aboriginal people and organisations.

Clarke and colleagues (2000) sum up: 'The *Bringing them home* report clearly describes the cycles of poverty, dislocation and ill health many families are burdened with as a result of generations of children being taken away under the assimilation policy. Positive steps need to be taken to ensure that Aboriginal families feel they can safely bring their children to hospital, and that they have access to the services, information and options to which they are entitled. Non-Aboriginal health professionals also need to be aware of the past in order to understand the fears and apprehensions that Aboriginal families experience today'.

Appendix A
Evaluation and sustainability

Change is a fundamental component of any improvement activity. Health services are frequently implementing system change to respond to areas of identified risk or need.

It is important to assess the impact of these changes to know if objectives have been achieved and whether there is visible improvement as a result of the changes. As well as identifying any unintended consequences that may have an adverse effect. The evaluation tool in table 1 can be used as a pre-post test to assess the extent to which the best practice framework has been implemented. The table on page 76 identifies some desired outcomes and suggests how they might be measured. Health Services are encouraged to use these tools as both a self-assessment tool and to assist in reporting on improvements to the Department.

Vulnerable Children Program Evaluation Tool

Responding to vulnerable babies, children and young people 38 point assessment of your health service's response

Assess before any program implementation and then every six months

The assessment is based on the principles and key elements of an effective health service response to vulnerable children outlined in the chapter 4 of the Babies, children and young people at risk of harm best practice framework for acute health services.

Health services are expected to have a holistic approach to identifying children at risk, with an effective and accessible hierarchy of responses, systems and resources to ensure clinicians and managers are prompted, encouraged and supported to identify risks or possible risks to babies, children and young people with whom they come in contact (even for a short period of time) and to take appropriate action. This should be linked into health service responses to issues of family violence and attending to the psychosocial environment of children and families where there may be health impacts.

Table 1 Vulnerable children program evaluation tool

Date of assessment:	/	/	/
Policies and protocols	**Yes/No**	**Yes/No**	**Yes/No**
Are policies and protocols specific to responding to babies, children and young people at risk of harm:			
1. ratified and present in the official health service policy manual?			
2. present within pertinent departments, clinics, wards and other services? (such as emergency departments, antenatal and paediatric clinics, paediatric wards, neonatal nurseries and mental health services)			
3. present and consistent across all sites of the health service?			
Do these protocols:			
4. state and indicate how protecting vulnerable babies, children and young people s everyone's responsibility?			
5. detail the role and responsibility of hospital staff (both mandated and non-mandated) in protecting vulnerable children?			
6. define child abuse and neglect?			
7. detail common high risk indicators and clinical presentations at all entry points to the health service for suspected child abuse and neglect?			
8. detail a hierarchy of responses for vulnerable babies, children and young people?			
9. detail responses and services sensitive to the culture, disability, gender, language, religion and sexuality of the baby, child, young person, their family and carer?			
10. identify internal sources of advice and expertise for responding to vulnerable babies, children and young people?			
11. have a collaborative, multidisciplinary approach to responding to vulnerable babies, children and young people?			
12. address referral to and note contact details and criteria for access to other relevant programs and agencies?			
13. detail how to make a report to Child Protection if a belief of significant harm is formed?			
Organisational commitment			
14. Does the health service have a committee or working group that manages reporting and strategic planning for vulnerable babies, children and young people?			
15. Is the group multidisciplinary (that is, include various disciplines, such as medical, nursing, allied health, mental health staff)?			
Does the group:			
16. have strategic goals and objectives?			
17. have consumer representation? (such as patient representatives, community welfare agency staff and Indigenous liaison officers or local Indigenous co-operative member)			
18. collect and review data on vulnerable babies, children and young people?			
19. report to the hospital executive and board?			
20. meet at least every two months?			
21. Has the group established a relationship with the local Child Protection service or does it have a Child Protection service member representative?			
22. Has the group established a relationship with the local Victoria Police or does it have a Victoria Police member representative?			

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Awareness and training			
23. Has clinical staff training in vulnerable babies, children and young people been scheduled in the past year?			
24. Is there evidence clinical staff training will be ongoing?			
25. Has non-clinical staff training been scheduled in the past year?			
26. Are staff mandated to attend vulnerable babies, children and young people training?			
27. Does new staff orientation include training and information on vulnerable babies, children and young people?			
28. Is training held during paid working hours on all shifts?			
29. Is there evaluation of the training's effectiveness?			
30. Has cultural awareness training occurred in the past year?			
Interventions for vulnerable babies, children and young people			
31. Are brochures or posters related to vulnerable babies, children and young people, child abuse and neglect on display anywhere in the health service?			
32. Is information related to vulnerable babies, children and young people, child abuse and neglect available for patients or parents and carers?			
Relationships and linkages			
33. Do hospital staff take part in interagency meetings at least every quarter (such as meetings involving Child Protection services, Victoria Police, community support agencies and Indigenous co-operatives)?			
34. Does the health service have an issue resolution process with vulnerable children interagency partners?			
Evaluations of practice			
35. Has there been an evaluation of the quality of assessment and documentation completed through a review of the medical record in the past 12 months?			
36. Has there been a root cause analysis of any sentinel events related to vulnerable babies, children and young people in the past 12 months?			
37. Have the policies and procedures been reviewed and updated to comply with evidence-based practice in the past 12 months?			
38. Does the health service practice reflect the baby, child or young person's best interests being at the heart of all decision-making and service delivery?			

Adapted with permission from New Zealand Ministry of Health 2002, *Family violence intervention guidelines: child and partner abuse*, Ministry of Health, Auckland.

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Table 2 Desired outcomes

Desired outcome	Performance outcome measure
1. Acute health services identifying and responding to the needs of babies, children and young people at risk of or experiencing child abuse and neglect	1.1 Evidence of appropriate identification and intervention through file audits 1.2 Increased number of appropriate reports of babies, children and young people at risk of child abuse and neglect to Child Protection by adult focused services
2. Within health services, improved case planning, conferencing and coordination of service delivery to babies, children and young people at risk of harm or experiencing child abuse and neglect	2.1 Evidence of case planning and coordination through file audits 2.2 Evidence of identification and effective responses put in place for babies, children and young people at risk of harm or experiencing child abuse and neglect
3. Child protection responsive to reports from acute health services	3.1 Increased number of appropriate reports which meet agreed criteria for investigation by Child Protection
4. Adverse events for babies, children and young people minimised	4.1 Evidence of reviews or investigations to assess adverse outcomes 4.2 Evidence of systems changes as a result of reviews of adverse outcomes 4.3 Decreased numbers of adverse outcomes for babies, children and young people within health services based on reviews of reportable incidents
5. Fewer child deaths due to acute hospitals identifying or intervening appropriately	5.1 Evidence of appropriate identification and intervention through file audits 5.2 Evidence of case planning through file audits 5.3 Decreased number of child deaths where contact with health services did not result in appropriate identification, reporting or intervention based on a review of reportable incidents and Victorian Child Death Review Committee reports

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Appendix B
Glossary

abuse, neglect	Generic terms used to describe an act or omission that endangers or impairs a child's physical or emotional health and development. It is the misuse of power by adults over children, and although abuse is not an accident, neither is it always the intention of the person to inflict harm or injury.
belief	Legally, a belief is based on reasonable grounds as defined in s.186 of the *Children, Youth and Families Act 2005*. The concept of 'forming a belief' is a thinking process where a person is more inclined to accept rather than reject that there is significant risk of harm for the child or young person.
care	In relation to a child, means the daily care and control of the child, whether or not involving custody of the child.
carer	A person who, while not a parent of the baby, child or young person, has actual custody of the child. Carers may provide the care with or without fee or reward and can include relatives, friends or acquaintances of a parent, residential care workers, childcare workers, youth workers, nursing staff and foster parents.
case management	The coordination and delivery of services provided as part of a case plan.
case conference/meeting	A meeting held with professionals and Child Protection representatives (the family can be invited where appropriate) to determine whether a report requiring further action needs to occur. A case conference can also be called at other times. A conference is usually convened by a Child Protection worker, although other professionals can initiate one. The purpose of a case conference is to: • clarify the seriousness of the protective concerns • share information and knowledge about the child and family • determine whether the protective concerns will be managed by existing community supports or whether further investigation by the Child Protection service is required.
case planning	A formal ongoing process of decision making for a child from the time of a report to case closure. The purpose is to: • identify the key changes necessary to enable the child to live safely and have their individual needs met • identify the activities and tasks necessary to bring about the key changes • identify those responsible for the specific activities and tasks • ensure intervention is targeted and tied to timelines.
child	a person aged 0–16 years or, if subject to a protection order, 0-17 years
Child FIRST	Under the new system a child, family information, referral and support team (Child FIRST) will operate on a subregional basis and provide entry (intake) to secondary child and family services in a local area. Health services and others can refer to Child FIRST if the have significant concerns about the wellbeing of a child.

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child in need of protection	A child who has suffered, or is likely to suffer, significant harm as a result of sexual, physical or emotional abuse, neglect or abandonment, and the child's parents have not protected or are unlikely to protect the child from that harm. The significant harm may be a result of one incident or the cumulative result of many incidents or a general pattern of behaviour or circumstances. (s.162 children, youth and families act 2005)
child protection	A term used to describe the whole community's approach to prevention of harm to children. It includes strategic action for early intervention, for protecting those considered most vulnerable and for responses to all forms of abuse.
Child Protection service	The Child Protection service of the Victorian Department of Human Services. This service has statutory responsibilities under the *Children, Youth and Families Act 2005* for ensuring a child's safety and wellbeing. Also referred to as Child Protection
Child Protection report	A report made to Child Protection under s.183 (voluntary reports) or s.184 (mandatory reports) of the Children, Youth and Families Act based on the reporter's belief that a child is in need of protection
child wellbeing referral	A referral made to a child, family information, referral and support team (Child FIRST) under s. 31 of the Children, Youth and Families Act based on the referrer's significant concern for a child's wellbeing
community-based child and family service	A service which provides advice, assistance and support to vulnerable children and their families and performs other functions consistent with the purposes specified in s. 22 of the Children, Youth and Families Act and which is registered under s.47.b of the Act
community service	A community-based child and family service or out-of-home care service or other service provided specifically to vulnerable children which is registered by the Secretary of the Department of Human Services and required to comply with service standards (s.3, s.46, s.47)
Cumulative harm	The accumulation of risk factors which when viewed together form a pattern of harm greater than that suggested by an single incident or risk factor.
family service	See community-based child and family service
family support services	Support services that assist families to identify and reduce personal and social stresses that can lead to family breakdown and/or child abuse. They include in-home family support, counselling, parenting support.
harm	The effect on a child from abusive acts by adults. It is specified in s. 62 of the Children, Youth and Families Act. (See also 'significant harm')

information holder	It is a police member, employee of any Victorian Government department, teacher, principal, nurse, psychologist, medical practitioner, or person in charge of a specified health service; a specified mental health service, a body funded to provide disability services, a body funded to provide drug or alcohol treatment services, a children's service, and other prescribed classes as defined in s. 3 of the Children, Youth and Families Act. These are all professionals who may have contact with vulnerable children or their parents in the course of their work.
intake	The phase wherein the initial assessment of a report takes place. The purpose of the intake phase is to establish whether the child's or young person's described circumstances fall within the legal definition of a child in need of protection. Primary responsibility is to assess the risks to the child or young person and the level of urgency.
intervention order	The *Crimes (Family Violence) Act 1987* gives legal protection to victims of family violence by enabling them to obtain an intervention order to restrain the alleged perpetrator from threatening or committing further acts of violence.
investigation	The phase following the intake phase, when Child Protection investigates a report directly in order to determine whether a child or young person has been or is likely to be at risk of significant harm. It is a process for gathering information about the report and may include interviews and other inquiries into all of the baby, child or young person's circumstances and any risk to their future safety and wellbeing.
mandatory reporting	A report made under s. 184 of the Children, Youth and Families Act to Child Protection by a mandated professional (police, doctor, nurse and others) that a child is in need of protection from sexual abuse or physical injury
report	A report made to Child Protection by any person who believes on reasonable grounds that a child is in need of protection. Section 162 of the Children, Youth and Families Act defines when a child is in need of protection.
out-of-home care service	A service which provides home/family-based or residential care for a child who is placed away from their family home and which is registered under s. 47.a of the *Children, Youth and Families Act*
out-of-home care	The term used to describe care and a baby, child or young person at a place other than their usual home and by a person who is not the baby, child or young person's parent or relative. It can include staying with friends and acquaintances, foster care, residential care, shared care and other forms of substitute care.

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protection order	An order listed in s. 275 of the Children, Youth and Families Act and made by the Children's Court where a child is found to be in need of protection or there are substantial and irreconcilable differences between the parent/caregiver and child to the extent that the care and control of the child is likely to be seriously disrupted. The court can make any one of the following protection orders: • an interim protection order not exceeding three months • an order requiring a person to give an undertaking • a supervision order • a custody to third party order • a supervised custody order • a custody to Secretary order • guardianship to Secretary order • a long-term guardianship to Secretary order (s.275 of the Children, Youth and Families Act)
protective intervention	Phase after a substantiation where Child Protection manages implementation of the protective plan. The protective plan is the action to be taken by agencies to protect a baby, child or young person from harm by providing care, services and support or apprehending and prosecuting those responsible for their harm.
protective response	Action that will most effectively ensure a child's safety and wellbeing
reasonable grounds	Defined in s. 186 of the Children, Youth and Families Act: • matters of which a person has become aware and • any opinions based on those matters. A person has reasonable grounds to report when: • a child tells them they have been harmed • a child tells them that they know someone who has been harmed • someone else tells them, such as a relative, friend, acquaintance or sibling of the child, that they know or believe that a child has been harmed • observations of the child's behaviour or development leads them to believe that the child has been harmed • they observe physical signs of harm.
secondary and specialist services	Services that provide more intensive and targeted support where a problem has been identified, and offer programs that identify and reduce the personal and social stresses on parents that lead to family breakdown and/or child abuse. They include in-home family support, financial and family counselling, respite care, drug and alcohol services, health and mental health services, disability services and housing services.
significant harm	Harm to the child that is more than trivial or insignificant, but need not be as high as serious. Is important or of consequence to the child's development but need not have lasting or permanent effect, nor necessarily be treatable. (Justice O'Bryan, Buckley vs CSV, supreme court, Victoria, 1992)

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signs	Behavioural or physical signs or symptoms that assist in the recognition of child abuse. Also called warning signs.
substantiation	The point at which a judgment is made in the Child Protection investigation process that harm has occurred or there is a likelihood of future harm and/or cumulative harm. Child Protection involvement will continue until the child's safety and wellbeing are addressed.
tertiary child protection services	Services that include the statutory Child Protection services and out-of-home care services for children who are unable to live at home because of the risk of harm. A strengthening of the secondary service sector, in line with current government policy on the broader service system support means that the role of the Child Protection service is targeted as a service of last resort.
universal services	Services that are offered to everyone. They include antenatal services, maternal and child health services, preschool and school education services, and general practitioners. Acute hospitals, while offering specialist care, also offer a universal service, particularly through their accident and emergency departments.
Victorian Risk Framework	The risk assessment model used by the Child Protection service. The framework provides a consistent and standardised model for the assessment of significant harm to children and guides Child Protection workers in the key activities of information gathering, analysis and judgment.
service agency	A State Government department or a program delivered or funded by the Department of Human Services in the fields of health (under s.141 of the *Health Services Act 1988*), mental health (under s. 120A of the *Mental Health Act 1986*), disability or drug and alcohol treatment services, or other prescribed bodies, as defined in s. 3 of the Children, Youth and Families Act. These departments and services are expected to take some responsibility for the vulnerable children of parents who may be their primary clients.
significant concern for a child's wellbeing	A referral to Child FIRST is made under s. 31 of the Children, Youth and Families Act. This term is not defined in the Act, but is intended to mean that the child is in a situation where they are not likely to suffer significant harm in the foreseeable future (or they would be viewed as being in need of protection) but where there are sufficient concerns to justify offering services to them or their family to reduce their vulnerability to long term harm.
therapeutic treatment report	A report made to Child Protection under s.185 of the Children, Youth and Families Act based on a belief that a child aged ten to 14 years is in need of therapeutic treatment as a result of exhibiting sexually abusive behaviours
therapeutic treatment order	An order issued by the court which will require a child aged ten to 14 years exhibiting sexually abusive behaviour to attend treatment

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vulnerable child	A child for whom there is a significant concern about their wellbeing (and who may also be in need of protection)
unborn child referral	A referral made to a family service intake under s. 32 of the children, youth and families act before the birth of a child and based on the reporter's significant concern for the child's wellbeing after the child is born
unborn child report	A report made to Child Protection under s. 29 of the Children, Youth and Families Act before the birth of a child and based on the reporter's significant concern for the child's wellbeing after the child is born
young person	Any person who is aged 16 years or above but who is under 17 years of age

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Appendix C
Contact information

Vulnerable children referral agencies	Contact	Notes
Victorian Forensic Paediatric Medical Services (VFPMS) **Metropolitan locations:** • Gatehouse Centre Royal Children's Hospital, Flemington Road, Parkville 3052 • Angela Taylor Child Protection Unit, Emergency Department, Monash Medical Centre, 246 Clayton Road, Clayton 3168	Phone: 1300 66 11 42 www.vfpms.org.au	Services include: • forensic paediatric assessments • secondary consultation and advice for health professionals • education on child abuse and neglect • research on child abuse and neglect.
Centres Against Sexual Assault (CASAs)	State wide Crisis Line: (03) 9344 2210 Rural Freecall: 1800 806 292 www.casa.org.au	There are 15 Centres Against Sexual Assault in Victoria as well as an after hours crisis line. Service locations can be found on the web site or in the telephone book.
Women's alcohol and Drug Service (WADS)	Phone: 9344 3631 Fax: 9344 2719 www.rwh.org.au/wads	Provide pregnancy care, professional support, education and training services. Contact information for other chemical dependency units in Victoria
Maternal and Child Health Nurse (24 hr service)	132 229	
Child and adolescent mental health services (Metropolitan and rural)	www.health.vic.gov.au/mentalhealth/services/child/index.htm	
Child Protection services		
Metropolitan		
Eastern Intake Unit	Phone: 1300 360 391 Fax: 9843 6300	
North & West Intake Unit	Phone: 1300 369 536 Fax: 9479 0119	
Southern Intake Unit	Phone: 1300 655 795 Fax: 9213 2199	

Rural		
Gippsland Intake Unit	Phone: 1800 020 202 Fax: 5136 24 84	
Grampians Intake Unit	Phone: 1800 000 551 Fax: 5333 6827	
Hume Intake Unit	Phone: 1800 650 227 Fax: 5722 0649	
Loddon Mallee Intake Unit	Phone: 1800 675 598 Fax: 5434 5677	
Barwon South Western Intake Unit	Phone: 1800 075 599 Fax: 5226 4741	
Child Protection After Hours Child Protection Emergency Service	Phone: 131278 Fax: 98435413	
Best Start	www.beststart.vic.gov.au	
Department of Human Services Office for Children Early Childhood Services • Maternal and child health • Early Childhood intervention services Family Services • Family services • Innovation Projects • Parenting Services Family Violence and Sexual Assault Services	www.office-for-children.vic.gov.au/children	Contact information for a range of universal and secondary services can be found on this site. There is also information on every child every chance, reforms to Victoria's child protection laws. These reforms are designed to improve outcomes for Victoria's children, youth and families.
Other agencies		
Domestic Violence and Incest Resource Centre	Phone: (03) 9380 4343	
Women's Domestic Violence Crisis Service of Victoria	Hotline: 1800 015 188	
Victoria Police Sexual Offences and Child Abuse Unit	Phone: (03) 9247 6936	
Maternal and Child Health Centre Directory	www.health.vic.gov.au/mchdirectory/index.htm	

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Aboriginal and Torres Strait Islander agencies		
Victorian Aboriginal Community Controlled Health Organisation	www.vaccho.org.au	Locations in Victoria include: Bairnsdale, Ballarat, Bendigo, Echuca, Geelong, Halls Gap, Heywood, Horsham, Kerang, Lake Tyers, Melbourne, Mildura, Morwell, Orbost, Portland, Robinvale, Rumbalara, Swan Hill, Warrnambool, Wodonga Contact details are available on the vaccho website
Victorian Aboriginal Child Care Agency Co-operative Limited	http://esvc000737.wic021u.server-web.com/flash.html	VACCA's objectives include the preservation, strengthening and protection of the cultural and spiritual identity of Indigenous children and to provide culturally appropriate and quality services which are responsive to the needs of the Indigenous community. VACCA provides the following services: family support, Lakidjeka Crisis Support, extended care and permanent care, family preservation, kurnai and a debriefing officer.
Secretariat of National Aboriginal and Islander Child Care	www.snaicc.asn.au	This web site has a service directory which can be searched for details of Indigenous family and children's services, health and legal services, government departments, peak bodies and resources agencies in a local area.
Related links		
National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn	www.health.nsw.gov.au/pubs/2006/ncg_druguse.html	

Local social service agencies (For health service to complete)		

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Appendix D
Screening and assessment tools

Case conferencing

It is widely acknowledged that a coordinated multidisciplinary, multi-agency response to issues of child abuse result in more effective interventions through more effective assessment and a more coordinated response to the needs of the child and their family.[33, 40]

Case conferencing involving multidisciplinary teams is an important tool for assessment and case planning. Early case conferencing provides an opportunity to share information and facilitate the valuation process for children suspected of having suffered abuse.

A recognised tool for case conferencing is the SCAN (Suspected child abuse neglect) Protocol which is a protocol for meetings between health professionals, Child Protection and the Police.

A SCAN team should include senior staff from:

- Child Protection
- Police
- Hospital medical staff; and
- Social work or other key areas associated with child protection

It is desirable that a meeting of the SCAN team occurs within 24 hours of a report to Child Protection or Victoria Police. The purpose of the meeting is to share information regarding the case and to initiate case planning. Information and current opinions from the three agencies are provided. Medical information to be provided should include:

- History of injury or concerns about child abuse
- Examination findings
- Child's past health, growth, development and previous injuries
- Psychosocial and family history
- Investigations ordered and results (if available)
- Consultation with other medical professionals (inc radiology)
- Opinion in relation to possibility that the child has experienced abuse

A written record of the meeting should be included in the patient record along with further action to be taken. Any differences in professional judgements regarding the nature of the abuse or neglect should be recorded. In relation to clinical opinion, where there are differences in opinion a senior, expert opinion should be sought which should be endorsement by the designated responsible person within the hospital.

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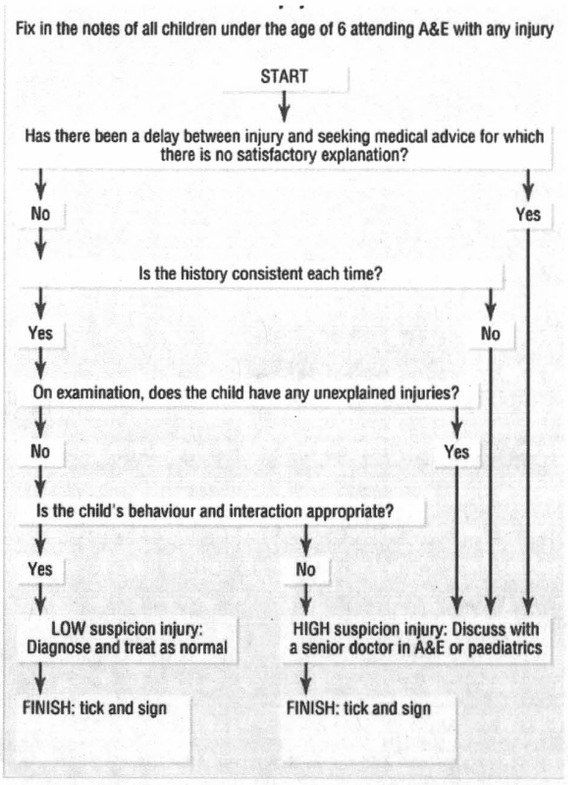
Emergency department prompts

It is recognised that Emergency Departments are busy places and child abuse can be overlooked. Equally, it is also acknowledged that Emergency Department staff have an important role in identifying child abuse and neglect and it is important that staff are encouraged and supported to identify and report suspected child abuse and neglect. The use of reminders and checklists has been shown to help improve staff awareness staff child abuse. Below is an example of a tool that was found to be effective in increasing consideration of intentional injury among preschool children attending emergency departments.

Figure 1 Paediatric injury flowchart



Source: Paediatric injury flowchart from Benger, JR & Pearce, AV 2002, 'Quality improvement report: simple intervention to improve detection of child abuse in emergency departments' British Medical Journal, vol. 324, pp. 780–2.

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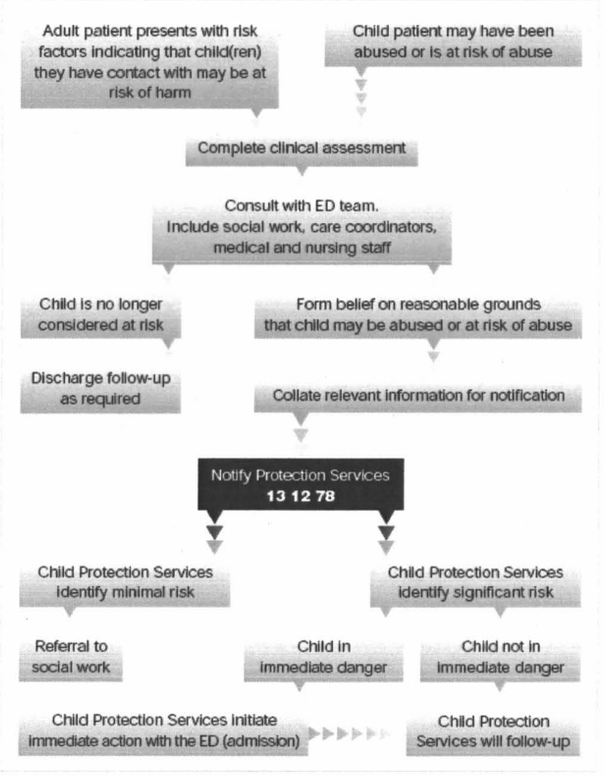
Further information specifically designed for emergency departments is available in the *Children at risk: information for Victorian emergency departments*[18] developed as a resource to assist clinicians in recognising and managing children presenting to Victorian emergency departments. The care process below has been taken from this document. For more information go to www.inform-ed.com.

Figure 2 Care process for children at risk in the ED



Source: Paediatric injury flowchart from Benger, JR & Pearce, AV 2002, 'Quality improvement report: simple intervention to improve detection of child abuse in emergency departments' British Medical Journal, vol. 324, pp. 780–2.

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Appendix E
Health forms

Protective intervention report form

Assemble as much information as possible (depending on urgency) prior to making the report. Allow sufficient time to discuss the concerns in detail with Child Protection intake staff when you call.

Date of report: / /		Time: am/pm	
Name of intake officer:		Call Reference No:	
CHILD			
Name:		Age: days/months/years	
Gender: Female/male	Date of birth: / /	Home phone:	
Home address:			Postcode:
Who currently has custody of the baby, child or young person?			
Where is the baby, child or young person's present location?			
Is the baby, child or young person safe now?			
Is the baby, child or young person:	Aboriginal? Yes/No	Torres Strait Islander? Yes/No	Non-English speaking background? Yes/No
If an interpreter is required, what language?			
School/campus/centre attended by baby, child or young person:			
ALLEGED ABUSE OR NEGLECT			
What are the grounds for the report? How did you form your belief of significant harm? Include description and details of present physical and behavioural indicators of suspected abuse or neglect.			
What response/intervention has been initiated by the hospital?			
What are the concerns held related to risk of harm to the baby, child or young person?			
How does the injury or medical condition impact or influence the risk of harm to the baby, child or young person?			
Are the child and/or family aware of the report?	Yes/No		
If yes, what was their reaction to the report?			
If no, why not?			
If this report is being made in relation to a young person, note whether the report has been discussed with the young person, and the views of the young person about this report.			

If this report is being made in relation to an Aboriginal or Torres Strait Islander baby, child or young person, has the child (if age-appropriate), young person or family been asked if they would like an Indigenous liaison officer or a local Indigenous co-operative member present?	Yes/No

FAMILY			
Family composition:			
Parents or carers and their relationship to the baby, child or young person:			
Name:		Name:	
Phone no.:		Phone no.:	
Relationship:		Relationship:	
Parents' marital status:			
Siblings:			
Name:	Name:	Name:	Name:
Relationship:	Relationship:	Relationship:	Relationship:
Other adults in the home:			
Extended family:			
Patterns of family interaction:			
History of violence, abuse or neglect:			
What other agencies involved with the baby, child, young person or their family?			

HEALTH SERVICE CONTACT DETAILS FOR THIS CASE		
Reporter name:	Reporter position:	
Phone no.:	Signature:	Date: / /
Address:		
Hospital contact person for additional information or feedback on report if different from above:		
Name and position:		Phone no.:

CONTACT LIST – VICTORIAN CHILD PROTECTION REGIONAL OFFICES			
Metropolitan regions		Rural regions	
Eastern Intake Unit	1300 360 391	Gippsland Intake Unit	1800 020 202
North & West Intake Unit	(03) 1300 369 536	Grampians Intake Unit	1800 000 551
Southern Intake Unit	1300 655 795	Hume Intake Unit	1800 650 227
		Loddon Mallee Intake Unit	1800 675 598
		Barwon South Western Intake Unit	1800 075 599
Child Protection crisis line for emergency child protection matters outside of normal business hours – 13 1278			

Adapted with permission from NSW Health (28).

Child wellbeing referral form

Assemble as much information as possible prior to making the referral. Allow sufficient time to discuss the concerns in detail with family services intake staff when you call.

Date of referral: / /		Time: am/pm	
Name of intake officer:		Call reference no.:	
CHILD			
Name:		Age: days/months/years	
Gender: Female/male	Date of birth: / /	Home phone:	
Home address:			Postcode:
Who currently has custody of the baby, child or young person?			
Where is the baby, child or young person's present location?			
Is the baby, child or young person:	Aboriginal? Yes/No	Torres Strait Islander? Yes/No	Non-English speaking background? Yes/No
If an interpreter is required, what language?			
School/campus/centre attended by baby, child or young person:			
REASON FOR CONCERN			
What are the grounds for the referral? Include description and details of reasons for concern.			
What response/intervention has been initiated by the hospital?			
How do the concerns raised or how are they likely to, impact on the baby, child or young person?			
Are the child and/or family aware of the referral?	Yes/No		
If yes, what was their reaction to the referral?			
If no, why not?			
If this referral is being made in relation to a young person, note whether the referral has been discussed with the young person, and the views of the young person about this referral.			
If this referral is being made in relation to an Aboriginal or Torres Strait Islander baby, child or young person, has the child (if age-appropriate), young person or family been asked whether they would like an Aboriginal liaison officer or a local Aboriginal co-operative member present?			Yes/No

FAMILY			
Family composition:			
Parents or carers and their relationship to the baby, child or young person:			
Name:		Name:	
Phone no.:		Phone no.:	
Relationship:		Relationship:	
Parents' marital status:			
Siblings:			
Name:	Name:	Name:	Name:
Relationship:	Relationship:	Relationship:	Relationship:
Other adults in the home:			
Extended family:			
Patterns of family interaction:			
History of violence, abuse or neglect:			
What other agencies are involved with the baby, child, young person or their family?			
CONTACT DETAILS OF PERSON MAKING THE REFERRAL			
Name:		Position:	
Phone no.:	Signature:	Date: / /	
Address:			
Hospital contact person for additional information or feedback on referral if different from the referrer:			
Name and position:		Phone no.:	

Request for information response form

Adapted with permission from the NSW Health (28).

CONFIDENTIAL – Response to request for information from Department of Human Services Child Protection services or Child, family information, referral and support team

Date report completed and sent to authorised requesting service: / /		
Date request received from authorised service: / /		
Name of authorised person requesting information:		
Position of authorised person requesting information:		Phone no.:
Name: (of baby, child, young person or family member)	Date of birth: / /	Gender: Female/Male
RELEVANT INFORMATION:		
(Please attach additional information as required)		
HOSPITAL CONTACT DETAILS		
Is there another hospital staff member approved for future contact in relation to this matter?		Yes/No
If yes, name and position:		Phone no.:
Name of hospital staff member completing this form:		
Position		Phone no.:
Name of hospital chief executive officer or delegate authorising release of information		
CEO signature:		Date: / /

Appendix F
Excerpts from relevant legislation

Summary of the relevant provisions of the Children, Youth and Families Act 2005

Mandatory reporting legislation

- Reports of a child in need of protection are made under section 184 of the Children Youth and Families Act 2005. Under Victorian law, a child is defined as being under 17 years of age, or in the case of a protection or interim order under the age of 18 years.

Legal definition of a child in need of protection

In Victoria, the legal definition of a child in need of protection is provided under Part 4.1, section 162 of the *Children, Youth and Families Act 2005*. For the purpose of this Act a child is in need of protection if any of the following grounds exist:

(a) the child has been abandoned by his or her parents and after reasonable inquiries:

  (i) the parents cannot be found; and

  (ii) no other suitable person can be found who is willing and able to care for the child

(b) the child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child

(c) the child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type

(d) the child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type

(e) the child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type

(f) the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care.

For the purposes of sub-sections (1)(c) to (1)(f), the harm may be constituted by a single act, omission or circumstance or accumulate through a series of continuing acts, omissions or circumstances.

It is the dual focus on harm, and the inability or unwillingness to protect, which enables the Child Protection Service to be involved. Interpretation of the parent's capacity and willingness to protect is made with regard to the degree of community support and services available to assist the parent in this responsibility.

- Section 84 of the Children Youth and Families Act 2005 states that certain professionals must report to Child Protection Services, when, in the course of their professional duty they form the belief that a child is in need of protection as legally defined above

Specifically, these mandated professions include:

- nurses
- doctors
- primary and secondary school principals and teachers
- police.

On and from the relevant date the following are also included as mandatory reporters:

- proprietor of or person with a post-secondary qualification working for a children's service (to which the *Children's Services Act 1996* applies)
- person with a post-secondary qualification in youth, social or welfare work who works in the health, education or community or welfare services field
- a person employed under Part 3 of the *Public Administration Act 2004* to perform the duties of a youth and child welfare worker
- a registered psychologist
- a youth justice or youth parole officer.

As a mandated professional

- It is your responsibility to report a belief, based on reasonable grounds, that a child or young person is in need of protection from physical injury or sexual abuse, when you form this belief in the course of practising your profession. In other words, you will not be legally obliged to report if you encounter abuse in your private life or when you are working in a capacity that is not directly related to the professional affiliation under which you are mandated.
- You must make the report as soon as practicable after forming the belief.
- You are required to report each time you become aware of any further reasonable grounds for your belief.
- You do not have to be able to prove that the abuse has occurred.
- It is your responsibility to report your belief – it is not the responsibility of your supervisor, principal, senior or boss. If you are one of a group of mandated notifiers who share the belief, based on reasonable grounds, that a child or young person is in need of protection from physical or sexual abuse, then only one mandated notifier needs to make the report. However, you must be satisfied that the report was made promptly and that all of the reasonable grounds were included in the report. (See www.office-for-children.vic.gov.au)

Non mandated report

- Section 183 of the Children, Youth and Families Act 2005 allows that any person who believes, on reasonable grounds, that a child is in need of protection may report that belief to a protective intervener along with the reasonable grounds for the belief.

This means that any person is voluntarily able to make a report to the Child Protection service when they believe a child is in need of protection and the child's parents are unable or unwilling to protect the child. Under this part of the Act, reports are made on moral grounds rather than because the law has compelled someone to do so.

Therapeutic treatment reporting

- Any person who forms the belief that a child who is aged 10 years or over and is under 15 years is exhibiting sexually abusive behaviours and is in need of therapeutic treatment can make a report to Child Protection under section 185 of the Children, Youth and Families Act 2005.

Wellbeing report

Under section 28 of the Children, Youth and Families Act 2005 reports can be made on the basis of significant concerns about the wellbeing of a child even though they may not be considered in need of protection as defined under the Act.

This reflects the need to intervene early to ensure children and young people are not only safe from physical or sexual harm but are given the best opportunity to develop and thrive.

Unborn child report

- Under section 29 a report may be made to Child Protection prior to the birth of a child where there are significant concerns for the wellbeing of the child post birth.

Referrals to community-based child and family services

In addition to reports to Child Protection referrals may also be made to community-based child and family services that are registered under section 46 of the Children, Youth and Families Act 2005 to provide services to meet the needs of children and families requiring care, support or protection. Information about registered community-based child and family services is to be available to the public on the Department of Human Services web site.

- Section 31 allows a person who has a significant concern for the wellbeing of a child to refer the matter to a community-based child and family service.
- Section 32 allows for referral to a community-based child and family service prior to birth where there is significant concern for the wellbeing of the child after his or her birth.

These referrals may be made to the child, family information, referral teams (Child FIRST).

Protection for reporters

Under section 40 of the Children, Youth and Families Act 2005 a report to Child Protection (sections 28 or 29) or a referral to a community-based child and family service (sections 31 or 32) when made in good faith, does not:

- constitute a breach of professional ethics or unprofessional conduct
- contravene section 141 of the *Health Services Act 1988* or section 120A of the *Mental Health Act 1986*
- subject the person to any liability in respect of the report or referral.

Protecting reporters' identity

- Under section 41 the identity of a person or any information that is likely to lead to the identification of the person who has made a report under sections 28 or 29 or referral under sections 31 or 32 cannot be disclosed, unless the person who made the report or referral gives written consent to Child Protection or in the case of community-based child and family service consent may be written or verbal.

Disclosure of information

When the risk to a child needs to be assessed and the best course of action determined it is important that professionals from a range of services provide or exchange information to facilitate that assessment and decision making for the safety and wellbeing of the child. There are a range of circumstances under which a person who is deemed an information holder can provide information to either Child Protection or a community-based family service.

Under the Children, Youth and Families Act 2005 an information holder means:

- a member of the police
- an employee of any government department
- a medical practitioner
- a psychologist
- a nurse
- a teacher or principal
- a person in charge of a specified health service, psychiatric service, children's service, disability services, drug or alcohol treatment services and other prescribed class of persons as defined in section 3 of the Act.

Under section 181 a protective intervener is the following:

- the secretary
- all members of the police force.

(a) When a referral has been received by an FSI (sections 31 and 32), the intake worker may (for the purposes of assessing risk or determining the agency best able to provide assistance) consult with: Child Protection (section 36.2.a); another family service (section 36.2.b); a service agency (section 36.2.c); or an information holder (section 36.2.d – only for assessing risk).

(b) When Child Protection receives a Child Wellbeing Report (sections 28 and 29), the intake worker may (for the purposes of assessing risk or determining the agency best able to provide assistance) consult with: a family service (section 35.1.a); a service agency (section 35.1.a); an information holder (to be added by amendment).

(c) Authorised people who are consulted and provide information to Child FIRST or Child Protection for the purposes of assessing risk or determining the agency best able to provide assistance are protected against legal and professional liability (section 37) and their identity will be treated as confidential unless disclosure of their identity is required by law or a court order.

Ongoing case management by family services:

(d) Following consultations as authorised above, further assessment of a referral to Child FIRST starts with family contact being made by a family service or a service agency to which the case is referred. From that point forward, information sharing (and service provision itself) requires consent (unless it is permitted by the Information Privacy Act), except where a family service needs to consult with Child Protection (section 38).

Child protection investigations:

(e) Where a report is classified as a protective intervention report (section 30.1.d or section 187.1.b), a Child Protection worker must investigate the report and may request information from an information holder or a person in charge of, or employed in, a registered community service (section 192) or from any person authorised by the Secretary (section 205 and section 206.2). People providing information in these circumstances are protected from legal and professional liability (section 208) and their identity is protected (section 209).

Ongoing case management by Child Protection:

(f) Following the completion of an investigation, and for as long as Child Protection has case management responsibility where a child is in need of protection, Child Protection may request and receive information from an information holder or a person in charge of, or employed in, a registered community service (section 192). People providing the information requested are protected (section 193).

The power to compel disclosure:

(g) Where the child is subject to a Children's Court Protection Order, the Secretary may authorise a direction (section 195) requiring an information holder to disclose information. Police officers and Children's Court Clinic practitioners are information holders but are specifically exempted from the power to compel by section 195 and section 196.4 respectively.

WIT.3031.001.1290_R

Appendix G References

1. Australian Bureau of Statistics. 1996. *Women's Safety Australia*. Rep. 4128.0, Australian Bureau of Statistics, Canberra
2. Australian Infant Child Adolescent and Family Mental Health Association Children of Parents with a Mental Illness (COPMI). 2003. *Principles and Actions for Services and People Working with Children of Parents with a Mental Illness*., Commonwealth Department of Health and Ageing, Canberra
3. Australian Institute of Health and Welfare. 2006. *Australia's Health 2006*. Rep. AUS 73, AIHW, Canberra
4. Bannon MJ, Carter YH. 2003. *Arch Dis Child* 88: 560-2
5. Clarke A, Andrews S, Austin N. 2000. Lookin' after our own. Supporting Aboriginal Families Through the Hospital Experience, Aboriginal Family Support Unit - Royal Children's Hospital, Melbourne
6. Department of Victorian Communities. 2005. *Changing Lives: a new approach to family violence in Victoria*
7. Disability Services Division. 1996. *Parents with an intellectual disability: a worker's manual,* Department of Human Services (146SE96)
8. Elder D. 2005. *Journal of Paediatric Child Health* 41: 473-4
9. Fanslow J. 2001. *Core Elements for Health Care Provider Response to Victims of Family Violence: The Bare Bones,* Injury Prevention Research Centre, University of Auckland for New Zealand Ministry of Health
10. Fish E, Bromfield L, Higgins D, for the Australian Institute of Family Studies. 2005. *Issues in Child Abuse and Prevention* 23
11. Fleming JM. 1997. *Medical Journal of Australia* 166: 65-8
12. Frederico M, Jackson A, Jones S. 2006. *Analysis of a group of ten child death inquiries: effective response to chronic neglect, final report*, commissioned by the Office for Child Safety Commissioner and the Victorian Child Death Review Committee
13. Goldson E. 1998. *Child Abuse Negl* 22: 663-7
14. Hall D. 2003. *Arch Dis Child* 88: 557-9
15. Health Policy Unit Royal Australian College of Physicians. 2000. *Protecting Children is Everybody's Business: Paediatricians Responding to the Challenge of Child Abuse*, Royal Australian College of Physicians, Sydney
16. Hobb GF, Hobbs CJ, Wynee JM. 1999. *Child Abuse and Neglect* 23: 1239-52
17. Human Rights and Equal Opportunity Commission. 1997. *Bringing them Home: Report of the National Inquiry into the Seperation of Aboriginal and Torres Straight Islander Children from their families*, Commonwealth of Australia, Sydney
18. InformED. 2003. *Children at risk: information for Victorian emergency departments*, Emergency Departments Promotion Health, Melbourne
19. John V, Messer LB, Arora R, Fung S, Hatzis E, et al. 1999. *Aust Dent J* 44: 259-67
20. King W, Reid C. 2003. *Emerg Med J* 20: 222-4
21. Laing L. 2000. *Australian Domestic and Family Violence Clearinghouse* Issues Paper 1
22. McLean J. 2002. *The Board's Clinical Governance Role: Discussion Paper*, Bayside Health, Melbourne
23. Ministry for Health. 2002. *Family Violence Intervention Guidelines - Child and Partner Abuse,* New Zealand

WIT.3031.001.1291_R

24. Ministry for Health. 2001. *Recommended referral process for GPs*, Ministry for Health, New Zealand
25. Morris J. 1998. *Child Abuse Rev* 18: 91-108
26. Mullen PE, Flemming J. 1998. *Long term effects of child sexual abuse*. Rep. 9, Australian Institute of Family Studies
27. NSW Health Department. 2000. *Child Protection Service Plan 2004-2007*, NSW Health Department, NSW
28. NSW Health Department. 2000. *NSW Health Frontline Procedures for the Protection of Children and Young People*, NSW Health Department, NSW
29. Raphael S. 1999. *NSW Public Health Bulletin* 10: 31-2
30. Ridgeway S. 1993. *Child Abuse Review 2*: 166-73
31. Roberts J. 1993. *Child Abuse Review* 1993: 3-14
32. Royal College of Psychiatrists. 2002. *Patients as parents: Addressing the needs, including the safety, of children whose parents have mental illness*. Rep. CR105, London Council Report, London
33. Smith JA, Efron D. 2005. *Journal of Paediatric Child Health* 41: 513-7
34. Stanley J, Tomison AM, Pocock J. 2003. *Child Abuse and Neglect in Indigenous Communities*, Australian Institute of Family Studies
35. Statewide Steering Committee to Reduce Family Violence. 2005. *Reforming the Family Violence System in Victoria*, Department for Victorian Communities, Melbourne
36. The Allen Consulting Group for The Office for Children. 2003. *The Child Protection Outcomes Project*
37. The Mental Health Co-ordinating Council (NSW) and The Department of Community Services (NSW). 2004. *Mind the Gap: The National Illicit Drug Strategy (NIDS) Project to Improve Support for Children from Families where there are Mental Illness and Substance Abuse (MISA) Issues*, The Mental Health Co-ordinating Council (NSW) and The Department of Community Services (NSW), Sydney
38. Tomison A. 1996. *Child Maltreatment and Substance Abuse: Discussion Paper. Rep. 2*, Australian Institute of Family Studies
39. Tomison A. for Australian Institute of Family Studies. 2000. *Issues in Child Abuse Prevention*, volume 13
40. Tomison AM, Stanley J. 2001. *Strategic Directions in Child Protection: Informing Policy and Practice. Brief no. 3 Social welfare framework: Models of collaborative service delivery in child protection,* South Australian Department of Human Services
41. Victorian Child Death Review Committee. 2005. *Annual Report of Inquiries into Child Deaths, Child Protection 2005*, Department of Human Services, Melbourne
42. Victorian Child Death Review Committee. 2004. *Child Death Inquiry - Group Analysis, Children with Complex Needs*, Melbourne
43. Victorian Institute of Forensic Medicine. 2006. *Paediatric Forensic Medicine*.
44. Wronski I. 1980. *The growth and development of under 5 Aboriginal children in Shepparton/Mooroopna*, Health Commission of Victoria, Melbourne
45. Ziegler DS, Sammut J, Piper AC. 2005. *J Paediatr Child Health* 41: 251-5