

# Child abuse and neglect education module

Responsibility, recognising and reporting

A resource for health professionals



**Queensland**  
Government



## Child abuse and neglect education module: Responsibility, recognising and reporting —a resource for health professionals

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# Introduction

## Target group

This module is available to all health professionals, specifically those who deliver services to children, young people and adults who have parental/carer responsibilities in relation to children and young people.

It will develop your capabilities, including responsibilities, the ability to recognise, and build your confidence to report suspicion of child abuse and neglect.

This module is not intended to support the development of advanced practice.

## Reflective exercise

In this module, you will be asked to answer questions about case scenarios. This will help you apply your learning to an actual clinical situation. You may develop your own scenario based on a clinical situation you have encountered or use one of the scenarios in Appendix A.

If you wish to develop your own scenario, please use the format below. If, while writing your scenario, it appears there is insufficient detail relevant to the module, please use one of the scenarios provided in Appendix A.

## Format for developing a case scenario

Please write down as much detail as you can about the following:

- Who was involved (children, adults, colleagues or agencies)?
- What were the presenting issues (from the perspective of all key people)?
- When did you first become aware of this situation and what was the timeline of events (as far as you know) before, during and after your involvement?
- Where were you working (the agency's role, your role within the agency and other disciplines represented)?

## Personal considerations

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

In this module, you may be exposed to content, scenarios and reactions that you may relate to (e.g. own experiences as a child and/or as a parent). If this is the case, it is important you seek assistance and support from your colleagues, manager or contact the Employee Assistance Program (EAP). Please refer to your Hospital EAP for details about accessing this service should you need support as a result of working through the content of this module.

# Section 1: Responsibility

## Objectives

Once you have completed Section 1 you will be able to:

1. Describe your legislative responsibility to report your suspicion of child abuse and neglect.
2. Describe your specific discipline's professional and/or competency standards, code of conduct and/or ethical behaviours in relation to child protection.
3. Describe the legislative and policy provisions in relation to unborn children who may be at risk of harm following their birth.
4. Describe the legislative protections you have in reporting your suspicion of child abuse and neglect.
5. Apply the above points to a specific practice scenario.

## Overarching principles

As adults we have an obligation to ensure our children are protected and cared for so they can grow and develop to their full potential.

The United Nations Convention on the Rights of the Child emphasises children have their own rights and entitlements, and because of their youth they need extra protection. In line with Australia's obligations as signatory to the Convention on the Rights of the Child the following principles apply:

- all children have a right to grow up in an environment free from neglect and abuse—their best interests are paramount.
- children and their families have the right to participate in decisions affecting them.
- improving the safety and wellbeing of children is a national priority.
- the safety and wellbeing of children is primarily the responsibility of their family, who should be supported by their community and government.
- Australian society values, supports and works in partnership with parents, families and others in fulfilling their caring responsibilities for children.
- children's rights are upheld by systems and institutions.
- policies and interventions are evidence based.

In addition the *Child Protection Act 1999* states the paramount principle for administering the act is to ensure the safety, wellbeing and best interests of a child, both through childhood and for the rest of the child's life. This paramount principle is underpinned by a number of general principles to guide professionals in ensuring the safety, wellbeing and best interests of the child. These general principles include:

- a child has a right to be protected from harm or risk of harm.
- a child's family has the primary responsibility for the child's upbringing, protection and development.
- the preferred way of ensuring a child's safety and wellbeing is through supporting the child's family.
- if a child does not have a parent who is able and willing to protect the child, the State is responsible for protecting the child.
- if a child is removed from the child's family, consideration should be given to placing the child, as a first option, in the care of kin.
- the child should be allowed to develop and maintain a connection with the child's family, culture, traditions, language and community.

## National framework

The same principles underpin the Council of Australian Governments (COAG) endorsed *National Framework for Protecting Australia's Children 2009–2020*.

The framework guides how the Australian Government works with non-government organisations to ensure children and young people are safe and well. Child abuse and neglect is recognised as one of Australia's most serious concerns—a collaborative approach is required by all levels of government and non-government organisations to improve the lives and opportunities of children and their families.

# Section 1: Responsibility (continued)

## Queensland Child Protection Reform Agenda

### Queensland Child Protection Commission of Inquiry

The Queensland Government established the Queensland Child Protection Commission of Inquiry (the Commission) on 1 July 2012, led by the Honourable Tim Carmody, QC (the Commissioner). The Commissioner presented the *'Taking Responsibility: A Roadmap for Queensland Child Protection'* report (the report) to Parliament on 1 July 2013. In the report there are 121 recommendations for the Queensland child protection system.

The overarching tenet of the report is that parents (and families) should take primary responsibility for the protection of their children and that, where appropriate, parents should receive support and guidance they need to keep their children safe. It is only as a last resort that government should intervene in a statutory role to ensure the protection of children who are at significant risk of harm.

The Queensland Government tabled its response to the report in parliament accepting or accepting in principle all the recommendations made in the report. It is important to note that in its response the Queensland Government outlined that the reforms are to be implemented progressively over the next five years resulting in the child protection landscape in Queensland being considerably different by 2019.

The Queensland Government is committed to protecting children and young people from harm. Queensland Health partners with the Department of Child Safety, Youth and Women (DCSYW); Queensland Police Service (QPS); and Department of Education (DoE) in a number of forums to ensure the safety and wellbeing of children and young people.

## Department of Child Safety, Youth and Women

The *Child Protection Act 1999* is the overarching legislation relating to the protection, welfare and best interests of children and young people, and is administered by DCSYW. Child Safety Services (CSS) is part of the DCSYW.

The role of CSS is to:

- investigate reports that allege a child has been significantly harmed or is at risk of significant harm and may not have a parent able and willing to protect the child from harm.
- ensure an ongoing provision of services to children who have been significantly harmed or are at risk of significant harm and may not have a parent able and willing to protect the child from harm.
- act as the lead agency in facilitating a whole-of-government response to child protection issues including the Suspected Child Abuse and Neglect (SCAN) team system and Information Coordination Meeting (ICM).

The Director-General of CSS (also the Chief Executive) and all child safety officers from CSS are authorised officers under section 149 of the *Child Protection Act 1999*. They have the power to investigate allegations of harm or alleged risk of harm to a child, and assess the child's need of protection or take appropriate action under the *Child Protection Act 1999*.

The 'information exchange' provisions contained in Chapter 5A of the *Child Protection Act 1999* provide an entitlement for certain service providers (e.g. health, child safety, community services, education and police officers) to share confidential information about a child where it is done in accordance with the Act to meet the protection and care needs of children and promote their wellbeing.

## Relevant legislation

The legal responsibilities of health professionals in Queensland are outlined in the following Sections of the relevant Acts:

### **Public Health Act 2005**

- Sections 197–213 (care and treatment orders)
- Section 158 (definition of harm) <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2005-048>

### **Child Protection Act 1999**

- Section 5 (principles of the Act)
- Section 5A (paramount principle)
- Sections 8–11 (key terms)
- Sections 13A–13D (general reporting provisions)
- Section 13E (mandatory reporters)
- Section 13G–13I (mandatory reporting)
- Section 21A (unborn children)
- Section 97 (carrying out medical examinations or treatment)
- Section 159B (service coordination and information sharing)
- Section 159J–159L (SCAN system)
- Section 159MA–159MF (information exchange)
- Section 159N–159NA (information exchange)
- Section 159O (information sharing)
- Section 186 (confidentiality of notifiers)
- Section 188E(5) (where information given by CSS to QPS includes details of a notifier, QPS must be made aware)
- Section 197 (protection from liability SCAN members)
- Section 197A (protection from liability) <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-1999-010>

### **Hospital and Health Boards Act 2011**

- Section 139 (definitions)
- Section 139A (defines designated person)

- Section 140 (defines parent for the purpose of child patient information)
- Section 142 (confidential information not to be disclosed)
- Section 142A (applies to prescribed health practitioners)
- Section 143 (exemption from Section 142 where disclosure is required or permitted by another Act or law)
- Section 144 (consent)
- Section 145 (exemption from Section 142 where information is required for the care or treatment of the person) <https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2011-032>
- Section 148 (disclosure for the protection, safety or wellbeing of a child)

### **Right to Information Act 2009**

<https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-013>

### **Information Privacy Act 2009**

## Reporting responsibilities

Health professionals have both mandatory and non-mandatory obligations under the *Child Protection Act 1999* to report a reasonable/reportable suspicion of child abuse and neglect.

Harm to a child is defined in the *Child Protection Act 1999* (section 9) as: *any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.*

It is immaterial how the harm is caused. Harm can be caused by:

- *physical, psychological or emotional abuse or neglect.*
- *sexual abuse or exploitation.*
- *a single act, omission or circumstance.*
- *a series or combination of acts, omissions or circumstances.*

# Section 1: Responsibility (continued)

## Mandatory reporting (Child Protection Act 1999)

### **Who is a mandatory reporter?**

Section 13E(1) of the *Child Protection Act 1999* provides that a doctor and a registered nurse are mandatory reporters. Under Schedule 3 of the *Child Protection Act 1999* a registered nurse means a person registered under the Health Practitioner Regulation National Law to practice in the nursing and midwifery profession as a nurse, other than a student; and in the registered nurse division of that profession.

### **A reportable suspicion**

A reportable suspicion is defined at Section 13E(2) of the *Child Protection Act 1999* as a reasonable suspicion that a child has suffered, is suffering, or is at unacceptable risk of suffering, significant harm caused by physical or sexual abuse; and may not have a parent able and willing to protect them from harm.

Section 13E(3) of the *Child Protection Act 1999* provides that a doctor or a registered nurse must give a written report to CSS through the Child Safety Services Regional Intake Services (CSS-RIS) if that person forms a 'reportable suspicion' in the course of their employment.

Under Section 13G(2) of the *Child Protection Act 1999*, this written report must contain the following details:

- (a) state the basis on which the person has formed the reportable suspicion; and
- (b) include the information prescribed by regulation, to the extent of the person's knowledge.

## Non-mandatory reporting (Child Protection Act 1999)

### **A reasonable suspicion**

All staff, including mandatory reporters, are able to report a reasonable suspicion that a child, or unborn child may be in need of protection under Section 13A of the *Child Protection Act 1999*, however they are not mandated to do so. The information given under Section 13A of the *Child Protection Act 1999* may include anything the person considers relevant to the person's suspicion.

## Professional standards and child protection issues

All clinical staff within their discipline have their own professional competency standards, codes of ethical behaviour and conduct. In addition, there are Queensland Health state-wide child protection guidelines and local HHS child protection procedures to guide practice. You should access these resources and consider the ways in which they influence and guide your professional response to child protection issues.

## Legal protection

### Health professionals

The legal protections afforded to health professionals reporting child harm, will depend on the specific role of the health professional at the time of reporting or providing the information, and will differ depending upon what legislation applies. If you have any doubt please seek assistance from a Hospital and Health Service based lawyer, departmental based lawyer or from an external legal advisor (as applicable).

Under Section 1590 of the *Child Protection Act 1999*, all health professionals are able to provide information directly to CSS, Childrens Court or a Queensland police officer if the information is relevant to:

- the protection or wellbeing of a child or young person; and/or
- with respect to an unborn child, this includes giving information before a child is born, that is relevant to the protection of the child after he or she is born.

In providing information to CSS, health professionals are given a number of legal protections under the *Child Protection Act 1999*.

These include:

- Section 13D of the *Child Protection Act 1999* clarifies that Section 197A of the *Child Protection Act 1999* provides for protection from liability when making a report to CSS.
- Section 197A of the *Child Protection Act 1999* protects a person from liability associated with the notifying, or giving information to, CSS or a Queensland police officer, regarding alleged harm or the risk of alleged harm to a child, and regarding a suspected risk of harm to an unborn child—provided the person is acting honestly and reasonably in providing that notification or information.

- Section 13H of the *Child Protection Act 1999* enables a health professional to discuss their suspicions with another health professional who is working in or for the same HHS, or who is employed by Queensland Health if the first health professional is also an employee of Queensland Health.
- Section 186 of the *Child Protection Act 1999* prohibits an authorised officer of CSS from disclosing a notifier's (health professional or other person) identity except in the specified circumstances outlined in Section 186(2) of the Act. These circumstances include when it is required to enable others to perform duties under the *Child Protection Act 1999* or another Act or under direction from a court or the Queensland Civil and Administrative Tribunal.

## Reflection

Please complete the following reflective exercise in relation to your case scenario:

- What is your responsibility in this situation?
- Is this a mandatory or non-mandatory responsibility?
- What is the relevant legislation pertaining to your actions in this situation?
- What professional codes of ethics are relevant to your decision (be specific as to relevant sections rather than just naming a professional code of ethics)?
- What legal protections do you have if you reported suspected child abuse and/or neglect?

# Section 2: Recognition

## Objectives

Once you have completed Section 2, you will be able to:

1. Describe how the terms harm, abuse, neglect and child in need of protection are used.
2. Describe four types of child abuse and common indicators of child abuse and neglect.
3. Describe how you would use a child protection perspective in the assessment of the health needs and the provision of health care to the unborn, child and young person.
4. Describe how you would use the common child protection indicator set when formulating a differential diagnosis that may include child abuse and neglect.
5. Identify who you could consult with when formulating a reasonable suspicion of child abuse and neglect.
6. Apply the above in relation to a specific case scenario.

## Legal definitions

There are a number of child protection definitions that are important to consider and these can be categorised as legal or operational.

In Queensland, a 'child' is defined in Section 8 of the *Child Protection Act 1999* as:

- an individual under 18 years.
- The term 'parent' of a child is defined in Section 11 of the *Child Protection Act 1999* as:
- the child's mother, father or someone else (other than the chief executive) having or exercising parental responsibility for the child.
- however, a person standing in the place of a parent of a child on a temporary basis is not the parent of the child<sup>1</sup>.
- a parent of an Aboriginal or Torres Strait Islander child includes a person who, under Aboriginal tradition or Island custom, is regarded as parent of the child<sup>1</sup>.

In section 9 of the *Child Protection Act 1999* 'harm' to a child is defined as: *any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing.*

*It is immaterial how the harm is caused. Harm can be caused by:*

- *physical, psychological or emotional abuse or neglect.*
- *sexual abuse or exploitation.*
- *a single act, omission or circumstance; or a series or combination of acts, omissions or circumstances.*

Health professionals are confronted daily with children and young people who have suffered harm. It would be unreasonable to report every sick or injured child that presents for care and treatment. The distinction for health professionals is there must be reasonable suspicion the harm may, or has been caused by abuse or neglect.

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

For child safety officers to respond to a report of child abuse and neglect, they have to be satisfied of the legislative requirements of Section 10 of the *Child Protection Act 1999* which state:

a child in need of protection is a child who:

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

<sup>1</sup> <http://legislation.govnet.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf>

## Operational definitions

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

### **Physical abuse:**

is any physical injury to a child that is not accidental<sup>2</sup>. It includes any injury caused by excessive discipline, severe beatings, punching, slapping, shaking, burning, biting, throwing, kicking, cutting, suffocation, drowning, strangulation or poisoning (this list is not exhaustive). Physical abuse can result in death.

### **Sexual abuse:**

occurs when a male or female adult, or a more powerful child or adolescent (including a sibling), uses power to involve a child in sexual activity. It can be physical, verbal or emotional, and includes any form of sexual touching, penetration, sexual suggestion, sexual exposure or exhibitionism, and child prostitution<sup>3</sup>.

### **Emotional abuse:**

occurs when children are not provided with the necessary and developmentally appropriate supportive environment to develop mentally and/or emotionally. Emotional abuse includes constant criticism, restriction of movement, patterns of belittling, denigrating, scape-goating, threatening, scaring, discriminating, exposure to domestic violence, ridiculing or other non-physical forms of hostile or rejecting treatment<sup>4,5</sup> (this list is not exhaustive).

### **Neglect:**

is depriving a child of their basic needs. These include food, clothing, warmth and shelter, emotional and physical security and protection, medical and dental care, cleanliness, education and supervision<sup>6</sup> (this list is not exhaustive).

<sup>2</sup> Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999, World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, pp. 13-17.

<sup>3</sup> Department of Child Safety, Child Safety Practice Manual, Intake and Investigation and Assessment, V1.0, pp. 29

<sup>4</sup> Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999, World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, pp. 13-17.

<sup>5</sup> Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999, World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, pp. 13-17

<sup>6</sup> Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999, World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, pp. 13-17.

## Section 2: Recognition (continued)

### Recognising child abuse and neglect

#### Possible presenting characteristics

Some general characteristics of child abuse and neglect relevant to everyday practice of health professionals are (this list is not exhaustive):

- child or young person discloses abuse.
- child or young person gives some indication their injury did not occur as stated.
- the explanation provided by the parents/caregivers does not account for the injury, symptoms, and/or behaviour.
- there is an unreasonable delay in the child's presentation for the child's injury or condition.
- child is dependent and unable to protect themselves.
- child is fearful of parent/caregiver or of going home.
- child has special needs which increase his/her vulnerability.
- parent's or caregiver/s capacity to meet the child's care and protective needs is impaired.
- parent or caregiver has unrealistic expectations or poor understanding of the child's developmental needs.
- child related behaviours or triggers present at time of abuse.
- abuse precipitated by family crisis.
- parental history of abuse/violence.

#### Common indicators of child abuse and neglect

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

One indicator in isolation may not indicate abuse or neglect. Each indicator needs to be considered in the context of a child's personal circumstances. Furthermore, child abuse and neglect can occur in the absence of any of these risk indicators.

Child indicators of abuse include (this list is not exhaustive):

- showing wariness and distrust of adults.
- rocking, sucking or biting excessively.
- bedwetting or soiling.
- demanding or aggressive behaviour.
- sleeping difficulties, often being tired and falling asleep.
- low self-esteem.
- difficulty relating to adults and peers.
- abusing alcohol or drugs.
- being seemingly accident prone.
- having broken bones or unexplained bruising, burns or welts in different stages of healing.
- being unable to explain an injury, or providing explanations that are inconsistent, vague or unbelievable.
- feeling suicidal or attempting suicide.
- having difficulty concentrating.
- being withdrawn or overly obedient.
- being reluctant to go home.
- creating stories, poems or artwork about abuse.

Child indicators of neglect include (this list is not exhaustive):

- slow weight gain (in infants).
- regressive behaviour in toddlers.
- delays or problems with language or other development.
- malnutrition, begging, stealing or hoarding food.
- poor hygiene, matted hair, dirty skin or body odour.
- unattended physical or medical problems.
- comments from a child that no one is home to provide care.
- being constantly tired.
- frequent lateness or absence from school.
- inappropriate clothing, especially inadequate clothing in winter.
- frequent illness, infections or sores.
- being left unsupervised for long periods.

For more information about signs of child abuse and neglect visit [www.communities.qld.gov.au/childsafety/protecting-children/what-child-abuse/signs-child-abuse-neglect](http://www.communities.qld.gov.au/childsafety/protecting-children/what-child-abuse/signs-child-abuse-neglect)

## Parental concerns

Some parental concerns that may impact parenting capacity include:

- substance abuse.
- poor mental health.
- intellectual or cognitive disability.
- domestic violence.
- physical disability.
- The parent is affected to the extent that the concern is having a negative impact on his or her capacity to parent the child. These concerns may lead to the parent not meeting the child's safety, wellbeing or protection needs.

A parent may exhibit behaviours that significantly affect the child including (but not limited to) where:

- on one or more occasions the parent did not provide the child with food, supervision, stable housing, safe living conditions or other basic care because the parent did not have the intellectual capacity to understand the child's needs, follow plans for meeting the child's needs, or make decisions about child needs.
- a parent's emotional status inhibits or prevents them from forming a relationship with their infant/newborn. For example, mother is depressed (including post natal depression) and not responsive to the infant.
- you observe a parent to be significantly impaired by substance use.
- a child is born and there is evidence that the child was exposed to alcohol or drugs.
- you are aware of, or suspect domestic violence (e.g. observations of power/control dynamics or threats of harm to adults in the household).

- you are aware of or suspect an increase in the number and severity of incidents of domestic violence. For example, there are now injuries that may not be significant, but there are repeated episodes of minor injuries and the injuries are getting worse or are happening more often <sup>7</sup>.

Your awareness may be based on personal observations or credible statements by the child or another person.

Note: This list of indicators is not exhaustive. Please consult with your line manager, CPLO or CPA if you need support when forming a reasonable suspicion of child abuse and neglect.

<sup>7</sup> Online Child Protection Guide [www.communities.qld.gov.au/childsafety/partners/our-government-partners/queensland-child-protection-guide/online-child-protection-guide](http://www.communities.qld.gov.au/childsafety/partners/our-government-partners/queensland-child-protection-guide/online-child-protection-guide) © The State of Queensland (Department of Child Safety, Youth and Women) 2010–2015.

## Section 2: Recognition (continued)

### **Antenatal assessment of risk:**

Midwifery assessments in the antenatal period should take into account family and social history as well as obstetric history and detail the family strengths as well as concerns. Emphasis should be placed on exploring areas such as domestic abuse, substance misuse, mental health difficulties and care of previous children as well as other issues that may impact on parental capacity. Fathers and/or mothers' partners should be included within this assessment as well as any other family members who may have a significant role to play in caring for the child or supporting the parents. However it is important to note that enquiries regarding domestic abuse shouldn't be carried out when the partner is present as this can heighten the risk to the victim and any children.<sup>8</sup>

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

### **Factors to be considered when undertaking an antenatal assessment of risk:**

Unborn baby	Parenting capacity	Family, household, environmental
<ul style="list-style-type: none"> <li>• Unwanted/concealed pregnancy</li> <li>• Lack of awareness of baby's needs</li> <li>• Unattached to unborn baby</li> <li>• Unrealistic expectations</li> <li>• Inappropriate parenting plans</li> <li>• Premature birth</li> <li>• Different/abnormal perceptions about the baby</li> <li>• Inability to prioritise baby's needs</li> <li>• Poor/nil antenatal care</li> <li>• Special/extra needs</li> </ul>	<ul style="list-style-type: none"> <li>• Negative childhood experience</li> <li>• Childhood abuse</li> <li>• Denial of past abuse</li> <li>• Multiple carers</li> <li>• Substance abuse</li> <li>• Family violence</li> <li>• Abuse/neglect of previous children</li> <li>• Age of parent, very young parent</li> <li>• Mental illness</li> <li>• Learning difficulties</li> <li>• Physical disabilities</li> <li>• Ill health</li> <li>• Inability/unwilling to work with professionals</li> <li>• Postnatal depression</li> <li>• Past antenatal/postnatal neglect</li> </ul>	<ul style="list-style-type: none"> <li>• Domestic violence</li> <li>• Violent network</li> <li>• Poor impulse control</li> <li>• Unsupportive partner</li> <li>• Isolation</li> <li>• High mobility/transience</li> <li>• No or little commitment to parenting</li> <li>• Relationship difficulties</li> <li>• Multiple relationships</li> <li>• Lack of community support</li> <li>• Poor engagement with professional services</li> </ul>

For more information about risk indicators and characteristics of child and family, and clinical findings of child abuse and neglect visit <http://qheps.health.qld.gov.au/csu/Factsheets.htm>

<sup>8</sup> <https://www.norfolkscb.org/about/policies-procedures/5-21-pre-birth-protocol>

## Forming a reasonable suspicion

### 1. Reasonable suspicion of child abuse and neglect

There is no legal definition of reasonable suspicion, it requires more than just an isolated fact that may or may not indicate harm. However, Section 13C of the *Child Protection Act 1999* describes some factors for consideration when forming a reasonable suspicion. To reach a reasonable suspicion means forming a concern or well-founded suspicion that is based on the presence of signs, disclosures, injuries, symptoms and behaviours that heighten concerns about the safety, health and wellbeing of a child or young person.

The process of information collection, clinical assessment, analysis and documentation are the basis of sound clinical practice and form the substantive basis of a reasonable suspicion of child abuse and neglect.

In forming a reasonable suspicion, it is not the responsibility of health professionals to prove abuse or neglect has occurred nor who might have caused it. Investigation of these matters remains the responsibility of CSS and Queensland police officers.

It is important to work within a set of principles that influence clinical practice when assessing the presence of a reasonable suspicion:

- always consider child protection when assessing the health needs of every unborn, child and young person.
- use a child centred approach where the safety and wellbeing of the child is paramount.
- consider the broader needs of the child, other children and family members.

### 2. Considerations when determining significant harm

Section 13C of the *Child Protection Act 1999* provides guidance when forming a reasonable suspicion about whether a child has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm.

The matters that the person may consider when forming a reasonable suspicion include:

- whether there are detrimental effects on the child's body or the child's psychological or emotional state—
  - that are evident to the reporter; or
  - that the reported considers are likely to become evident in the future; and
- in relation to any detrimental effects to the child the reporter may consider:
  - their nature and severity; and
  - the likelihood that they will continue; and
- the child's age
- the reporters consideration may be informed by an observation of the child, other knowledge about the child or any other relevant knowledge, training or experience that the reporter may have.

### 3. May not have a parent able and willing

- 'Able and willing' is an important consideration. A parent may be willing to protect a child, but not have capacity to do so, that is they are 'unable'. This includes situations where the parents' inability is due to factors such as intellectual impairment or ill health.
- Alternatively, a parent may have the capacity to protect a child, that is they are able, but may choose not to do so, that is, they are 'unwilling'. This includes situations where parents choose an ongoing relationship with a person who is abusing their child and are thus unwilling to protect the child.

## Section 2: Recognition (continued)

### Is your suspicion reasonable?

Additional actions to undertake when forming a reasonable suspicion include:

- a review of the child's record to ascertain previous presentations and/or concerns.
- discussion with health colleagues who have had contact with the child and family.
- discussion and consultation with colleagues, social workers where available, line managers, team leaders, and the hospital and health service child protection advisor or child protection liaison officer.

If through your clinical assessment you reach a reasonable suspicion of child abuse and neglect, you must immediately report your concerns to CSS-RIS on a Report of suspected child in need of protection form. It is important to ensure the report to CSS-RIS contains information that is relevant, child focussed, accurate and reflective of a holistic clinical assessment.

### Responding to children, parent/s and carer/s

It is important to communicate clearly and openly with children and their families when collecting information to support an assessment. For best practice please ensure you follow the guidelines below.

#### Child or young person

- stay calm.
- communicate in a way that is appropriate to their age and understanding.
- if possible, provide a private and child-friendly environment.
- respond in a caring and sensitive manner.
- provide support without being judgemental.
- listen to what the child wants to tell you.
- use open-ended questions.
- do not probe for details, or ask leading/direct questions of the child—this may prejudice subsequent investigations.

- do not promise confidentiality.
- minimise the number of medical and nursing personnel examining and interviewing the child or young person.
- avoid emotional expressions or responses (anger, pity, outrage or taking sides).

#### Parent/s and carer/s

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

### Reflection

Please complete the following reflective exercise in relation to your case scenario:

- What presenting characteristics of the child and/or family might lead you to consider the possibility of harm to a child?
- Using the indicators for child abuse and neglect, which specific indicators were/are evident?
- Who do you consult to assist in the formulation of a reportable suspicion?
- Did/would your suspicions reach the threshold to report?
- What is the evidence that would suggest that your suspicions were/are reportable?
- What are the principles of assessment of a reasonable suspicion of child abuse and neglect? In what ways does the assessment in this situation reflect these principles.

# Section 3: Reporting

## Objectives

Once you have completed Section 3 you will be able to:

- Describe the process of making a report to CSS.
- Complete a Report of suspected child in need of protection form in relation to a specific case scenario.

## Making a report

Given the sensitive nature of child abuse and neglect, and the serious potential outcomes for those involved, the need for objectivity and impartiality is important.

When you form a reasonable or reportable suspicion you are required to immediately report your concerns in writing to Child Safety Services Regional Intake Service (CSS-RIS) or Child Safety After Hours Service (CSAHS) using a Report of suspected child in need of protection form. It is recommended that you telephone CSS-RIS or CSAHS and document the date, time and name of the person you spoke to in the clients record.

- telephone your local CSS-RIS (9–5 pm Monday to Friday)
- telephone the CSAHS (after business hours).

For further information visit [www.communities.qld.gov.au/childsafety/about-us/contact-us](http://www.communities.qld.gov.au/childsafety/about-us/contact-us)

## Written report

If you are submitting the Report of suspected child in need of protection form electronically, you are required to print a copy to file in the client's record. Forward a copy of the form to the Hospital and Health Service (HHS) Child Protection Liaison Officer (CPLD).

If you are completing a paper copy of the Report of suspected child in need of protection form, you should fax or email the form to CSS-RIS or CSAHS. File the original form in the clients record and forward a copy of the form to the HHS CPLD.

If you are unable to access the Report of suspected child in need of protection form you must provide a written report to CSS-RIS or CSAHS including details of the child, the nature of the harm and contact details of the person making the report.

It is your responsibility to document all actions and conversations in relation to this report in the client's record.

Contact with CSS-RIS is your responsibility if you have formed a reasonable or reportable suspicion, and cannot be undertaken by, or delegated to, another colleague, clinical team member or manager.

## Other issues to consider when making a report

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

Credibility is reliant on the report being impartial, factual and free of any possible interpretation or judgement of an individual's values, morals or religious or cultural beliefs. Achieving credibility in reporting suspicions of child abuse and neglect is important to maximise opportunities for the safety, wellbeing and development of children or young people who have been harmed or are at risk of harm. Credibility relates to the quality of the information you have collected and which forms the basis of your reasonable suspicion. Relevant, professionally sound, and accurate data are critical elements of a credible report.

Professional boundaries are grounded within a clearly articulated ethical framework that is comprised of four central principles:

1. beneficence (of always doing good for the patient).
2. non-maleficence (of avoiding doing harm).
3. respect for patient autonomy in making decisions for themselves.
4. justice (treating everyone equally).

## Section 3: Reporting (continued)

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

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

### Documentation

Reporting requires the completion in writing of the Report of suspected child in need of protection form. It is important you document in the individual's medical record, a summary of your discussion, the name and details of the child safety officer you spoke to.

Maintaining an accurate, factual, considered, objective and up-to-date account of your concerns, consultations, contacts, actions and plans will facilitate you and your colleagues' involvement in any subsequent response or intervention.

Your entries may form part of the assessment, treatment and ongoing care of this child or young person and in the determination if abuse and neglect has been perpetrated on this child.

Guidelines for child protection documentation:

- Include the date, time and reason for the presentation and who accompanied the child.
- Record the findings, outcomes of all interviews (child, parent, carer or the person accompanying the child), treatments and interventions (medical and psychosocial).
- Record disclosures made by the child or caregiver. These should be recorded as verbatim quotations

e.g. mother said 'I left him with his stepfather' or paraphrasing e.g. 'mother stated she left him with his stepfather'.

- Be objective, stick to the facts e.g. 'child presented with mother... minimal interaction observed... child withdrawn'. Do not include any documentation of feelings, judgemental reactions or intuitive responses. They play a role in care delivery however they do not belong in medical record documentation.
- Use precise anatomical descriptions and describe each discreet injury separately and use a body map to document injuries.
- Be clear on the basis for your suspicion and include specific indicators (please refer to Section 2: Recognition).
- Document discussions that support your suspicion. Remember there are experts in your Hospital and Health Service (medical, nursing and allied health) to assist you with determining if your suspicion is reasonable.
- Consultation is essential.
- Consider clinical photography in relevant cases; you will need to refer to your local consent for medical photography policy to assist you through this process; QPS may initiate this if there is an investigation.
- Write legibly, sign the entry and print your name for clarification.

When reporting to CSS-RIS or CSAHS, the minimal information requirements are contained in the Report of suspected child in need of protection form. However, in your discussion with the child safety officer, additional information will be sought to assist them in their assessment and determination of the appropriate level of response.

You may be asked very specific questions related to:

- the harm which is the basis for the report e.g. body location of an injury, severity, cause of reported/suspected injury.
- the child or young person's presentation e.g. appearance, developmental and emotional capacity, attachment to parents/caregivers and/or behaviour.

- the parents/caregivers presentation e.g. their protective capacity of the child, attachment to child, relationship history, parenting capacity and/or behaviour during presentation.
- family characteristics such as their family/household type e.g. step, single, blended, mobility, social isolation and/or cultural factors.
- the child's environment e.g. type of housing and/or living conditions.
- presence of any immediate safety concerns.
- presence of any factors that may affect worker safety should a notification result.
- source of the information being provided e.g. child/parental disclosure, hearsay from others, direct observation, deduction, other possible corroborative sources.

Your response to these questions needs to be objective and honest. If you are unable to answer, state this along with the reason you are unable to do so. For example, you may not have asked about a topic, or didn't observe anything in relation the question. It is important to co-operate with the child safety officer to provide as much relevant information as possible as your report may be critical to the safety and wellbeing of the child. Remember, you are a reporter not an investigator. Your capacity and willingness to be re-contacted by the child safety officer may also be discussed.

### Possible report outcomes

When a report is made to CSS-RIS, CSS take one of the following actions:

- recorded as an intake enquiry,
- a child concern report,
- a notification.

#### 1. An intake enquiry

This is a report that does not contain any child protection concerns, or there is insufficient information about a child's need for protection. For example:

- the report contains no allegations of harm or risk of harm to the child.
- the information relates to extra-familial abuse and the parents are willing and able to protect the child.
- the information relates to a child who lives in another state or country.

#### 2. A child concern report (CCR)

A CCR is a child protection concern that does not meet the legislative threshold for recording a child protection notification. It does not result in a full investigation and assessment by CSS. While there may be some concern for the child or young person's safety and wellbeing, it is not of a significant nature to warrant any statutory departmental intervention.

When information is recorded as a CCR, CSS may make a referral to a family support agency. After obtaining client consent, staff in the public healthcare sector are able to refer families directly to Family and Child Connect (FaCC) or Intensive Family Support (IFS) services.

#### 3. A child protection notification

A matter is determined to be a child protection notification when CSS receives information which indicates a reasonable suspicion that a child is in need of protection. A child in need of protection is defined as a child who:

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

A notification response will result in an investigation and assessment by child safety officers of the allegations of abuse and/or neglect and the family circumstances of the child or young person.

If the information by CSS received indicates a criminal offence, the information will be referred by CSS to the QPS.

## Section 3: Reporting (continued)

### Involvement after making a report

There are other child protection processes that may be initiated after a report has been submitted which may include the involvement of health professionals.

This includes:

- a referral to the relevant SCAN team system.
- involvement in court proceedings.
- provision of ongoing health and therapeutic care responsibilities.

### Remember yourself and access support

A child protection situation can be very stressful for health professionals. Being confronted with a child with serious injuries or even their death is distressing and painful. Also, having regular contact with a child who is being constantly neglected by their parents can result in feelings of frustration, powerlessness and anger. Being mandated to report may not sit comfortably with you on a philosophical basis.

The act of making a report about a child can also be demanding. You may worry about the implications of your actions.

- Have I done the right thing?
- What will happen to the child now?
- Will the child be removed from their parents?
- Do I advise the parents that I am making a report?
  - This depends on the relationship you have with the parent/s. By law you are obliged to report a situation and this can be explained to the parents if appropriate however, you are not obliged to advise parents of your report.

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

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

There are 'individual indicators of distress' which can tell us all that we are at an increasing risk for developing secondary trauma.

Emotional indicators		Physical indicators	
Anger, sadness.	Prolonged grief, anxiety or depression.	Headaches or stomach aches.	Lethargy or depression.
Personal indicators		Workplace indicators	
Self-isolation or cynicism.	Mood swings, or irritability with family or spouse.	Avoidance of certain clients or tardiness.	Missed appointments or lack of motivation.

If you have been impacted by an incident or your participation in a situation of abuse and neglect you should seek appropriate support.

As a colleague, supervisor or manager you should assist by:

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

## Reflection

Complete the following reflective exercise in relation to your case scenario:

- Complete the Report of suspected child in need of protection form.
- What would you document in the client record?
- Reflect on your professional boundaries and write down some specific strategies you can use to ensure that these boundaries are not exceeded.

## Referral to support services

If through your clinical assessment your concerns do not reach the threshold for a report to CSS, and the child young person or family have multiple and/or or complex needs and would benefit from ongoing support the following options are available:

- refer the child, young person or family directly to an appropriate support service
- refer the child, young person or family to an intensive family support service to assist in preventing the concerns from escalating
- refer the child, young person or family to Family and Child Connect (FaCC) to assist in determining the most appropriate support service for the family.

## Family and Child Connect (13 32 64)

- Under Section 159MD of the *Child Protection Act 1999* a prescribed entity can refer families to FaCC or Intensive family support service without their consent to prevent a child from becoming in need of protection.
- FaCC provide another pathway for accessing support services where further assistance is required to ensure that the family is linked to the right service.
- FaCC will undertake active engagement with the family and assess the family's needs to ensure the family receives a coordinated and holistic response.
- FaCC will host two specialist support roles a Principal Child Protection Practitioner and a Domestic and Family Violence worker.

If a family refuses to consent for a referral, it is recommended that you consult with your line manager, local child protection liaison officer/child protection advisor and/or other health professional to determine the next course of action.

## Ongoing roles for health professionals

Your responsibilities to children, young people and families do not cease with the completion of a report to CSS or a referral to a support service. Ongoing roles for health professionals may include:

- provision of clinical services to a child as an inpatient or outpatient.
- provision of clinical services to parent/s.
- participation in case planning.
- attendance at relevant case discussions/meetings.
- monitoring child's health and behaviour needs during the delivery of clinical services.
- advocating access to appropriate services to ensure good health outcomes.
- providing progress reports to SCAN, CSS or other relevant agencies.

## Section 3: Reporting (continued)

### Care and Treatment Orders

Under Section 197 of the *Public Health Act 2005* a Care and Treatment Order for a Child enables a designated medical officer to order that a child be held at a health service facility for an initial period not exceeding 48 hours, if the designated medical officer reasonably suspects that the child has been harmed, or is at risk of harm, AND the child is likely to be taken from the facility and suffer harm if immediate action is not taken. The order may be extended for an additional 48 hours only with the agreement of a second designated medical officer.

A designated medical officer (DMO) means a doctor appointed as, or who is, a DMO under Section 188 of the *Public Health Act 2005*.

It is Queensland Health's policy position that a Care and Treatment Order for a Child only be invoked in circumstances where:

- a child is likely to suffer harm or is at risk of harm, AND
- the harm is suspected as being significant, AND
- the child is likely to be taken/removed from the health service facility if immediate action is not taken, AND
- health professionals' efforts to engage and gain parental cooperation to secure the child's immediate safety, health and well being are unsuccessful, AND
- it is not possible to use the custody provisions of the *Child Protection Act 1999*, which in general is the preferred course of action.

This recognises that the DCSYW has primary responsibility for child protection.

Note: Importantly a Care and Treatment Order does not constitute a mandatory report under Section 13E of the *Child Protection Act 1999* or reporting under Section 13A of the *Child Protection Act 1999*. If a reasonable suspicion of significant harm caused by child abuse and neglect and that a child may not have a parent able and willing to protect them from this harm, the DCSYW must be notified in writing immediately. This should be made on the Report of suspected child in need of protection form.

Please also refer to:

- Care and Treatment Order for a Child Information Booklet <http://qhps.health.qld.gov.au/csu/careandtreat.htm>
- The Queensland Health Guideline Care and Treatment order for a Child [www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-942.pdf](http://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-942.pdf)

### Suspected Child Abuse and Neglect (SCAN) team system and Information Coordination Meetings (ICM)

Keeping children safe and providing opportunities for them to reach their full potential cannot be achieved by one government agency. Responsive service provision relies on solid, respectful and trusting partnerships within and across government and non-government organisations and local communities.

SCAN and ICM provides a forum for core member agencies:

- Department of Child Safety, Youth and Women
- Queensland Health
- Queensland Police Service
- Department of Education
- The Independent Aboriginal or Torres Strait Islander entity for Aboriginal and Torres Strait Islander children.

#### SCAN

Enables a coordinated multi-agency response to children where statutory intervention is required to assess and meet their protection needs. This will be achieved by:

- timely information sharing between SCAN team core members.
- planning and coordination of actions to assess and respond to the protection needs of children who have experienced harm or are at risk of harm.
- holistic and culturally responsive assessment of children's protection needs.

## ICM

This is a forum where the SCAN team core member agency representatives can seek further information regarding the rationale for a child safety intake decision. ICM provides the opportunity for multi-agency discussion.

## Court proceedings

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

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

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

When confronted with these requests, seek support, direction and advice from your service supervisor or manager, CPA or CPLO and remember this is part of your professional responsibilities to the children and young people of Queensland who have been harmed or who are at risk of harm. You will be supported in your performance of these responsibilities. You may also wish to seek advice from a legal unit.

## Right to information

The Queensland Right to Information reforms provides the public with a legally enforceable right to obtain information held by the government, to seek amendment to information held by the government concerning their personal affairs if that information is inaccurate or incomplete, out-of-date or misleading.

Legislation on the rights of access under *Right to Information Act 2009* and *Information Privacy Act 2009* are subject to certain exclusions and exemptions specified in the legislation which may, in certain circumstances, provide grounds for refusing to grant access to information held by the government (e.g. information contained in a SCAN record). It is not possible to give absolute assurances that information could not be released under Right to Information legislation in any circumstances. However, in relation to child protection issues, there are very strong arguments in favour of exemption for:

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

For more information on right to information contact your designated right to information officer or visit <https://www.qld.gov.au/law/your-rights/privacy-and-right-to-information/privacy-rights>

# Appendix A: Case scenarios

## Scenario one

### Details

Mother: Trudy Black (age 25)  
Son: Tommy Hayworth (age 3)  
Daughter: Jaycee Hayworth (age 5)  
Father: Jason Hayworth (age 23)  
Address: 4/236 Grey Street, Strathpine

You have been providing a service to a three-year-old child (Tommy) and he has arrived with his mother (Trudy) for his third appointment.

Last visit you noticed he was somewhat unkempt with uncombed hair and unclean clothes. Today he appears the same and is not wearing any shoes.

Trudy tells you he has been a real handful lately and shouts at him to sit down. Trudy usually has a support worker accompany her as she has an intellectual disability. She informs you she doesn't need them and that her partner (Jason) has returned to live with her. She said she needed help with the children, especially Tommy as he is so naughty, and when the new baby is born.

Trudy had previously told you she was in a domestic violence situation with Jason but he had left. She tells you they are getting along, but Jason still gets angry quickly, especially when Tommy is naughty and she has no other family to help. She also says Jason is trying hard not to use as many drugs as before.

Tommy takes off his jacket and you notice several bluish, patterned bruises on both upper arms and around his neck. Trudy tells you he fell off his bike about a week ago and refuses to elaborate, but informs you she didn't take him to the doctor. Tommy hangs his head and says nothing.

You know Trudy tries hard and Tommy is a lively little boy, but you are worried how she will cope when the new baby arrives.

## Scenario two

### Details

Mother: Judy Smith (age 18)  
Daughter: Taylee Brown (age 5 months)  
Address: 4/3 Peel Street, Bay Park  
Phone: 3827 4146

Judy Smith (mother), 18 years of age, comes to the ward via the emergency department with her five-month-old baby daughter Taylee Brown. Taylee was admitted for failure to thrive. Child Health Services referred Taylee to the hospital for very poor weight gain (she is of thin appearance). Judy reported Taylee was not taking feeds.

Judy was only on the ward for a few minutes when she advised a nurse she was going out for a smoke. Judy does not return for over an hour. When Judy was asked to feed Taylee her bottle she asked a nurse to do it because she was tired. Eventually Judy agrees to feed Taylee and when the nurse returns later there is half a bottle left. Judy informs the nurse, Taylee would not drink the milk and leaves to go home at 5 pm. The nurse tries Taylee with the bottle and she drinks all the remaining formula.

The next day Judy arrived at 12 pm and looks tired. Judy said she had a few drinks with her new partner last night and slept in. Taylee had taken her formula feeds overnight and in the morning. When Judy was advised of this she just shrugged and started reading a magazine. Judy was told the times of Taylee's next feeds with the expectation she will be present, plus attend to her care. During the day Judy has to be prompted to attend to Taylee's cares and again reports that Taylee is not taking the formula, however she feeds well for nursing staff.

When Taylee has a blood test and cries, Judy berated her and called her a little sook.

Over the next few days, Judy is observed to be late to arrive on ward, slow to respond to Taylee's crying, and is rough with nappy changing. Taylee's grandmother visits on the third day and informs you she has concerns that Judy is drinking alcohol, spending a lot of time with her new partner and not attending to Taylee. The

grandmother says Taylee is always lying in her cot when she visits. The grandmother said her daughter's last partner (father of Taylee) was violent and this caused her to increase her alcohol consumption.

Taylee's tests reveal no metabolic cause for failure to thrive and she has gained 250 grams in three days. The mother of a patient next door takes you aside and said she just saw Judy pour Taylee's formula down the sink. When you ask Judy about this she gets angry, said Taylee did not want it and walks off.

## Scenario three

### Details

Mother: Mary Jones (age 30)  
Baby: Jack Black (age 2 months)  
Sibling: Krystal Black (age 3)  
Address: 42 Millar Street, Greenwood  
Phone: 0437 516 687

You are home visiting a mother (Mary) for the third time, she has a two-month-old baby boy, a three-year-old daughter and recently separated from her partner. She has a history of previous drug abuse and depression. She presents as tired and yawning frequently.

You go into the bathroom to wash your hands and notice there are used syringes uncapped on the bathtub. Mary insists these belong to a friend who visited last night and she is going to dispose of them soon.

You examine the baby and observe a small purple bruise on the baby's left thigh. Mary tells you she is not sure how he got the bruise but thinks the three-year-old may have hit the baby as she is jealous of him. When you weigh the baby he has only gained 50 grams in two weeks but Mary says he is drinking 120 millilitres of formula, six feeds a day. The three-year-old comes into the room and asks for breakfast. Mary tells her to stop hassling her, she will get it in a minute, it is now 11 am.

## Scenario four

### Details

Father: Nick Brown (age 40)  
Daughter: Kylie Brown (age 11)  
Son: Jake Brown (age 8)  
Son: Josh Brown (age 6)

Nick Brown, a 40-year-old single father, presents following a hanging incident at home. Nick is well known to mental health services, with some brief in-patient stays over the past three years for depression. Nick's 11-year-old daughter Kylie found him and called the ambulance. Nick has two younger children, Jake (eight years old) and Josh (six years old) but you are unable to ascertain their whereabouts or who is currently looking after the children. Eventually a next door neighbour presents with the children and says that she can look after them for the time being.



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