



Child abuse and neglect education module

Responsibility, recognising and reporting

A resource for the interdisciplinary team

**Child abuse and neglect education module:
Responsibility, recognising and reporting
–A resource for the interdisciplinary team**

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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 to build the 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 were 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 Employment Assistance Scheme (EAS). Please refer to your Hospital and Health Service EAS policy for details about accessing this service should you need support as a result of the content in this module.

Section 1: Responsibility

Objectives

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

1. Describe your legislative and/or duty of care 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.

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 will work 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.

Queensland whole-of-government approach

The Queensland Government is committed to protecting children and young people from harm. The department partners with the Department of Communities, Child Safety and Disability Services (DCCSDS); Queensland Police Service (QPS); and Department of Education, Training and Employment (DETE) in a number of forums to ensure the safety and wellbeing of children and young people.

Department of Communities, Child Safety and Disability Services

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 DCCSDS.

The role of Child Safety Services (CSS) is to:

- investigate reports that allege a child has been harmed or is at risk of harm
- ensure an ongoing provision of services to children who have been assessed as experiencing, or being at risk of experiencing, significant harm in the future
- act as the lead agency in facilitating a whole-of-government response to child protection issues including the SCAN and ICM.

The Director-General (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* provides an entitlement for certain service providers (e.g. health, child safety, community services, education and police officers) to share or exchange confidential information about a child where it is done so in accordance with the Act to meet the protection and care needs of children and promote their wellbeing.

Queensland Police Service

Queensland police officers have legal provisions within the *Child Protection Act 1999* for child protection investigations and responses, given the possibility of the commission of a criminal offence related to the alleged harm to a child¹.

Section 1590 of the *Child Protection Act 1999* says all health professionals are allowed to provide confidential information directly to Queensland police officers if it is relevant to the protection or wellbeing of a child.

Department of Education, Training and Employment

Senior guidance officers are core member agency representative of SCAN teams across Queensland. They assist state and non-state school principals with the referral of cases to an ICM or SCAN team meeting subject to the respective referral criteria.

¹ Section 14(2) of the *Child Protection Act 1999*

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 158, 191 and 192 (mandatory reporting)
- Sections 195, 196 (protection from liability and confidentiality of notifiers)
- Sections 197–200 (care and treatment orders)

www.legislation.qld.gov.au/LEGISLTN/CURRENT/P/PubHealA05.pdf

Child Protection Act 1999

- Section 5 (principles of the Act)
- Sections 8–11 (key terms)
- Section 21A (unborn children)
- Sections 22 (protection from liability of notifiers)
- Section 159B (service coordination and information exchange)
- Section 159J–159L (SCAN system)
- Section 159O (information exchange)
- Section 186 (confidentiality of notifiers)

www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf

Hospital and Health Boards Act 2011

- Section 142 (confidential information not to be disclosed)
- Section 143 (exemption from Section 142 where disclosure is required or permitted by another Act or law)
- Section 145 (exemption from Section 142 where information is required for the care or treatment of the person)

www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HHNA11.pdf

Right to Information Act 2009

www.legislation.qld.gov.au/LEGISLTN/CURRENT/R/RightInfoA09.pdf

Reporting responsibilities

Health professionals are required to report a reasonable suspicion of child abuse and neglect. The obligation to report arises from legislation (under a specific Act) and from the common law (judge made law). Reporting requirements arise under legislation such as the *Public Health Act 2005* and the *Child Protection Act 1999*. The common law requires reporting as a result of the principle of a duty of care. The two types of reporting mandatory and non- mandatory are explained below.

Duty of care

Under the common law principle: duty of care—all health professionals have an obligation to report a reasonable suspicion of child abuse and neglect. This legal principle requires all clinical staff to exercise proper professional care in their duties, responsibilities, as well as to take all reasonable and practical steps to prevent harm.

Harm to a child is defined in the *Public Health Act 2005* (Section 158) as:

any detrimental effect on the child's physical, psychological or emotional wellbeing:

- *that is of a significant nature*
- *that has been caused by:*
 - *physical, psychological or emotional abuse or neglect*
 - *sexual abuse or exploitation.*

Mandatory reporting (*Public Health Act 2005*)

Mandatory reporting is a legislative requirement, set out in Sections 158, 191 and 192 of the *Public Health Act 2005*.

In Section 158, a professional is defined as:

a doctor or registered nurse.

Doctors and registered nurses are mandated to report suspected child abuse and neglect directly to CSS under Section 191 of the *Public Health Act 2005*. This relates only to concerns or suspicions they recognise in the course of their professional practice.

Doctors and registered nurses who fail to report their suspicions can be found to have committed an offence and may receive a prescribed penalty up to 50 penalty units (currently \$110 per penalty unit) under Section 193 of the act.

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

All other clinical staff are able to report suspicions of child abuse and neglect under Section 1590 of the *Child Protection Act 1999* in accordance with the information exchange provisions under that legislation, however they are not mandated to do so.

Whilst all other clinical staff are not mandated to report suspicions of child abuse and neglect, the department's *Protecting Children and Young People Policy* requires that all staff in the course of their work have a responsibility to consider and report reasonable suspicions of child abuse and neglect.

Unborn children

It is not mandatory for staff (e.g. doctor, registered nurse) to report concerns relating to an unborn child, however this does not prevent them to report their concerns to CSS about the potential risk of harm to a child following their birth.

The department's *Protecting Children and Young People Policy* states all reports relating to an unborn child are to be discussed with the health service child protection advisor or child protection liaison officer prior to the report being made to CSS.

Section 21A of the *Child Protection Act 1999* enables CSS to take appropriate action when it suspects an unborn child may be at risk of harm after birth. The purpose is not to interfere with the rights or liberties of the pregnant woman, but to provide assistance and support that would reduce the likelihood her child will be subject to abuse or neglect after birth.

CSS are able to initiate an Unborn Child High Risk Alert. This means there are significant protective concerns about the unborn child and the parent/s may have refused to participate or be engaged in an assessment of their circumstances. An alert is initiated after a child safety officer has assessed the child will be in need of protection after he or she is born. The alert must not be disclosed to the pregnant woman.

Section 22 of the *Child Protection Act 1999* protects a person from liability associated with notifying of, or giving information to CSS or a Queensland police officer, about an unborn child who may be at risk of harm after he or she is born.

It is the responsibility of the admitting midwife to undertake the relevant inquiries associated with these alerts—by accessing the Unborn Child High Risk Alert toolkit and to facilitate advice to CSS when the woman presents at hospital for delivery (please refer to protocol for responding to an Unborn Child High Risk Alert at <http://qheps.health.qld.gov.au/policy/docs/ptl/qh-ptl-078-1-1.pdf>).

The existence of an alert does not prevent clinical staff from making further reports to CSS if they suspect an unborn child will be in need of protection after birth.

Professional standards and child protection issues

All clinical staff within their discipline have their own professional competency standards, codes of ethical behaviour and conduct. 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 allowed to provide information directly to CSS 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 this information, health professionals are given a number of legal protections under the *Public Health Act 2005* (doctors and registered nurses only) and/or the *Child Protection Act 1999* (all health professionals).

These include:

- Health professionals (only doctors and registered nurses) who are mandated to report child harm under Section 191 of the *Public Health Act 2005* are deemed not civilly liable for making the report (Section 456 of the *Public Health Act 2005*)
- Section 195 of the *Public Health Act 2005* also enables a health professional to discuss their suspicions with another health professional. For example, a junior registered nurse may be uncertain about whether a particular presentation indicates child harm, so they would be able to discuss the presentation with a more senior registered nurse
- other health professionals who give information about child harm to a health professional (doctors and registered nurses) under Section 195 of the *Public Health Act 2005* are deemed not to have breached any duties of confidentiality or privacy and are not liable to criminal, civil or disciplinary action for giving the information
- all health professionals under Section 22 of the *Child Protection Act 1999* are afforded legal protection from civil and criminal liability for making a notification or giving information about child harm to CSS or a Queensland police officer. For instance, a person who notifies CSS of harm to a child or young person has a defence against a claim for defamation and cannot be held to have breached any duty of confidentiality or code of professional ethics
- 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.

Non-health professionals

A person who gives information to a health professional (doctor or registered nurse) about child harm is also afforded legal protection (Sections 195 and 196 of the *Public Health Act 2005*). For example, a grandparent who gives information to a doctor about harm to a child can do so without fear of the doctor or CSS revealing to the parent/s of the child that the information came from the grandparent.

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 duty of care 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 and neglect are used in child protection and health contexts.
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. Indicate 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.

Definition of harm, abuse and neglect

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

Legal

In Queensland, a child is defined in the *Public Health Act 2005* as:

an individual under 18 years.

Harm to a child is defined in the *Public Health Act 2005* (Section 158) as:

any detrimental effect on the child's physical, psychological or emotional wellbeing:

- *that is of a significant nature*
- *that has been caused by:*
 - *physical, psychological or emotional abuse or neglect*
 - *sexual abuse or exploitation.*

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.

Significant harm means:

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

For more information on effects of harm visit www.communities.qld.gov.au/childsafety/protecting-children/what-is-child-abuse/effects-of-harm

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

a child in need of protection is a child who:

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

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

- *the child's mother, father or someone else (other than the chief executive) having 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*
- *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 child².*

Operational

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 accidental³. 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 prostitution⁴.

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^{5, 6} (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 supervision⁷ (this list is not exhaustive).

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

3 www.yesican.org/definitions/WHO.html

4 Department of Child Safety, Child Safety Practice Manual, Intake and Investigation and Assessment, V1.0, pp. 29

5 www.yesican.org/definitions/WHO.html

6 World Health Organisation, Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999

7 www.yesican.org/definitions/WHO.html

Recognising child abuse and neglect

Possible presenting characteristics

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

- 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 him or herself
- 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 (this list is not exhaustive).

Signs of child abuse and neglect

A child who has been, or may be experiencing abuse may show behavioural, emotional or physical signs of stress and abuse.

Common indicators of child abuse and neglect

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

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

Some indicators of child abuse include:

- 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 (this list is not exhaustive).

Some indicators of neglect include:

- 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 (this list is not exhaustive).

For more information about signs of child abuse and neglect visit www.communities.qld.gov.au/childsafety/protecting-children/what-is-child-abuse/signs-of-child-abuse-and-neglect

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>

Antenatal assessment of risk:

Antenatal assessment is a valuable opportunity to develop a proactive multi-agency approach to families where there is an identified risk. The aim is to provide support for families, to identify and protect vulnerable children and to plan effective care programmes, recognising long-term benefits of early intervention on the welfare of the child⁸.

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

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

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

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

Forming a reasonable suspicion of child abuse and neglect

To fulfil their responsibilities as mandatory reporters, doctors and registered nurses are required to **immediately** notify CSS of a reasonable suspicion that a child has been, is being, or is likely to be harmed. This threshold is relevant to all clinical staff who have a duty of care obligation to report.

(Note—immediately is defined in the department’s *Protecting Children and Young People Policy* as ‘without delay or intervention, at once, instantly’).

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

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

- always consider child protection when assessing the health needs of every unborn, child and young person
- 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.

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

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.

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 to report child abuse and neglect.

It is important the report of reasonable suspicion of child abuse and neglect to CSS 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 reasonable suspicion?
- Did/would your suspicions reach the threshold to report?
- What is the evidence that would suggest that your suspicions were/are reasonable?
- What are the core principles of assessment of a reasonable suspicion of child abuse and neglect? In what ways does the assessment in this situation reflect these core principles?

Section 3: Reporting

Objectives

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

1. Describe each process of making a verbal and written report of reasonable suspicion of child abuse and neglect.
2. Complete a Report of a Reasonable Suspicion of Child Abuse and Neglect (SW010) 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 making a report to CCS there are two steps to reporting, verbal and written.

Verbal report

Verbal contact with an authorised officer of the Child Safety Services Regional Intake Service (CSS-RIS) or Child Safety After Hours Service Centre (CSAHSC) is the first step you take when reporting. This is referred to by CSS-RIS as an 'intake'. During this process the child safety officer will ask a specific set of questions to assist them in determining the response level for the report,

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

For further information visit www.communities.qld.gov.au/childsafety/about-us/contact-us

Written report

The department's SW010 form has been developed to mirror the 'intake' questions you will be asked during the verbal 'intake' call. It may be helpful to work through the form prior to your telephone conversation with the CSS-RIS authorised officer. The completion of the SW010 form will facilitate effective and efficient communication between you and the CSS-RIS or CSAHSC.

How to complete the written report

1. Fill in the SW010 form.
2. Additional information may be given on a separate sheet.
3. Fax a copy of the SW010 form to CSS-RIS or CSAHSC.
4. File the SW010 original copy in the individual's medical record.
5. Forward the yellow carbon copy of the SW010 form to your child protection liaison officer (contact details for your local child protection liaison officer are available on QHEPS at <http://qheps.health.qld.gov.au/csu/districtpacplo.htm>).
6. Document your concerns and actions in the individual's medical record.

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

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

Other issues to consider when making a report

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 comprises 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 as a decision making individual
4. justice (treating everyone equally).

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 to 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 of the SW010 form. The information you provide verbally to CSS-RIS or CSAHSC may be more extensive than your written SW010 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 name for clarification.

CSS-RIS intake process

When reporting a reasonable suspicion of child abuse and neglect to CSS-RIS or CSAHSC, the minimal information requirements are contained in the prescribed SW010 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 to 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 it is either:

- recorded as an intake enquiry, or
- recorded as a:
 - child concern report, or
 - 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 Intensive Family Support (IFS) services and RAI services, in areas where these services exist.

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 harm, is suffering harm, or is at unacceptable risk of suffering harm, and does not have a parent able and willing to protect him/her from 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 received indicates a criminal offence, the information will be referred to the QPS.

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 judicial 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 his/her 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, 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 counseling.

Reflection

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

- Complete the SW010 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.

Additional information

Care and Treatment Orders

Under Section 197 of the *Public Health Act 2005*, designated medical officers have the power to hold a child in hospital for up to 48 hours where it is suspected that a child has been harmed or is at risk of harm. This power is only initiated in circumstances where other protective mechanisms for the child or young person's safety, available under the *Child Protection Act 1999*, are unable to be accessed or invoked.

A Care and Treatment Order may be considered if a parent, guardian or person claiming to be entitled to the custody of the child is incapable of caring for a child so that it is likely to be subject to unnecessary injury, suffering or danger.

It is important to inform parents/caregivers of the availability of this legislative power when presented with such situations. It should not be done so in a manner that can be considered by the parents as coercive or discriminatory. All other means should be attempted to gain cooperation and consent by parents before consideration of invoking an order.

Please refer to:

- Care and Treatment Order for a Child Information Booklet
<http://qheps.health.qld.gov.au/csu/careandtreat.htm>
- *Protecting Children and Young People Policy*
www.health.qld.gov.au/qhpolicy/html/index-p.asp

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:

- DCCSDS
- Queensland Health
- QPS
- DETE
- The recognised 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.

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

It is important to remember 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, child protection advisor or child protection liaison officer 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.

Other possibilities

Other ongoing roles for health professionals can 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.

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

Right to information

The Queensland *Right to Information Act 2009* provides the public with a legally enforceable right to obtain information held by government. To seek amendment to information held by government concerning their personal affairs if that information is inaccurate or incomplete, out-of-date or misleading.

The rights of access under *Right to Information Act 2009* are subject to certain exclusions and exemptions specified in the act which may, in certain circumstances, provide grounds for refusing to grant access to information held by 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 Act 2009* 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 www.health.qld.gov.au/foi/docs/rti_ip_contacts.pdf

Resources

www.legislation.qld.gov.au/OQPChome.htm

<http://qheps.health.qld.gov.au/csu/pdf/26419.pdf>

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

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

www.communities.qld.gov.au/childsafety/child-safety-practice-manual

World Health Organisation, Report of the Consultation on Child Abuse Prevention, Geneva, 29-31 March 1999

www.yesican.org/definitions/WHO.html

Child Abuse Homicides in Australia: Incidence, Circumstances, Prevention and Control by Health Strang

Carol Bellambi, UNICEF Executive Director referring to the Convention outcome

www.unicef.org/crc/crc.htm

Appendix A: Case scenarios

Scenario one

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.

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

Scenario two

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.

Details

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

Scenario three

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.

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

