Queensland Health

Documentation and storage of child protection information

Queensland Health Guideline QH-GDL-979

Purpose

The safety and wellbeing of children and young people and their protection from abuse and neglect is an important and shared responsibility for the community. All employees, volunteers and service providers in the Queensland (Qld) Health system have a responsibility to respect and promote the rights of children and young people.

Given the sensitive nature of child abuse and neglect and the potential for serious consequences for those involved, including legal placement/protection orders for a child or young person; criminal prosecution of alleged offenders and access to justice for survivors, it is important that all Qld Health staff (whether employees or contractors) recognise the need for accuracy, objectivity and impartiality when documenting suspicions of child abuse and neglect and other relevant information. Of comparable importance is the secure storage of such information.

The purpose of this document is to outline best practice principles for Hospital and Health Services (HHSs) regarding the documentation and storage of child protection information, and to promote consistency of practice across the State as HHSs increasingly share access to electronic medical records. Some degree of local variation in practice may be appropriate. Each HHS is required to consider the most appropriate local solution. All child protection documentation must also comply with record keeping legislative and policy requirements.

All information sharing must be compliant with the child protection legislative framework. If you are uncertain or have any questions seek advice from your local Child Protection Unit (CPU) or HHS legal service.

Scope

This guideline applies to all HHS employees and other persons working for or in a HHS to provide a service, including contractors, consultants, students (i.e. staff) who are responsible for documentation and storage of child protection related information. This will include but is not limited to health professionals who provide direct care to infants, children and young people; and/or to adult patients who have parental/carer responsibilities; and/or to those who are pregnant. If uncertain, staff should check with their local health information service or legal service. The scope of this guideline does not replace other reporting requirements and should also be considered alongside Qld Health Guideline *Reporting concerns of child abuse and neglect to Child Safety and sexual offences against children to the Police*.

System Policy Branch,
Strategy, Policy and Reform Division.
Effective date 29 February 2024

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Related Procedures, Guidelines, Protocols

Queensland Health child protection guidelines are available by searching the Guidelines section https://qheps.health.qld.gov.au/csu

- Queensland Health Information Sharing in Child Protection: Clinical practice guide
- Child Safety's: Information Sharing Guidelines: to meet the protection and care needs and promote the wellbeing of children
- Reporting Concerns of Child Abuse and Neglect to Child Safety and Sexual Offences against Children to the Police
- *Limited Write Access: CIMHA for Queensland Health staff in specialist child protection roles*
- Responding to an Unborn Child High Risk Alert
- Our Child - When a child in care is reported missing
- SCAN Practice Manual

Legislation

- *Child Protection Act 1999* (Qld)
- *Hospital and Health Boards Act 2011* (Qld)
- *Criminal Code Act 1899* (Qld)
- *Information Privacy Act 2009* (Qld)
- *Right to Information Act 2009* (Qld)
- *Public Records Act 2002* (Qld)

Other

- HHS Instrument of delegation (refer to your HHS legal service)
- MOU between Queensland Health and the Queensland Police Service: Confidential Information Disclosure

Key Principles

Patient confidentially

- As with all confidential health information, filing and storage of child protection-related information must be secure. Reasonable steps must be taken to protect the information held to avoid unauthorised access, use, modification, disclosure, destruction, or loss.
- Examples of confidentiality risks include staff carrying identifiable patient information in the form of loose notes, or information on unsecured portable devices such as laptops, iPads, smartphones, and unencrypted or non-password protected USB drives.
- Staff should ensure they are up to date with required training about confidential information and information security (including cyber security).

Access to relevant information for staff

- Timely access to information relevant to a child's safety is a tenet of the government's legislative framework for the protection of children. Information must be available to relevant staff at the time it is required, which may be outside office hours.
- In such instances, systems for the filing and sharing of child protection related information are required to permit adequate access on a need-to-know basis subject to lawful authority.

Security of patient health records

- In general, child protection related information within paper health records or electronic health records (e.g. ieMR & CIMHA) does not require any additional physical or electronic protection compared to that of other health records. For example, a high level of security is already integrated into electronic health record systems that are utilised by HHSs including audit trails which allow identification of improper access to records.
- Staff who observe or suspect inappropriate access to paper or electronic health records must report this to their line manager, and the relevant HHS health information management service, medico-legal unit, or integrity unit as per local HHS process.

Protection of notifiers

- Staff identity, where they are a confidential notifier(reporter) to Child Safety, is protected under section *186A(1) of the Child Protection Act 1999 (CP Act)* however there are exceptions as noted in 186A(2), 186B, 186C. HHSs have a responsibility to reduce the risk of a notifier's identity being released under these provisions. HHSs (through staff) are responsible for ensuring that the notifier's identity is not inadvertently released and is only released if legally permitted. For example, care must be taken not to provide the name, position, or any other identifying information of a staff member who is a notifier to the family, an external person, or service providing assistance to the child and /or family.
- Staff are not liable for breach of confidentially by making a report to Child Safety under section *197A of the CP Act*, provided they acted honestly and reasonably in making the report.

Documenting and storing child protection information

This section details best practice when documenting and storing child protection information.

Documentation:

- All HHSs should refer to eHealth Queensland's *Clinical Documentation Guideline* and have local procedures that underpin this document. If there is any uncertainty, staff should seek clarification from their local health information service and/or HHS legal service.

- Include all details about the incident, the date, time, location, reason for the presentation and details of other persons accompanying the patient at the time of presentation.
- Record the findings and outcomes and date of all conversations, interviews (child / parent / carer / person accompanying the child), treatments and interventions (medical and psychosocial) and follow-up actions.
- Record all allegations or disclosures made by the child or caregiver and date, names of those involved, including witnesses. These should be recorded as verbatim quotations. For example: mother said, *'I left him with his xx (name and relationship)'.*
- Be objective. State the facts and any clinical or professional opinion (not a personal opinion) For example, *'child presents with xx (name and relationship) ...minimal interaction observed...child withdrawn'*. Do not include any documentation of feelings, judgmental reactions or intuitive responses. Whilst feelings, judgmental reactions and intuitive responses play a role in care delivery, they do not belong in health record documentation.
- Use precise anatomical descriptions. Describe each discreet injury separately. Staff can record the injuries on a body map. Documenting injuries via clinical photography where appropriate is also recommended. Please refer to guidance noted further in this section.
- For sexual assault, all HHSs should refer to the Qld Health Forensic and Scientific Services *Paediatric Forensic Medical Examination Records* for children and younger adolescents and consider local guidelines where indicated.
- Document and date discussions with colleagues who have specialist skills in child protection (Child Protection Specialist Roles eg. Child Protection Liaison Officers, Child Protection Advisors, and/or Social Workers). This consultation is essential and will assist staff to determine if their suspicion is reasonable.
- Staff should refer to local HHS policy about obtaining patient/child consent for clinical photography to guide them in this process. The Queensland Police Service (QPS) may initiate arrangements for and undertake forensic photography to inform any subsequent criminal investigations that may result. Please seek advice from your local Child Protection Advisor (CPA) or HHS legal service for further details and assistance when needed.
- Generally, the use of personal mobile devices for clinical photography raises legal complexities and risks and is strongly discouraged. Subject to local HHS policy, personal mobile devices should not be used except in urgent and exceptional circumstances and a detailed record of the circumstances kept. For example, within the scope of child protection practice, the use of a personal mobile device may occasionally be warranted when an HHS issued camera is not readily available and photographs are considered necessary and time-critical to deliver care:
    - eg., where urgent consultation with other health professionals to assess injuries is required, *or*
    - if there is an expected delay in the QPS attending the HHS to complete forensic photography and a HHS issued camera is not available.
- However, you will need to refer to local HHS policy and guidelines and seek advice from the HHS legal service as required. NOTE: In circumstances where a personal mobile device has been authorised by the HHS for use on a regular basis the user should also comply with the *BYOD Self-managed service*.

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- The use of private email accounts or systems and messaging applications, for government related business poses a security risk, prevents the proper management of records, and is prohibited with limited exception. Please refer to *Public Service Commission private email use policy*.
- For paper health records, staff must write legibly, provide sufficient detail, sign, print and date their name against each entry in the health record. In circumstances where the note is written retrospectively there should be a distinction made between the date and time of the entry and the date and time when actual events took place (e.g. assessment).
- Maintaining an accurate, considered, objective and up to date account of concerns, consultations, contacts, plans and actions will facilitate the effectiveness and appropriateness of any subsequent response or intervention involving the child or young person. Note: Providing relevant contextual information can allow the record's value as evidence to remain relevant over time, e.g. who created the record, when it was created, file reference numbers or parts of files to show linkages and references to other supporting documents so that their relevance is not lost.
- Accurate documentation clearly demonstrates staff responsibility for reporting and reflects professionalism and clinical skill. It may also be relied on as evidence in court or legal proceedings relating to the child or young person.
- **And remember,** disclosures of childhood abuse can occur at any time. Recordkeeping is not only an organisational issue but a deeply personal one for survivors where access to health records can occur at any stage of a person's lifetime. Language should enable a clear voice for the child, young person or adult survivor, be both objective and respectful while keeping the best interests of the person uppermost in all aspects of staff conduct. Further to these requirements, each HHS will likely have specific individual statutory obligations in relation to ensuring all reasonable care is taken for the safety and wellbeing of persons in their care and those they interact with (*Guideline on creating and keeping records for the proactive protection of vulnerable persons*).

Specific categories of child protection information

- **Reports of a suspected child in need of protection:** (Refer to: *Reporting Concerns of Child Abuse and Neglect to Child Safety and Sexual Offences against Children to the Police located on QHEPS*). When HHS staff make a report of a suspected child in need of protection to an authorised officer of Child Safety Regional Intake Service (CS-RIS) or Child Safety After Hours Service (CSAHS), they are required to provide the report in writing via a *'Report of suspected child in need of protection E-Report'* located on QHEPS. The completed report, or a printout of this form, should be filed in the subject patient's health record. The outcome of the report once received from Child Safety, should also be filed in the subject patient's health record.
- If health records for other persons noted in the report also exist within the local HHS, Child Protection Liaison Officers within the HHS should use their clinical judgement to determine if additional documentation is to be placed in the relevant person's record. For example, information that may be helpful to facilitate communication and coordinate care between services within the HHS as well as other agencies providing care to the child and family to reduce the impacts of further harm. In all instances it should be documented that if further information is required or child protection concerns are identified that contact is to be made with the local Child Protection Liaison Officer (CPLO).

- Clinical judgement to determine the above should be guided by:
    - The relevance and purpose of the information being shared. Health records can be accessed by several different health professionals over time so it should be purposeful and provide relevant context so as not to negatively influence care being provided.
        - For example, a report may be submitted to Child Safety however the concerns may not reach the threshold for further investigation or action by Child Safety.
    - The sensitivity of the information and who may be impacted if it is inadvertently shared.
        - For example, risks to safety if documentation of victim and survivor accounts is recorded in alleged perpetrators health records and/or the potential impacts to Child Safety or police investigations and access to justice for victims and survivors.
    - Legislative provisions.
        - For example, under section *186A(1) of the CP Act* which provides that it is an offence for a person who becomes aware of the identity of the notifier/reporter to disclose the identity of the notifier unless a statutory exception applies.
        - It may be necessary to de-identify/ redact the notifier details. HHS legal advice should be sought about any proposed redaction of a copy of a health record.
    - Consideration of documentation format.
        - For example, whether a written entry in the health record providing relevant information and context rather than direct filing of reports would be more appropriate.
    - Where possible, flag the document or information as relating to another patient health record.
- When uncertain, it is recommended that HHS Child Protection Specialist roles consult with their local health information and legal service to determine any additional requirements under legislation including the *Hospital and Health Boards Act 2011; Public Health Act 2005; Public Records Act 2002; Child Protection Act 1999*; *Information Privacy Act 2009 and Right to Information Act 2009*.
- Recommendations: whether the health record is a paper health record or an electronic health record, the report form and outcome should be filed in the 'LEGAL' section of ieMR or the paper health record.
- For reports made by Mental Health, please refer to *'Limited Write Access: CIMHA for Queensland Health staff in specialist child protection roles'* for filing in CIMHA.
- **Reporting sexual offences against children to police under the Qld Criminal Code:** There is currently no state-wide electronic reporting form or written reporting form when staff make a report to the Queensland Police Service (QPS) regarding concerns that a sexual offence has been committed against a child. (Refer to - *Reporting Concerns of Child Abuse and Neglect to Child Safety and Sexual Offences against Children to the Police*, section 5.5).

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- **Information sharing under 159 of the *Child Protection Act 1999 (Qld)*:**
  - When Child Safety request information under *Chapter 5A Part 4 of the CP Act* and a response is provided by a HHS delegated position (please refer to local HHS information regarding delegated positions), it is recommended that staff consult with their local HHS health information service and legal service to determine how the release of this information is to be delivered (i.e. written or verbal), documented and stored.
  - The guiding points noted in the previous section should be considered when making a clinical decision to document and store information in other patient health records.

- **Child Death and Injury Review Model (CDIRM):**

  When undertaking an internal review, the responsible officer may complete the following documents:

  - *Preliminary review form (mandatory)*
  - *Internal review plan (optional)*
  - *Child death review report* OR *Child serious injury review report (mandatory)*

  - Reviewing officers should store documents associated with the internal review process in a secure location that will ensure the confidentiality of the information and comply with at least departmental *Corporate information management (or relevant HHS policy framework)*, *HHS records management*, *Privacy* policies and procedures and confidentiality provisions in the *CP Act*.
  - Consistent with practices relating to SCAN records, which are also administrative records, internal review-related documents should be stored securely and separately from the patient health records, following local HHS Child Death Serious Injury Review procedure regarding documentation.
  - For further information on the CDIRM, please refer to the Queensland Health intranet page or *Queensland Health Guidelines: Internal review following a child's death or serious physical injury*.

- **Discharge escalation pathway for a child at risk (the Pathway):**
  Details of the escalation actions and details, discussions with the child, their parent/s, HHSs, Child Safety colleagues and other relevant parties must be documented on the escalation pathway *clinical form* and in the child's health record. Please refer to the Queensland Health *Discharge escalation pathway for a child at risk intranet page* or Pathway *Guidelines* for further information.

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Storage of Child Protection Information

The following section details recommendations for storing child protection documentation on the patient's health record. See Appendix 1: Child Protection Specialist Activities for further explanation.

Please follow your local health information service/legal service procedures regarding where to store information in ieMR.

Child Protection Documentation	**ieMR Record Title (Team-Role-Reason)**	**ieMR Folder**	**ieMR – Documentation Format /Encounter Type**	**Paper Health Record folder tab or location for paper document** (check with local health information service)
Reports of Reasonable Suspicion of Child Abuse and Neglect				
Child Protection Report [paper]	Child Protection Report	LEGAL	Scanned to start date of encounter	LEGAL
Report Outcome [phone call]	CPU – role - Child Protection Report Outcome	LEGAL	Free Text Note	LEGAL
Report Outcome [email]	CPU – role - Child Protection Report Outcome	LEGAL	Refer to local HHS process for managing emails into ieMR	LEGAL
Professional Child Safety Report Outcome [paper]	N/A (ieMR upload)	LEGAL	Scanned to start date of encounter	LEGAL
Child Protection Consultation and Advice				
Staff Child Protection Enquiry	CPU - role - Child Protection Record of Enquiry	Child Protection	Free Text Note	Progress note Inpatient or Outpatient according to patient status
CSO / Child Safety Contact	CPU – role - Phone call from Child Safety Officer	Child Protection	Free Text Note	Progress note Inpatient or Outpatient according to patient status
Child Protection Case Note	CPU - role - Child Protection Case Note	Child Protection	Free Text Note	Relevant Inpatient/Outpatient clinical notes
Child Protection Unit meetings/ activities	CPU – role - Child Protection Case Discussion	Child Protection	Free Text Note	Relevant Inpatient/Outpatient clinical notes

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Information Requests				
159 Requests for Information [Paper form request]	N/A (ieMR upload)	LEGAL	Scanned to start date of encounter	LEGAL
159 Requests for Information [Verbal]	CPU – role - Request for Information 159 N / M (*CP Act*)	LEGAL	Free Text Note	LEGAL
159 Requests for Information [email request]	CPU – role - Request for Information 159 N / M (*CP Act*)	LEGAL	Refer to local HHS process for managing emails into ieMR	LEGAL
Requests for information from other HHS's [Paper form]	N/A (ieMR upload)	LEGAL	Scanned to start date of encounter	LEGAL
Requests for information from other HHS's [email request]	CPU - role - Request for Information *(Hospital and Health Boards Act s148)*	LEGAL	Refer to local HHS process for managing emails into ieMR	LEGAL
Requests for information from other HHS's [verbal request]	CPU - role - Request for Information *(Hospital and Health Boards Act s148)*	LEGAL	Free Text Note	LEGAL
Alerts and Orders				
UCHRA Refer to Guideline: **found on the Child Protection & Wellbeing page on QHEPS.**	N/A (ieMR upload)	ALERTS and PROBLEMS	Scanned to start date of encounter	Alert
Care and Treatment Order Refer to Guideline: **found on the Child Protection & Wellbeing page on QHEPS.**	N/A (ieMR upload)	LEGAL	Scanned to start date of encounter	LEGAL
Child Protection Orders	N/A (ieMR upload)	LEGAL		LEGAL

SCAN Documentation (file note in clinical record of referral & outcome)	CPU - role - SCAN file note	Child Protection		Progress note Inpatient or Outpatient accordingly to patient status See SCAN Information Sharing Processes below
Discharge escalation pathway for a child at risk clinical form **Refer to Guideline found on the Child Protection & Wellbeing page on QHEPS.**	N/A (ieMR upload)	Child Protection	Scanned to start date of encounter	LEGAL
For noting				
If an enquiry is received and there isn't sufficient information to create a Unit Record Number (URN), please speak with your local health information service for advice on documentation and storage of this information.				

Documentation and storage of images for the purposes of forensic assessment and reporting (including for education or peer review purposes)

- HHSs may make local decisions to store certain documents, e.g. highly sensitive and protected (Refer to: Information Security Classification and Handling Standard) clinical and forensic images, outside the health record. In such instances, the media (USB, DVD, external drive) must be stored on an appropriately secured local hard drive for example by using password protection when sharing electronic files and maintaining confidentiality of documentation, or in the case of physical media, a locked cabinet, and their existence and location documented in the child protection section of the health record (Note: Categorisation of records as 'sensitive' or 'protected ' under the Information Security Classification and Handling Standard requires an assessment of each individual record).

- Examples of PROTECTED information include:
    - Information under the protection of the *Child Protection Act 1999 (Qld)* and *Mental Health Act 2016* (Qld), such as the address details of a patient under the protection of a Mental Health Court confidentiality order, pictures, videos or detailed clinical reports of children under the protection of the *Child Protection Act 1999 (Qld).*

- Medico-legal reports provided to the Queensland Police Service and Child Safety which contain medical opinion and advice, and which may include additional records used to inform this assessment (e.g. photographs/ witness statements) should also be stored securely. This may be in a secure local hard drive, or in the case of physical media, a locked cabinet and their existence and location documented in the child protection section of the

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health record. Please follow your local health information service/legal service procedures regarding where to store sensitive and protected information.

- Please ensure the sensitive and protected information is stored in a manner aligned to the Information Security Classification Framework
- **And remember, ensuring the maintenance and retention of records** may provide evidence for any incidents, allegations, disclosures and investigations relevant to the interaction with vulnerable persons including children, young people and adult survivors (Guideline on Creating and Keeping Records for the Proactive Protection of Vulnerable Persons).

ALERT

If in any doubt regarding where to appropriately store child protection information, or transfer or handle this information, please contact your local Child Protection Liaison Officer within the HHS Child Protection Unit, health information service and/or HHS legal service.

Consultation

Key stakeholders who reviewed the Guideline:

- Chief of Medicine, Children's Health Queensland
- Director, Child Protection and Forensic Medical Service, Children's Health Queensland
- Health Information Management Speciality Sub-Group (HIM SSG)
- Strategy, Youth Justice and Child Protection, System Policy Branch, Strategy, Policy and Reform Division, Department of Health.
- Statewide Child Protection Clinical Partnership (SCPCP) Steering Committee (Version 1.1)
- SCPCP sub-groups: Information Sharing Subgroup, and Queensland Child Protection Liaison Officer Clinical Networks (Northern and Southern) (Version 1.1)

Definition of terms

Term	Definition	Source
Child in need of protection	A child in need of protection is a child who: a. has suffered significant harm, is suffering significant harm, or is at unacceptable risk of suffering significant harm; AND b. does not have a parent able and willing to protect the child from the harm.	s.10 *Child Protection Act 1999 (Qld)*
Child Protection Specialist role - *Child Protection Advisor*	The Child Protection Advisor (CPA) is a nominated HHS position. The CPA plays a key role in providing advice and the provision of child protection services both at a health service and an interagency level.	Department of Health - *Key HHS child protection roles* fact sheet
Child Protection Specialist role - *Child Protection Liaison Officer*	The role of the Child Protection Liaison Officer (CPLO) is to provide a single point of contact for child protection issues. CPLOs are able to provide consultation on child protection concerns and child protection support and advice to health staff.	Department of Health - *Key HHS child protection roles* fact sheet
Care and Treatment Order	An order made by a Designated Medical Officer (DMO). This order enables a DMO to direct that a child be held at a health service facility for an initial period not exceeding 48 hours if the DMO reasonably suspects that the child has been harmed, or is at risk of harm, AND, that the child is likely to leave or be taken from the facility and suffer harm unless immediate action is taken. The order may be extended for an additional 48 hours, only with the agreement of a second DMO.	*s.197 Public Health Act 2005*

Harm	Harm, to a child, is any detrimental effect of a significant nature on the child's physical, psychological or emotional wellbeing. 1. It is immaterial how the harm is caused. 2. Harm can be caused by – • Physical, psychological or emotional abuse or neglect; or • Sexual abuse or exploitation. 3. Harm can be caused by – • A single act, omission or circumstance; or • a series or combination of acts, omissions or circumstances.	s.9 *Child Protection Act 1999 (Qld)*
Medical Examination	A medical examination includes a physical, psychiatric, psychological or dental examination, assessment or procedure and includes forensic examination and an examination or assessment carried out by a health practitioner	*Schedule 3 Child Protection Act 1999 (Qld)*
SCAN	The purpose of the SCAN team system is to enable a coordinated response to the protection needs of children. This is achieved by facilitating: • the sharing of information between members of the system under the *Child Protection Act 1999 (Qld), Chapter 5A, part 4,* • the planning and coordinating of actions to assess and respond to children's protection needs, and • a holistic and culturally responsive assessment of children's protection needs.	*SCAN Team System Manual* (Found on the Child Protection & Wellbeing page on QHEPS).
Unborn Child High Risk Alert (UCHRA)	*Section 22 of the Child Protection Act 1999 (Qld)* enables Child Safety to: Investigate the circumstances and assess the likelihood that an unborn child will need protection after he or she is born; or offer help and support to the pregnant woman. An Unborn Child High Risk Alert (UCHRA) is generated by Child Safety in response to child protection concerns raised prior to the birth of a child.	*s.22 Child Protection Act 1999* *Child Safety Practice Manual*

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Child Safety	The term 'Child Safety' is used throughout this document when referring to the *Department of Child Safety, Seniors and Disability Services* This is the Queensland government department that is responsible for i. investigating concerns that a child or young person has been harmed or is at risk of significant harm; and ii. ii. providing ongoing services to children and young people who are experiencing or are at risk of experiencing significant harm. This 'department' is periodically subject to name change dependent on the machinery of government in operation at the time.	*Child Safety website*

References and suggested reading

NOTE: Queensland Health child protection guidelines are available by searching the Guidelines section https://qheps.health.qld.gov.au/csu

- SCAN: Information sharing processes – attached below
- eHealth Clinical documentation guideline
- Guideline on creating and keeping records for the proactive protection of vulnerable persons
- BYOD Self-managed service
- Public Service Commission private email use policy
- Information Security Classification and Handling standard
- Information Security Classification and handling guideline
- Local Hospital and Health Services health information or health records contacts
- Principles for clinical documentation across Qld Health facilities

SCAN: Information sharing processes – Chapter 5A Child Protection Act 1999 (Qld)

NB: this is a guide to assist staff only – local Hospital and Health Service (HHS) procedures and local legal advice should be followed

The information sharing principles in section 159B of the *Child Protection Act 1999 (Qld)* and the SCAN Core member responsibilities in section 159L of the *Child Protection Act 1999 (Qld)* together with the Department of Children, Youth Justice and Multicultural Affairs' *Information Sharing Guidelines* (section 159C of the *Child Protection Act 1999 (Qld)*) - underpin this document.

	What & Why	Type of Record	Who	Steps to take in accessing ALL Statewide public patient records (electronic and paper records) & Requesting information from another HHS/CPU	Access and use of patient information permitted under legislation	Steps to take to disclose patient information	Disclosure of patient information permitted under legislation	Documentation
Row A	• Suspected Child Abuse and Neglect (SCAN) team referral made by QH or received about child/ family • Child/family referred to SCAN to enable a coordinated response	• All Statewide public patient records (includes all electronic and paper records)	• QH SCAN Core Rep (SCR) • Child Protection Liaison Officer (CPLO) ○ preparing information to inform SCAN meeting about child/family	**1. Search & Identify relevant records** SCR/CPLO conducts search on 'The Viewer' to determine facilities/HHSs which may hold any relevant information in relation to the SCAN referral **2. Access and collate relevant information held within own CPU to present to SCAN Team** SCR/CPLO may access and prepare a report of all relevant information regarding any person/s stated in the SCAN referral from the Statewide electronic or paper records held within their facility /HHS **3. Access and collate relevant information held outside own CPU to present to SCAN Team** **[refer to the "Documentation" column in this guideline]** ➢ **Notify:** all relevant CPUs identified in 'The Viewer' search (within or outside of own HHS) via email of the SCAN referral (note: only if proceeding with information sharing to the SCAN Team) ➢ **Advise:** which Statewide electronic and paper records have already been accessed and collated for the purpose of sharing with the SCAN team (note only if proceeding with information sharing to the SCAN Team) ➢ **Request:** the relevant CPU/Health Information Access Unit (HIU) provide any additional information relevant to the SCAN referral (from electronic and paper records) **[refer to Row B below on how to request this information]** ➢ **Documentation:** request that the CPU/HIU document the SCAN request for information into their administrative patient record (as per local process)	NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act	**4. Disclosing of information** This section applies to disclosing patient information within QH/HHSs/CPUs between QH/ HHSs/ CPUs to the SCAN Team SCR/CPLO discloses the relevant information to the SCAN meeting including: • (A summary of) relevant Statewide electronic and paper records accessed by their CPU • (A summary of) all relevant electronic and paper records obtained from outside their CPU • Any additional relevant information	s.143(1) HHB Act & NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act Applies to disclosing patient information: ➢ within QH/HHSs/CPUs ➢ between QH/HHSs/CPUs ➢ to the SCAN Team **NB:** s.148 HHB Act may ONLY be relied on to disclose public patient information about a person OTHER THAN the subject child	SCR/CPLO must notify all relevant CPUs (both within and outside their own HHS) via email of the following: SCAN information: ➢ SCAN Case/File Name ➢ Date case tabled at the SCAN Team meeting ➢ Patients details (name/DOB) ➢ If relevant, request any additional information in both electronic and paper records – and state the authority that permits the records to be disclosed **[**s.143(1) HHB Act & NPP 2(1)(f) IP Act In conjunction with s.159MD(1) CP Act**]** ➢ If a request for additional information is made to a CPU/HIU – clearly state the date the information is required by ➢ Confirmation that the patient's Statewide electronic and paper records have been disclosed and the relevant authority **[**s.143(1) HHB Act & NPP 2(1)(f) IP Act In conjunction with s.159MD(1) CP Act**] AND clearly identify who/entity the patient's records have been disclosed to**
Row B	• CPU/Health Information Access Unit (HIU) receives request for information from SCR/CPLO to inform a SCAN meeting [refer to Row A above]	• All Statewide public patient records (includes all electronic and paper records)	• Other CPU (CPLO/Child Protection Advisor (CPA)/ Paediatrician) ➢ HIU prepares response to request from other SCR/CPLO	Access & provide relevant Statewide electronic or paper records/information held within their own CPU/HIU regarding any person/s stated in the SCAN referral request for purposes of presenting at a SCAN Team meeting	NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act		s.143(1) HHB Act & NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act **NB:** s.148 HHB Act may ONLY be relied on to disclose public patient information about a person OTHER THAN the subject child	**Example of CPU/HIU documentation:** "A request for information has been received from the **XX SCR/CPLO (name/ facility)**. On [date] the following information was provided to **XX SCR/CPLO** under authority of **XX** [s.143(1) HHB Act & NPP 2(1)(f) IP Act in conjunction with s.159MD(1) CP Act] for the purpose of presenting and discussing this information at a SCAN Team meeting, details of information disclosed is filed in legal section of the patients medical records"

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SCAN: Information sharing process between HHSs

The purpose of this guideline is to provide standardised best practice guidance to ensure consistency of practice by all Queensland Health (QH) and Hospital and Health Service (HHS) Child Protection Liaison Officers (CPLOs); Child Protection Advisors (CPAs); and QH/HHS Suspected Child Abuse and Neglect (SCAN) Core Representatives (SCRs) when accessing, recording and sharing information for the purposes of SCAN.

This guideline provides overarching guidance, and local HHSs are encouraged to operationalise this guideline via local procedures to meet their local requirements.

This guideline is an appendix to Queensland Health's *Information sharing in child protection – Clinical practice guide* which can be found here: ISCP_clinicalpracticeguide.pdf (health.qld.gov.au). It is suggested this guideline be read in conjunction with the Clinical Practice Guide.

Background

What is SCAN:

The purpose of the SCAN system is to enable a coordinated response to the protection needs of children.

This is achieved by facilitating:

- the sharing of information between members of the system under the *Child Protection Act 1999 (Qld),* Chapter 5A, part 4,
- the planning and coordinating of actions to assess and respond to children's protection needs, and
- a holistic and culturally responsive assessment of children's protection needs.

Legislative Framework:

The *Child Protection Act 1999 (Qld)* [sections 159I – 159L], provides the legislative basis for the establishment of, and activities undertaken by, the SCAN system. In accordance with the *Child Protection Act 1999 (Qld),* section 159L, SCAN team core members have a legislative responsibility to:

- contribute to the operation of the SCAN system through their appropriate knowledge and experience in child protection,
- use their best endeavours to agree on recommendations to give to the chief executive, Department of Children, Youth Justice and Multicultural Affairs about assessing and responding to the protection needs of children,
- share information about the children, their families and other relevant persons,
- identify relevant resources of members or other entities,
- act as required under the recommendations, monitor the implementation of recommendations and review their effectiveness, and
- invite and facilitate contributions from other prescribed entities or service providers with knowledge, experience or resources that would help achieve the purpose of the SCAN system.

SCAN Core Representatives:

- The Department of Children, Youth Justice and Multicultural Affairs is the lead agency for the SCAN system and whole of government response to child protection in Queensland.
- Core member agencies of the SCAN system are currently: the Queensland Police Service (QPS); Queensland Health, along with Hospital and Health Services; and the Department of Education (DoE).

To identify who your local Scan Core Representative is, follow this link: Queensland Health SCAN Core Representatives

Appendix 1: Child Protection Specialist Activities

The following information provides an overview of the type of activities performed by Queensland Health HHS Child Protection Specialists (Child Protection Advisors and Child Protection Liaison Officers) and what should be documented in the patient record.

Activity	Explanation
Clinical consultations	HHS staff contact local CPLO/CPA for clinical advice in relation to child protection concerns/ presentations.
Case Progress/ Updates	Case information and referrals from Child Safety and other service providers (e.g. NGOs/ government agencies/ HHSs) should be recorded in the patient's health record.
Child Protection Unit meetings/ activities	Multidisciplinary Team (MDT) meetings, case discussion, child protection plans regarding a specific child/parent should be recorded in the patient's health record.
Child Protection Alerts	The application of a child protection alert to an electronic health record can provide additional information when formulating information regarding child protection matters.
Child Under Order	If the HHS is provided a copy of a current Child Protection Order (CPO) for a child, this is to be stored in the LEGAL section of the patient's health record
Information Requests and Responses	Recording when a CPLO/CPA has accessed and shared information from the patient's health record under the provisions of: • *sections 159MA-159MD of the Child Protection Act 1999 (Qld) (CP Act)* • *section 159N of the CP Act* • *section 159O of the CP Act* • *section 148 Hospital and Health Boards Act 2011.* See also *Information sharing in child protection: clinical practice guide* on QHEPS for specific guidance.
UCHRA	An Unborn Child High Risk Alert (UCHRA) is generated by the Department of Child Safety in response to child protection concerns raised prior to the birth of a child and should be documented in the alert section of the patient's health record. Please refer to *Qld Health Responding to an Unborn Child High Risk Alert guideline* for specific guidance

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