

Policy Statement

Southern Health Staff will work together to appropriately identify risks and maximise the safety of families with vulnerable unborn babies, children and young people in collaboration with child protection partner agencies Department of Human Services and Child First.

Purpose and Rationale

The Vulnerable Babies, Children and Young People at Risk of Harm – Best Practice Framework for Acute Health Services (DHS 2006) is part of a broad, multi-pronged approach by the Department of Human Services.

This Best Practice Framework is a Victorian Government Initiative intended to enable acute health services to;

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

The framework is relevant to all those who deliver and are responsible for the provision of acute health care.

The Framework has some general principles. These include:

- **Child protection is everyone's business.** All services that work with families will share responsibility for and contribute to the well being and safety of babies, children and young people
- The best interest of babies, children and young people will be at the heart of all decision making and service delivery across the service system [insert hyperlink]
<http://www.vfpms.org.au/childrenatrisk/vuln.htm>
- Health and other services will act together to form an integrated, cohesive and coordinated system so that babies, children , young people and their families receive the best combination of services to meet their needs
- Health services will deliver services that are appropriate and sensitive to the culture, disability, gender, language, religion and sexuality of the baby, child or young person, their family and caregivers.

(The Vulnerable Babies, Children and Young People at risk of harm – Best practice framework for acute health services 2006 Vic DHS)

Scope

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

Definitions

Baby/Child/Young Person: A person aged 0-16 years or, if subject to a protection order 0-17.

Unborn Baby: The developing young in utero at any gestation once the pregnancy is confirmed.

Vulnerable Child: A child for whom there is significant concern about their wellbeing (who may also be in need of protection)

A Child in Need of Protection: A child who has suffered or is likely to suffer, significant harm as a result of sexual, physical or emotional abuse, neglect or abandonment, and the child's parents have not protected or are unlikely to protect the child from that harm. The significant harm may be the result of one incident or the cumulative result of many incidents or a general pattern of behaviour or circumstances. (*S162 Children Youth and Families Act 2005*)

Harm: The effect on a child from abusive acts by adults and may include acts of omission.

Abuse, neglect: Generic terms to describe an act or omission that endangers or impairs a child's physical or emotional health and development. It is the misuse of power by adults over children, and although abuse is not an accident, neither is it always the intention of the person to inflict harm or injury.

Child protection: a term to describe the whole community's approach to prevention of harm to children. It includes strategic action for early intervention, for protecting those considered most vulnerable and for responses to all forms of abuse.

Mandatory reporting: A report made under s.184 of the Children Youth and families Act 2005 to Child Protection by a mandated professional (police, doctor, nurse, teacher and others) that a child is in need of protection from sexual abuse or physical injury.

Protective Intervener: The Secretary (delegated to Child Protection Practitioners and Officers) and all members of the police force

Child Protection Services: The Child Protection Service of the Victorian Department of Human Services. This service has statutory responsibilities under the *Children, Youth and Families Act 2005* for ensuring a child's safety and wellbeing. Also referred to as Child Protection or DHS.

Case conference: a multidisciplinary meeting or Case Conference to discuss care and discharge plans with internal and external service providers as required

Child FIRST: Child and Family Information, Referral and Support Team. Operating on a sub-regional basis and provides entry (intake) to secondary child and family services in a local area. Health services and others can refer to Child FIRST if they have significant concerns about a child's wellbeing. As holders of information, Child FIRST can work collaboratively with Child Protection and Health Services to meet the needs of children. **Community based child and family Service:** A service which provides advice, assistance and support to vulnerable children and their families. This may include in-home family support, counselling, and parenting support and assist families to identify personal and social stresses that can lead to family breakdown and/or child abuse. These services are registered by the Secretary of the Dept of Human Services and are required to comply with service standards.

Cumulative Harm

Cumulative harm refers to the effects of harm over time that may impact on a child's safety and development. The focus is on an accumulation of risk factors rather than a single incident.

Victoria Police: in relation to vulnerable children, Victoria Police deals with criminal matters that arise in child abuse and neglect investigations. They assist Child protection where there are concerns about the safety of workers and family members. Victoria Police investigates and enforces intervention orders.

The Victorian Forensic Paediatric Medical Service [VFPMS]: A Statewide coordinated medical service providing assessments and care for abused, assaulted and neglected children and young people. The Victorian Forensic Paediatric Medical Service provides these services in business hours in the Angela Taylor Child Protection Unit, Monash Medical Centre; and The Gatehouse Centre, Royal Children's Hospital. The Victorian Forensic Paediatric Medical Service welcomes enquiries regarding possible child abuse and neglect. The Victorian Forensic Paediatric Medical Service provide 24 hour access to expert medical opinion. Early consultation is encouraged because this may minimize complications and reduce angst.

The South Eastern Centre Against Sexual Assault [SECASA]: This service provides crisis care and counselling services across the southern region for babies, children & young persons who have been sexually abused / assaulted. [South Eastern Centre Against Sexual Assault also provide crisis care & counselling services to adult victims of sexual assault]

All cases of suspected sexual abuse of children and adolescents are to be referred to the South Eastern Centre Against Sexual Assault duty worker [24 hour service]. Forensic medical services are provided by Victorian Forensic Paediatric Medical Service.

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1. What is child abuse?

Child abuse" occurs when an adult responsible for the care of a child either harms the child or fails to protect that child from harm. Child abuse may be categorised into four main areas:

- a. Physical abuse including striking, shaking or burning
- b. Sexual abuse including genital touching, oral-genital contact and sexual intercourse
- c. Emotional abuse including behaviour towards the child which impairs their emotional development
- d. Neglect including failure to provide adequate shelter, clothing, nourishment and medical care.

A baby, child or young person is at risk of harm when it is considered likely that he or she may suffer physical, psychological or emotional harm as a result of what is done (physical, sexual or emotional abuse) or not done (neglect) by another person, often an adult responsible for a child's care. Young people may also be at risk of physical, psychological, sexual or emotional harm as a result of environmental factors (e.g. homelessness) or self harming behaviours.

Children from all cultural and socioeconomic backgrounds may be abused or neglected.

Abuse may occur as a result of a single incident or may occur over time. The type of abuse and neglect that occurs over time is often referred to as *cumulative harm*.

E Learning Tool <http://www.vfpms.org.au/childrenatrisk/vuln.htm>

Physical Abuse

Physical abuse refers to harm from an injury inflicted by a parent or caregiver.

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

Physical injury and significant harm to a baby, child or young person may also result from neglect by a parent or caregiver or from failure to adequately ensure the safety of a child.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer feigns the symptoms, of, or deliberately causes ill health to a child whom they are looking after. This situation is commonly described using terms such as, fabricated illness by proxy or Munchausen's Syndrome by proxy.

Sexual Abuse

Sexual abuse involves a person using power or authority over a baby, child or young person to involve them in sexual activities, whether or not the child is consenting or aware of what is happening. The activities may involve physical contact, including penetrative (i.e. vaginal, oral or anal rape or buggery) and non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of pornographic materials, watching sexual activities or encouraging children to behave in sexually inappropriate ways.

Adults, adolescents or older children who sexually assault younger children or young people exploit their immaturity and dependency. The apparent consent of a child or young person does not mean that the abuse did not occur.

It must be remembered that child sexual abuse is an extremely emotive and sensitive subject for all concerned. Boys and girls of all ages may be sexually abused and are frequently scared to say anything due to guilt and/or fear. Recognition can be difficult, as there may be no physical signs and indications are likely to be emotional/behavioural. A child or young person who is exhibiting sexually problematic or abusive behaviour should be considered at risk of harm.

Under section 185 of the Children, Youth and Families Act 2005 there is a provision for a report to be made to Child Protection based on a belief that a child aged 10-14 years is in need of therapeutic treatment as a result of exhibiting sexually abusive behaviours.

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

Emotional Harm

Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent effects on the child's emotional development, and may involve:

- ◆ Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person
- ◆ Developmentally inappropriate expectations being imposed on children
- ◆ Causing children to feel frightened or in danger
- ◆ Exploitation or corruption of children.

Some level of emotional abuse is involved in all types of ill treatment of children, though emotional abuse

may occur alone.

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

Neglect

Neglect involves the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health and development. This may involve failure to provide adequate food, shelter or clothing, failure to protect from physical harm or danger or failure to ensure access to appropriate medical care or treatment. It may also include neglect of a child's basic emotional needs.

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

Medical Neglect

Medical neglect may arise where the parent or carer is unable or unwilling to provide the medical care required to maintain the child's well-being, health and development. These children may often require complex medical care to maintain their health or palliative care during terminal illness. Situations may also arise where a parent's refusal to allow medical intervention could impact on a child's long term wellbeing.

Cumulative Harm

see Definitions

Risk Factors:

There is no one single factor which causes child abuse; abuse usually occurs in families where there is a combination of risk factors. Abuse and neglect occur most often in families who are under pressure and lack support. Most abuse other than sexual abuse occurs in families to which some, or all, of the following apply. It is important to consider the impact one or a cluster of these risk factors might play in the degree of risk a child is placed in when assessing the professionals' role in investigating the situation.

<http://www.aifs.gov.au/nch/pubs/issues/issues30/issues30.html>

Jordan and Sketchley A stitch in time saves nine:

Preventing and responding to the abuse and neglect of infants (2009) Child Abuse Prevention Issues No. 30,

- Parental Substance Misuse
- Maternal and/or paternal mental illness
- Parents with intellectual disabilities
- Adolescent mothers
- Parents of infants with poor health (special needs)
- Family violence

Table 1: Examples of risk and protective factors

Risk factors and Protective factors

Childhood factors

- birth injury/disability/low birth weight • social skills
- insecure attachment • attachment to family
- poor social skills • school achievement

Family factors

- poor parental supervision and discipline • supportive caring parents
- parental substance abuse • parental employment
- family conflict and domestic violence • access to support networks
- social isolation/lack of support networks

School factors

- school failure • positive school climate
- negative peer group influences • sense of belonging/bonding
- bullying • opportunities for some success at school
- poor attachment to school and recognition of achievement

Community factors

- neighbourhood violence and crime • access to support services
- lack of support services • community networking
- social or cultural discrimination • participation in community groups

REF: http://www.community.nsw.gov.au/docswr/assets/main/documents/researchnotes_resilience.pdf

Family Violence

Children living in situation where there is family violence are likely to suffer harm both emotionally and physically. A baby, child or young person may be harmed indirectly or directly by physical violence when they are attempting to protect another person or they are caught up in an incident of violence. The child may also experience emotional and psychological harm by living in a climate of fear and intimidation in a home where family violence occurs. Family violence has harmful effects on children’s physical, cognitive, emotional, behavioural and social development.

There are some community or society attitudes that may encourage child abuse. These include:

- Acceptance of the use of violence and force
- Acceptance of physical punishment of children
- Acceptance of parents "ownership" of children and their right to treat children as they see fit
- Racism
- Inequality between men and women

Research indicates a close link between family violence and child abuse. Family violence is also a factor in more than half of the reported cases to Child Protection.

Ref: http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/what-is-child-abuse?SQ_DESIGN_NAME=print

2. Responding to Vulnerable Children and Children at Risk

Please refer to Southern Health’s Management of Vulnerable Babies Children and Young People Procedure

Worried about a Child?

Consider the possibility that harm to a baby or child may be non-accidental.

Some important questions to ask yourself are:

- Is the child at immediate risk of harm?
- Has the child been physically or sexually assaulted?
- Does the mother appear to have an emotional attachment to the baby?
- Does the parent have the capacity to meet the child's needs?
- Are the child's basic needs being met?
- Is the parent's lifestyle or behaviour impacting negatively or likely to impact on the care of the child? (e.g. mental health, drug and alcohol issues, transience)
- Does the family have somewhere to live?
- Are the family isolated from friends, family or community?
- Is the young person engaging in risk taking behaviours? (e.g. self harm, substance abuse, transience?)
- Is the young person behaving in an aggressive or violent way towards others?

There may be signs in a child's behaviour or physical presentation which assist in recognising child abuse. These are known as indicators. A single indicator can be as important an indicator as the presence of several indicators and a build up of indicators over time may represent cumulative harm. A child's behaviour is likely to be affected if he/she is under stress. There could be many reasons why a child is under stress, including child abuse, and it is important to find out specifically what is causing the stress, within the context of the child's current situation and circumstances.

"Behavioural or physical signs which assist in recognising child abuse are known as indicators. A single indicator can be as important an indicator as the presence of several indicators. A child's behaviour is likely to be affected if he/she is under stress. There can be many causes of stress, including child abuse, and it is important to find out specifically what is causing the stress." http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/what-is-child-abuse?SQ_DESIGN_NAME=print

Another useful resource is

<http://docs.health.vic.gov.au/docs/doc/Vulnerable-babies--children-and-young-people-at-risk-of-harm---An-intervention-guide>

3. RESPONDING TO VULNERABLE BABIES AT RISK

Please refer to Southern Health's Management of Unborn Babies Management Procedure

Worried about an Unborn Child and the potential of harm to this child following birth?

Victorian Government Legislation supports early intervention and prevention to improve outcomes for vulnerable children and their families including expectant mothers of an unborn child. Sections 29 and 32 of the Children, Youth and Family Act promote reports to both Child Protection and Child First where there is "a significant concern for the wellbeing of a child after his or her birth".

Some important questions to ask yourself?

- Has another child within this family previously suffered significant abuse or neglect whilst in the care of either parent

- Has a sibling been previously removed by court order from either parent
- Has a parent or other adult in the household been convicted of a sexual offence or any other offence against a child
- Is parental substance abuse likely to significantly impact on the child's safety and development after birth
- Is parental mental health or impairment likely to significantly impact on the child's safety and development after birth
- Is family violence likely to significantly impact on the child's safety and development after birth
- Are there significant concerns about a parent's capability to care for the child following birth for example a parent with a significant intellectual disability
- Is the mother of the child herself the subject of a Protective Intervention Report
- Is the mother of the child less than 17 years of age and without significant supports
- Is Child protection already involved?

Some things to keep in mind

Timely Reporting

- The Children Young Persons and Family Act (2005) states that a report about an unborn child can be received at any stage of a woman's pregnancy and as a general rule should be made as early as possible after the confirmation of the pregnancy to allow for "well informed assessment" and appropriate planning http://www.austlii.edu.au/au/legis/vic/consol_act/cyafa2005252/ Sect 29
- In practice Southern Health recognises that until the pregnancy is viable at 20 weeks gestation the role for Department of Human Services is limited and recommends reporting to Child Protection by a concerned practitioner at 24 weeks gestation or as soon as possible further on in the pregnancy.

Case Conference

- A case conference must take place for each child where significant need and risk issues are identified

Voluntary status of working with parents of unborn babies

- Although the Legislation provides for reports on unborn babies to be made and for child protection to gather and share information in regards to risks, Child Protection's investigative and **statutory** powers do not apply until after the child's birth. Therefore the mother's verbal consent **is** required to work with Child Protection and Child First in order to put in place various services of support. Her consent is also required for a case conference where she is present. Please note where there are significant concerns for the safety and wellbeing of a child following birth Child Protection can convene a case conference with health professionals only without the consent of the parents

Confidentiality for Reporters

- As with other reports the identity of the reporter is confidential under s.191 of the Children Youth and families Act 2005

4. Information Sharing

Information Sharing Guide

The “*Children, Youth and Families Act 2005*” provides information sharing arrangements between professionals and those services that support families and protect children.

This legislation should be used in conjunction with other privacy and confidentiality laws such as the *Information privacy Act 2000* and *Health Records Act 2001*.

As a health professional in Victoria, you have a key role to play in ensuring that vulnerable children are protected and supported. This may involve sharing information about a child where authorised to do so by law.

The table below is intended to inform you under what circumstance you **must** and those where you **may** share information about a child.

Should you choose to share information in situations where you **may** do so, you are protected by legislation from legal or professional consequences, such as libel action, providing the information you share is done so in good faith and in the best interests of the child.

It is best practice to obtain parental consent (or consent of a young person) to share information with other services. However, on some occasions this is not possible or not in the best interests of the child (i.e. when this may place the child at further risk).

As a general principle, shared information should be relevant to the current situation/investigation or intervention and should not include information about third parties, hearsay or personal opinion.

If you are unsure about your responsibilities relating to sharing information, privacy and confidentiality, please contact the Southern Health Legal Office at Monash Medical Centre, Clayton.

See Table on next page

ACTION	Is this Required By Law? (Where not required by law, it may be good practice to do so voluntarily)	Is this Authorised by the Children Youth and Family Act 2005?	Is my Identity protected by the Children Youth and Family Act 2005?	Am I protected from negative legal and professional consequences by the Children Youth and Family Act 2005?
Making a referral to Child FIRST	NO	YES	YES	YES
Making a report to Child Protection	NO	YES	YES	YES
Making a mandatory report to Child Protection	YES	YES	YES	YES
Sharing information when you are consulted by Child FIRST or Child protection	NO	YES	NO but it will be held in confidence on request	YES
Sharing information with	NO	NO	NO	NO

family services when they are providing services to a family				
Sharing information with Child Protection during an investigation	NO	YES	YES	NO but it will be held in confidence on request
Sharing information with Child Protection to support ongoing case planning after an investigation	NO	YES	NO but it will be held in confidence on request	YES
Sharing information with Child Protection on request when a child is subject to a Children’s Court Protection Order	NO	YES	NO but it will be held in confidence on request	YES
Sharing information with Child Protection when a child is subject to a Children’s Court Protection Order and when you are directed by an officer authorised by the Secretary of the Department of Human Services	YES	YES	NO but it will be held in confidence on request	YES

5. Case Conferencing

It is good practice in all cases involving vulnerable children to hold a multidisciplinary meeting or Case Conference to discuss care and discharge plans. When a report to Child Protection is made there must be a Child at Risk Case Conference prior to discharge of the patient.

The aim of a Case Conference is to enable those professionals most involved with the child and family, and the family themselves, to hear all the relevant information and to plan how best to ensure the child is safe and that his or her needs are met.

A case conference should occur at the earliest opportunity. Refer to family meeting procedure for more information (LINK) In cases of suspected physical and sexual abuse, this should be within 24 hours of admittance. At this stage, the case conference should enable

- Early engagement of the family in the investigation process
- Sharing of information between agencies to aid both investigation and planning
- Planning for the child’s care and treatment both in hospital and on discharge which may include further assessment
- Planning for further action by Police, Child Protection or other agency, if appropriate

It may be appropriate to hold a review case conference prior to the child's discharge in order to update the family and other professionals on the plans and outcomes for the child.

It is extremely important that the plans and outcomes of case conferences are documented in the Medical record.

Case conferences for vulnerable children are a good way to bring everyone together to discuss how best to support the family and ensure all the child's needs are met. This may include support agencies if appropriate and should always include the family and, if appropriate, the young person.

Case conferences bring together a multidisciplinary and multi agency group such as:

- Parents
- Young Person
- Social Work
- Relevant medical staff (e.g. emergency medicine consultant/VFPMS)
- Nursing /Midwifery
- Community Maternal Child Health Nurse
- Community health services and/or hospital in the home services
- General Practitioner
- Community service agency (e.g. drug & alcohol service, disability service)
- Child First or
- Child Protection

Social Work often undertake to convene and chair case conferences however, anyone can convene and chair the case conference as long as they are able to

- Encourage participation of all meeting members
- Facilitate family participation
- Facilitate the planning process
- Arrange for the meeting outcomes to be clearly documented on the medical record and made available for meeting members

For Child at Risk Case Conferences, Child Protection may convene and chair the conference and invite other agencies and professionals to participate. If a Child at Risk Case Conference is arranged for a child who is not admitted to hospital, Child Protection may request attendance by health professionals who have been or will be involved with the child.

6. Documentation

Meticulous documentation is of critical importance where there is suspected or actual harm. The need for a report to Child Protection may not be clear initially but may become apparent following accumulation

of evidence and accurate information will be critical in this decision making. Also legal proceedings may occur now or in the future and medical notes may be required for court.

All Southern Health professionals are required to diligently document their findings, communications and opinions in the child's unit record.

Some relevant extracts from the [Southern Health Medical Record Documentation And Data Capture Standards](#) are included here for guidance.

Purpose of a Medical Record

The main purpose of the Southern Health medical record is to accurately and adequately document a Patient/consumer's life and health history, including past and present illness(es) and treatment(s), with emphasis on the events affecting the Patient/consumer during the current episode of care. (SH Documentation Standards – revised 2008)

For vulnerable children accurate and adequate documentation is vital to ensuring quality and effective response and planning for the multidisciplinary team involved. All concerns, assessments and outcomes should be recorded to provide a holistic picture of the patient's episode of care and life circumstances.

Clinical staff and Consultants are responsible for the overall quality of the documentation in the medical record.

- *Reviewing the content of the medical record to ascertain that the documented clinical information is pertinent for the purpose of providing and evaluating Patient/consumer care. Ensuring the information is timely and complete, is adequate for use in quality assessment activities and for retrieval of data for information management, research, and medicolegal purposes.*

The implementation of the "Vulnerable Babies, children and young People at Risk of Harm: A Best Practice Framework for Acute Health Settings" will be evaluated on an annual basis and quality improvement activity may arise from that evaluation.

Accurate and Objective

*Documentation **must** be accurate and objective; that is, it **must** be a true account of what was assessed, observed and undertaken. Documentation **must** reflect what occurred, or be based on information that can be clearly measured for example, the results of a blood test. The clinician **should** record facts, actual events and **should** not include subjective statements about the Patient/consumer. It is important that the clinician distinguishes facts from impressions of the Patient/consumer.*

*It is also important to remember that care and objectivity **should** always be used in making clinical entries, as the entries **may** be viewed by the Patient/consumer under the Freedom of Information Act 1982. Any disparaging and unsubstantiated comments could become a matter of litigation.*

7. Working with Department of Human Services Child Protection

Child Protection and Reports

Any person is able to make a report to Child Protection if they believe that a child is need of protection. However, the Children, Youth and Families Act 2005 requires that certain professionals are legally obliged to make a Report to Child Protection in certain circumstances. These are "**mandated professionals**"

The mandated professionals are

Nurses, doctors, school principals, teachers and the police.

The circumstances are that when in the course of their professional duty

“the professional forms the belief on reasonable grounds that a child is in need of protection because the child has suffered, or is likely to suffer, significant harm.”

These grounds include:

- 1) *physical injury and the child’s parents have not protected or are unlikely to protect, the child from harm of that type*
Or the child has suffered, or is likely to suffer, significant harm as a result of
- 2) *sexual abuse and the child’s parents have not or are unlikely to protect, the child from harm of that type.*

Reasonable Grounds may include if a child has told someone they have been abused or if a carer or parent tells you the child has been abused. However, it is also reasonable grounds if your observations of the child’s behaviour, development or physical presentation lead you to believe that they have been abused (see “*Signs and Symptoms of Abuse*” table in Section 4)

When doubt exists about interpretation of a physical sign in relation to injury causation, a forensic opinion should be sought from Victorian Forensic Paediatric Medical Service.

Your Report should be made promptly and each time you become aware of further grounds for your belief. It is your responsibility to report your belief; it is not the responsibility of your supervisor, principal, senior or manager.

Mandatory reporting requirements take precedence over professional codes of practice where confidentiality or client privilege is claimed and you do not require the consent or permission from parents or caregivers to make a report nor do they need to be told that a report has been made.

Remember – If you make a report in good faith, you cannot be held legally liable, regardless of the outcome of the report.

Consultation with line management and/or with social work should occur prior to making a report to Child Protection. This should occur for a number of reasons

- So you feel supported in your decision and judgement
- So Social Work can assist and offer support
- So your manager is aware of the situation
- So the organisation is aware of this situation

NB. It is not the job of the professional making the report to investigate or prove the abuse has occurred. This is the role of the Child Protection Worker.

How do I make a Report?

To make a report to Child Protection, contact your regional [Child Protection Office](#) as soon as possible. There is an [After Hours Service](#) available outside normal business hours including evening and weekends. This service is a crisis service only so if the matter is not responded to immediately, it will be referred to the region in which the child resides for follow up during business hours.

What information will be required?

It can sometimes take some time to make a report so depending on the urgency, make sure you gather all the relevant information prior to making the report and allow time to discuss the information. Even if you do not have all the information a report should still be made.

The information required can be recorded on the **proforma** and will usually include the following

Baby, Child or Young Person

- Name, age, gender, cultural background and address
- Who is the carer for the child/with whom does the child live?
- The child's present location
- Is the baby, child or young person safe now?

Alleged Abuse

- Description of the injuries and behaviours observed
- Presence of risk indicators of harm
- What are the safety and risk of harm concerns?

What has the health service done so far and what is planned

The family

- Composition, name, age of siblings, parents and carers
- Parent's marital status
- Other adults in the home
- Extended family
- Patterns of interaction
- History of violence or abuse
- Other agency involvement
- Likely reaction to Child Protection

The reporter

- Hospital, name, position
- What are your reasonable grounds/what is it that leads you to believe the child has been or is likely to be harmed?
- Relationship to child
- Is family/child aware of report?

What will happen now?

The period when a report is first received by child Protection is called the *intake phase*. The intake worker will look to see if Child Protection has had contact with any members of the family before. If the child is currently involved with Child Protection, the worker for the child will be notified. If the child is not a current client, a new intake will be created. This will either be in a new file or in an existing but closed file if the child has had Child protection involvement previously.

Child Protection intake workers may make contact with any other services or professionals involved with the child or family to ascertain if there are any further concerns or to see if they have relevant information about the child and family. They may also call a case conference to assist in determining what further

action is necessary.

Child Protection will complete an initial assessment of the risk for the child and make a decision regarding what further action is required. They may decide to

- Refer the case to ChildFIRST for support for the child or family
- Take no further action
- Investigate further

Further investigation

Investigations are classified as urgent and requiring a visit within 48 hours or non-urgent and needing a visit within 14 days.

An investigation will occur if

- The child's circumstances fall within the legal definition of a child in need of protection and
- The protective concerns cannot be adequately addressed without child protection involvement

The *response team* undertake the investigation and any required referrals or intervention. The Child Protection service will inform the professional about this decision as soon as possible.

Direct contact is made with the child and family to assess the child's safety, the validity of the allegations and the child's needs and make a decision about the most appropriate course of action. This will be determined by whether abuse or neglect has or is likely to occur, whether the child's parent or caregiver is able or willing to protect the child and whether there is a need for ongoing Child Protection involvement.

On completion of the Investigation, a decision will be made as to the outcome of the investigation. The case will be closed at this point if abuse or neglect has not occurred or if it has and the child is now safe from recurrence.

If it has been determined that abuse or neglect has occurred, a *Best Interests Planning Meeting* will be called. The purpose of this meeting is to allow the family and professionals to collaborate to make a plan to ensure the child's safety and to ensure the child's best interests are met. The Child Protection worker may invite you to this meeting if you remain involved with the child or family in a professional capacity (for example, if the child is still an inpatient).

The work now undertaken in relation to the plan made at the meeting is called *Protective Intervention*. Sometimes, the case may be managed by ChildFIRST or another community support service or by the family themselves. However, sometimes it is necessary to seek court intervention because the plan isn't working or because something else has happened which puts the child at risk.

Court intervention can occur at any point during Child Protection involvement. This may or may not involve taking a child into safe custody (removing the child from the unsafe environment or parent/carer). If a child is taken into safe custody, the parents will be issued with a Protection Application and the matter is brought before the court within 24 hours.

Feedback following a report

It is good practice for child Protection to provide feedback to professionals who make Child Protection Reports. This enables health care staff to continue working with families with an awareness of their current status of Child Protection involvement. During the investigation, exchange of information and feedback will occur through telephone calls and meetings. The hospital should nominate a contact person to keep all hospital parties informed of the progress or status of the report. This may be the social worker.

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

For further information and guidance:

[How to make a referral or report: Child Protection and Family Services](#)

8. Working with Child First

Child FIRST – Child and Family Information and Referral Support Teams

The Children youth and families Act 2005 provides the legislative basis for the provision of services to vulnerable children, young people and their families. The new legislation places children at the heart of all decision making and service delivery. A range of enhanced service arrangements are being implemented to reflect the intent of the legislation; in particular earlier intervention with vulnerable children and families.

Child Protection will continue to have a clear role and statutory responsibility for children in need of protection. They will work closely with family services to support assessment and engagement of vulnerable children and families in community based services.

ChildFIRST provides a central intake and referral service, on a sub regional basis, for families and professionals wishing to access community based services (see appendix 1 for contact details and regions). Experienced family services practitioners assess the needs of families based on the referrals received and will either

- Provide information to the family or professional
- Refer to an appropriate service
- Provide support to the child and family until a referral is actioned

Facilitate report to Child Protection where appropriate (i.e. the child becomes in need of protection)

Making a referral to ChildFIRST requires some information to be gathered about the child and their family and the support that is likely to be required. You may find the following proforma helpful:

[Referral to Family Services](#)

9. Useful links and bibliography

Vulnerable Babies, Children and Young People at Risk of Harm. Best practice Framework for Acute Health Services – DHS 2006

<http://www.health.vic.gov.au/childrenatrisk/index.htm>

Vulnerable Babies, Children and Young People at Risk. An Intervention Guide – DHS 2006

<http://www.health.vic.gov.au/childrenatrisk/intervention.pdf>

Children Youth and Families Act 2005 Part 1.2 principles

http://www.austlii.edu.au/cgi-bin/download.cgi/au/legis/vic/consol_act/cyafa2005252.txt

[http://docs.health.vic.gov.au/docs/doc/F0E5243F21C16FC5CA2579820009FC28/\\$FILE/intervention.pdf](http://docs.health.vic.gov.au/docs/doc/F0E5243F21C16FC5CA2579820009FC28/$FILE/intervention.pdf)

Useful Website Links

www.vfpms.org.au/pages/index.php

www.office-for-children.vic.gov.au/every-child-every-chance/home

www.secasa.com.au

10. Service Contact Information

Vulnerable Children E-Learning Tool

This resource located on the Victorian Paediatric Medical Service website will provide you with information about identifying and responding to cases where you may suspect that child abuse or neglect has occurred. It comprises of a set of modules with hypothetical case studies to assist you to better identify vulnerable children, respond to situations where abuse or neglect are suspected, and to understand the child protection service system.

Please Note it is **mandatory** for Southern Health Women’s and Children’s program clinical staff to complete this E-Learning Tool.

Vulnerable Children – e-learning tool link <http://www.vfpms.org.au/favicon.ico>

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