

Child Abuse, Neglect, Care & Protection

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Applicable for which staff members?	All Auckland DHB staff, contractors and students, including all inpatient and all outpatient services
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1. Purpose of policy

To ensure that any services provided or actions taken regarding suspected or potential child abuse and neglect are guided by the following kaupapa/principles within Auckland District Health Board (Auckland DHB).

2. Policy kaupapa and general principles

Any services provided or actions taken in respect of child abuse and neglect, or suspected or potential child abuse and neglect situations, must be guided by the following kaupapa/principles.

“The welfare and interests of the child or young person shall be the first and paramount consideration” (CYP&F Act 1989).

The primary role of the whānau in providing for the care, welfare and safety of children and young people must be valued, maintained, strengthened and supported by health services. Valuing the development and maintenance of relationships with whānau, while working in partnership to determine their needs must be a core competency for all health practitioners when there are concerns about child protection.

Responding to the needs of whānau must be central to all decision making and planning in an effort to reduce child protection risks. This practice requires a dual focus on proactively responding to child protection concerns while also supporting whānau and families' engagement with and confidence in health services

The Code of Rights must be carefully adhered to in all child protection processes and practice. In particular a high standard of practice is required in relation to informed consent.

Tamariki/children and rangatahi/young persons are our taonga/treasures. They have a right to full emotional, spiritual and physical well-being, as well as being able to develop their own potential in an environment which is nurturing and protective and in which they are safe from abuse.

The protection and nurturing of children and young people is the responsibility of adults. Children are not responsible for abuse inflicted on them by others. Health services must contribute to the nurturing and protection of children and young people and advocate for them as part of their role to promote, protect and preserve public health. Health professionals must be well trained in child and partner abuse procedures. Health services must be responsive and pro-active to take any measures which may prevent abuse or minimise risk. Health services must be built on a bicultural partnership in accordance with the Treaty of Waitangi.

All children and their whānau have the right to quality health services which includes our ability to respond appropriately to care and protection concerns. These services must be

easily accessible, culturally safe and appropriate, with regard for varying backgrounds and cultural needs. It is particularly important for abused children and young people that services are provided in environments which are comfortable and appropriate to their needs. Safeguarding children requires effective information sharing, collaboration and understanding between agencies and professionals.

Auckland DHB recognises that child abuse is a form of family violence, and often co-exists with intimate partner violence. Child abuse and intimate partner violence therefore need to be addressed in a co-ordinated fashion. Effective child protection assessment and intervention requires active liaison between disciplines and with whānau, statutory agencies and the community. Health services must work collaboratively and in partnership with relevant services and groups from all the cultures and communities where children live.

Auckland DHB staff members should not work alone but confer with appropriate colleagues. Child protection work is recognised as complex and stressful. A consultative process is essential to ensure the safety of the child or young person and ensure adequate support for workers.

When forums are mandated to make interdisciplinary decisions regarding Reports of Concern to Child Youth and Family, their decision making process regarding the appropriate timeline for referral must be respected, except where doing so would unduly compromise the safety of any individual.

Staff members involved in child protection or care of abused or neglected children must be provided with adequate training and professional support.

3. Principles in relation to pregnant women

This policy also applies to assessment and management of risk to pregnant women and their growing baby. This must take account of the antenatal care provided to the mother who is wholly responsible for clinical consent during the antenatal period, even where this impacts upon the safety and wellbeing of the pregnancy.

Responding to the needs of pregnant women, which includes responding to risk and the planning of care, must be undertaken in close consultation with maternity services that are responsible for working with pregnant women and their whānau.

A close partnership with the Lead Maternity Carer is a critical element of this practice, and all efforts must be made to maintain this relationship, whilst also responding to identified concerns. Referrals can be made to Wahine Ora (the Vulnerable Pregnant Women's Group) where on-going support with decision making and planning of care can be provided. All health practitioners working with pregnant women must be familiar with the Wahine Ora clinical pathway and are encouraged to engage the support of this forum in situations where there is a conflict between the interests of the mother and a substantive

risk of harm to the baby during the pregnancy, or an anticipated risk in the early months of life.

When working with pregnant women, maternal autonomy and its impact on the appropriate care of the woman when child protection concerns are identified must be acknowledged and respected.

Reports of Concern can be made to CYF during the antenatal period, and in some circumstances court orders may be obtained, however these are ordinarily enforceable only after the baby's birth.

4. Definitions

For the purposes of this document the term “child abuse and neglect” incorporates both tamariki/child and rangatahi/young person.

Terms and definitions used within this document:

Child abuse (CAN)	This is the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect or deprivation of any child or young person (CYP&F Act).
Child	This is a boy or girl under the age of 14 years. This includes an unborn child, subjected to the principles with regard to pregnant women expressed above.
Young person	This is a boy or girl over the age of 14 years but under the age of 17 years.
Child or young person in need of care or protection	This is a child or young person who is being, or is likely to be, abused in any of the ways described in the definition above (CYP&F Act s14).
Intimate Partner Violence (IPV)	Physical or sexual violence, psychological/emotional abuse, or threat of physical or sexual violence that occurs between intimate partners. Intimate partners include: current spouses (including de facto spouses), current non-marital partners (including dating partners, heterosexual or same-sex), former marital partners and former non-marital partners.
CYF	Child, Youth and Family
Shine	SHINE (Safer Homes in New Zealand Everyday) is a national domestic abuse charity that provides a range of services to help keep people safe from domestic abuse and family violence, including a domestic abuse helpline (http://www.2shine.org.nz)
Te Puaruruhau (“sheltering the bud”)	Te Puaruruhau is Auckland DHB’s specialist multi-disciplinary child protection team. It provides assessment, intervention and follow-up for children/young people where there are concerns about CAN. For physical abuse and neglect, children and young people are seen up to 16 years. For sexual abuse, they are seen up to the age of 19 years

	(16 years after hours). This service is available 24 hours a day, seven days a week. Te Puaruruhau is situated at 99 Grafton Rd, within Puawaitahi (“blossoming in unity”). This is a multi-agency service between Auckland DHB, Child Youth & Family and the Auckland City Police.
Tu Tangata Tonu	Tu Tangata Tonu is a service for children of parents with a mental illness and it is located at the Kari Centre
Wahine Ora	The Wahine Ora multi-disciplinary team provide pregnant women with identified child welfare and protection concerns support, including safety and the health and wellbeing of both mother and baby.

5. Training

All Auckland DHB employed clinicians and contractors who work with children and whānau must receive training in recognising potential or actual CAN and IPV and in taking appropriate action.

The rationale for this is that many clinicians have had little or no exposure to, or training in, the management of suspected CAN and/or IPV. This is despite good evidence that CAN and IPV are relatively common in New Zealand society and are often missed or handled poorly, resulting in poor outcomes. Many health professionals find this a difficult area to understand or address, and yet the health system can play a key role in early and successful intervention.

Training will promote close working relationships between healthcare staff members, whānau and the community and statutory agencies involved in care and protection. This must involve supporting community training initiatives and contributing personnel and information to joint training with agencies involved in the prevention, recognition and management of child abuse and intimate partner violence in the community.

Because of the relationship between CAN and IPV, training concerning both must be undertaken at the same time.

The services that require training are:

- Adult Health
- Allied Health
- Mental Health and Addictions
- National Women’s Health
- Starship Children’s Health, including Community Child Health and Disability Services and Newborn Services

Training to Auckland DHB staff members must be provided by suitably qualified trainers. Priority should be given to the application of training resources within Auckland DHB.

Core training will include (but is not limited to):

- Bicultural issues in relation to child protection
- CAN awareness, indicators and risks
- Child protection legislation
- Communication with children/young people and whānau/families
- Consultation and referral pathways
- Cultural issues in relation to child protection
- Impact of CAN including neglect of medical care on children and whānau/families
- Impact of IPV on children and whānau/families
- Information about possible action taken after referral and the effectiveness of these actions
- Informed consent
- Maternal autonomy and its implications for child protection practice
- Multi-disciplinary practice
- Safety Planning
- Site-specific referral protocols and procedures
- Specific scenarios relevant to health employees
- Working with the statutory authorities

This training will be offered regularly, as indicated in the Child Protection Training schedule on the Learning and Development intranet site and Family Violence web page. All clinicians must be encouraged to attend on appointment and will be updated regularly thereafter. Specialised training will be provided for those staff members involved in assessment, primary prevention, treatment, therapy and staff training.

6. Best practice guidelines and interagency/interdisciplinary protocols

This policy has been developed to assist staff members to respond to children and young people at risk of CAN. It provides minimum requirements for this response. Services that have regular contact with families must develop more detailed local procedures and recommended best practice guidelines relevant for their service.

Interagency/interdisciplinary protocols

Interagency practice between Auckland DHB, CYF and the Police are guided by the Memorandum of Understanding (August 2011) and associated schedules, including:

1. Children admitted to hospital with suspected or confirmed abuse or neglect
2. Child, Youth and Family/District Health Board Liaison Social Worker.
3. Joint Standard Operating Procedures for Children in Clandestine Laboratories
4. Neglect of Medical Care

Additional schedules are likely to be added over time. The above documents are or will be available from: <https://www.starship.org.nz/for-health-professionals/new-zealand-child-and-youth-clinical-networks/clinical-network-for-child-protection>.

Other key guidelines or points of reference include:

- The Ministry of Health Family Violence Assessment and Intervention Guideline – Child Abuse and Intimate Partner Violence (FVAIG 2016), (available from <http://www.health.govt.nz/publication/family-violence-assessment-and-intervention-guideline-child-abuse-and-intimate-partner-violence>)
- Supporting Parents Healthy Children: A Guideline for Mental Health and Addiction Services (available from <http://www.health.govt.nz/publication/supporting-parents-healthy-children>).
- Sharing personal information of families and vulnerable children: A guide for interdisciplinary groups, and an associated escalation ladder. (Both available from the Office of the Privacy Commissioner at <https://www.privacy.org.nz/privacy-for-agencies/sharing-information-about-vulnerable-children>)
- The Children’s Action Plan for Identifying, Supporting and Protecting Vulnerable Children (further information available at <http://childrensactionplan.govt.nz>).

7. Consultation

7.1 Decision making

Unless the child or young person is in immediate danger, decisions about children/young people or their whānau must not be made by one staff member working alone. Concerns about CAN or IPV should be discussed with the line manager, supervisor, charge nurse, charge midwife or team leader.

Staff members who have been identified as having experience in the management of CAN or IPV should be consulted. Multi-disciplinary consultation is best.

In the Auckland DHB, appropriate sources of consultation include:

- Te Puaruruhau (24 hours, seven days a week). During the working week ring 09 307 2860, or 021 492 365. After hours, through the Auckland DHB operator, ask for the paediatrician on call in Te Puaruruhau
- Women’s and Children’s social work. Consult the social worker attached to the appropriate team, through the intranet directory. After hours: Auckland DHB operator, ask for the social worker on call in National Women’s and Children’s Health
- Wahine Ora, the recommended forum for consultation within National Women’s Health for pregnant women with identified child protection concerns (via your social worker or e-mail wahineora@adhb.govt.nz)
- Family Safety Facilitator within Mental Health Services
- Family Violence call SHINE (24 hours, 7 days a week), 0508DVHELP or 0508 384 357
- The Auckland DHB Child Protection Co-ordinator, who has a key responsibility regarding Auckland DHB child protection systems and processes (021 827 409).
- The Auckland DHB CYF Liaison Practice Leader is available for consultation and assistance, particularly where there are difficulties or other issues in engaging with CYF (09 917 5391, which is forwarded to their cell phone).

Further options include other social workers, senior practitioners, experienced colleagues or professional leaders.

The range of examples given is to ensure that opportunities for consultation can occur 24 hours a day, seven days per week.

Consultation can also occur with CYF or the Police, although (except in an emergency) this would normally be preceded by consultation within the Auckland DHB.

- CYF (24 hours seven days a week). National Contact Centre: phone 0508 Family
- NZ Police (24 hours seven days a week), Auckland Central: 09 302 6400

All consultation must be documented fully in the clinical record.

7.2 Cultural consultation

An appropriate staff member of the same ethnicity as the child/young person should be involved in the decision-making/consultation wherever possible. Where the child/young person is Māori, a Māori health professional should be involved in this consultation wherever possible. Other appropriate staff members for Māori may include Kaiatawhai, Māori social worker, Māori community health worker and Māori Midwifery Advisor. Where the child/young person are of Pacific ethnicity, the appropriate Pacific Health Navigator staff members, Tautai Fakataha Service or Pacific community health workers should be consulted.

Where cultural issues are identified, appropriate cultural support should be sought. As a general rule, cultural support persons should not be used as interpreters. Auckland DHB interpreters should always be used where there appears to be language issues. As a general rule, family members should not be used as interpreters (see Auckland DHB Policy on [Interpreters](#))

7.3 Guidelines for consultation and timing of action

The following factors must be considered in the context of each situation:

- The nature and severity of abuse or risk of abuse
- The child's immediate safety including emotional safety (eg physical safety from an alleged abuser, general health, suicidality)
- Whether abuse has been observed/disclosed, or is suspected
- Potential risk of harm to a pregnant women and her baby, and whether early intervention is appropriate to help meet their needs in order to increase wellbeing and reduce risk
- Health needs of the pregnant woman and her baby
- Disclosure of IPV by an adult (consider the impact this is having on the children)
- Other parental stress factors eg social isolation, mental illness, neglect, drug and alcohol misuse and their negative impact on children

- Whether parents/caregivers are able to be engaged and have the capacity to respond in helpful ways to keep the child safe
- Timing of last incident of abuse
- Previous interventions, patterns and trends
- Level of support from whānau/family or significant others, and the appropriate timing for making contact with them
- Obtaining culturally appropriate input
- The need for statutory intervention

8. Responding to children and young people at risk of abuse

The steps set out in this section are summarised from [the Ministry of Health Family Violence Assessment and Intervention Guideline 2016 \(FVAIG\)](#). This policy should be used in conjunction with that guideline, and readers are referred to the relevant sections of the FVAIG for more comprehensive discussion of the steps set out below.

8.1 Step 1: Identification of signs and symptoms

Unlike IPV, *“routine enquiry about CAN is not recommended. Health care providers do, however, need to be alert for signs and symptoms that require further assessment, or that might be indicative of violence and abuse. Health care providers should also review the child’s medical records, as previous presentations or admissions may indicate risk”* (FVAIG, p31).

This section outlines one approach to identifying signs and symptoms. This is a complex area of clinical practice, and the brief description here must be supported by close consultation with experienced practitioners. Consultation can occur at any point during the assessment and referral process. It is best to consult early.

If it is believed that the child or young person is in immediate danger, call the Police (111) and consider a Code Orange (777) for inpatient areas.

If there is no immediate danger, follow the process outlined in the FVAIG, bearing in mind that *“There is no ‘one-size-fits-all’ approach to the identification of children or young people at risk. If engaged with a family through the provision of health care to the mother, the health-care provider’s first point of concern may be the parent–child interactions that they observe. If engaged through the provision of health care to a child with an injury, their first point of concern may be how that injury was sustained. The health care provider should begin with their first point of concern. However, they should also be aware that, if they are concerned about a child or young person, all the aspects described below may need to be assessed. The younger and more vulnerable the child (such as a pre-verbal infant), the more important this becomes”* (FVAIG, p34).

The following aspects are described in detail in the FVAIG, 2016, p34 – 40:

- 1.1 Observing child – caregiver interactions
- 1.2 Taking a history from parents and caregivers
- 1.3 Asking children about possible abuse and/or neglect: an area of specialist practice
- 1.4 Asking young people about possible abuse
- 1.5 Past history
- 1.6 Social history
- 1.7 Physical examination
- 1.8 Using a checklist or flow chart for children under two years old
- 1.9 Collection of physical evidence

8.2 Step 2: Validation and Support

“If you have developed concerns about the safety of a child or young person, then you will need to act on those concerns. Sooner or later (depending on the urgency of the situation) someone is going to have to have a frank conversation with the caregivers and (if old enough to understand) with the child. While your actions are intended to support and validate the child or young person, they may not (depending on the circumstances) be seen as supporting or validating their caregiver(s)” (FVAIG, p40).

However, you should not assume that raising care and protection concerns with a family will necessarily result in a hostile reception. Some caregivers may appreciate your honesty and be willing to accept help, and it may not be apparent until you raise your concerns, which adults in the family are protective” (FVAIG, p40).

Responding to child protection concerns in a health context requires us to have these difficult conversations, whilst also doing our best to maintain the engagement with, and access to health services. This requires a relational approach, and in the case of midwifery practice, maintaining a partnership with women, without judgement.

The following aspects are described in detail in the FVAIG, p40 – 42:

- 2.1 Talking with parents/caregivers of the child
- 2.2 Health care provider response to child’s disclosure of abuse
- 2.3 Health care provider response to parent/caregiver’s disclosure of abuse

8.3 Step 3. Health and risk assessment

Immediate protection of a child is required if the child has suffered harm and the environment to which the child is returning is unsafe. In these circumstances, following discussion with a line manager in the first instance, discuss with Te Puaruruhau.

“Risk assessment around CAN is not a reliable science. The more information you have about the child and family the better, but safety lies not so much in a particular risk

assessment tool, but in following a safe process. Even then there is no absolute guarantee of safety.

Thorough risk assessment needs to be conducted prior to the development of appropriate intervention plans. Health care providers are responsible for conducting a preliminary risk assessment with victims of abuse and/or neglect, in order to identify appropriate referral options. Note that this is different from the role of conducting investigations to determine who is responsible for perpetrating the abuse and/or neglect, which is the role of CYF or the Police” (FVAIG, p43).

There may be situations where you have concerns relating to an adult who is a parent or caregiver with children in their care eg a homeless parent, or a parent with mental illness or addictions or who has disclosed IPV.

Do not jump to conclusions, and never make decisions about risk without consultation ([see Section 7](#) above). Such consultation and any recommendations or plans should be documented in the clinical records.

The following aspects are described in more detail in the FVAIG, p43 – 45:

- 3.1 Risk to the child or young person**
- 3.2 Mental health assessment**
- 3.3 Risk to other children or young people**
- 3.4 Co-occurrence of CAN and IPV**
- 3.5 Other risk factors**

8.4 Step 4: Intervention/safety planning

If there are concerns about immediate safety (including your own) contact the Police, Security, Duty Manager, and CYF.

“If CAN is identified or suspected, then a plan is required for ensuring the safety of the child, or for providing help and support to the family. Information from the health and risk assessment process described in the previous section will help to ensure that acute needs are identified and can be included in the safety plan. Work with a multi-disciplinary team whenever possible or consult with a senior colleague” (FVAIG, p45)

“When undertaking safety planning, assessing for positive/protective factors is an important part of identifying resources that may help improve the situation. These can include the family’s efforts to actively pursue the safety and wellbeing of the child/young person, their willingness and capacity to respond, or their willingness to engage with, or develop a relationship with a service provider. The identification of support needs within the family (eg health, education or disability) can be a strength if meeting these needs assists in establishing connections with other services” (FVAIG, p46).

“In non-critical situations, multiple referral and follow-up pathways are possible. For healthcare providers, the key issue is whether the child is ‘at risk’ (but there are pathways

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of referral open to them which are likely to reduce that risk, see [4.2](#)), or whether the child is actually already coming to harm (see [4.1](#)).

A child who, in the opinion of the healthcare provider, is already coming to harm, should be notified to CYF as a 'Report of Concern.' (FVAIG, p 46).

The following aspects are described in more detail in the FVAIG, p45 – 48:

4.1 Child being harmed

4.2 Child at risk

4.3 Co-occurrence of child abuse and intimate partner violence

4.4 Talking to parents and caregivers about referral to the statutory authorities

"Remember, JOINT safety planning and referral processes need to be implemented when both intimate partner violence and child abuse are identified" (FVAIG, p47).

8.5 Step 5: Referral and follow-up

"Follow-up and referral plans need to be developed...based on the information obtained...and the collaborative planning undertaken by the health care provider and those they consulted with...the tasks at this stage are:

- *Make referrals as appropriate, and ensure that relevant information is appropriately and accurately transferred to receiving individuals/agencies.*
- *Ensure there is a plan for review and follow-up. What is the timeframe for the referral and follow-up plan? Who, when, and how, will the plan be reviewed?"* (FVAIG, p48).

5.1 Child coming to harm

The CYP&F Act does not require mandatory reporting to the statutory authorities. However, it has been adopted as policy within the public health system through Interagency Protocols (see the MOU between ADHB, CYF and the Police, August 2011). This policy is based on those protocols.

Any situation within Auckland DHB where, after full consultation as per [Section 7](#) above, CAN is disclosed, diagnosed or suspected must be referred for consultation and/or assessment to CYF and/or the Police, following the procedures detailed in this document.

Exception: Sexual Health Services and Te Puaruruhau follow their own management guidelines for complaints/disclosure of recent rape of adults and adolescents, which incorporate the principles of this policy.

This policy will assist Auckland DHB personnel to appropriately manage disclosed, diagnosed or suspected CAN, and situations where there is a high risk of abuse or neglect of the pregnant woman and/or her baby, during pregnancy or after birth.

In the instance of concerns relating to a pregnant woman and potential harm to her baby, there does need to be a discussion within the maternity multidisciplinary team in the first instance. Then, if a decision is made that there is potential harm to the unborn baby, a

discussion with the woman. Consideration needs to be given as to how and when this information is communicated with the woman and who within the multidisciplinary team would be best placed to have this conversation, considering support for the woman and maintaining a respectful ongoing partnership between the lead maternity carer/midwife and the woman (to promote the best possible outcome for mother and baby). For antenatal Reports of Concern, CYF acknowledge they need to engage with parents, wider whānau, and all other professionals (including the lead maternity carer/LMC/midwife) at the earliest possible opportunity to support the woman and promote sensitive, non-judgemental engagement and planning, where a positive outcome for mother and baby is a mutual goal. The value of providing a collaborative interagency approach and a proactive intervention (see supporting evidence section for CYF practice guidelines) in these circumstances must not be underestimated. It requires sensitive handling in order to support the woman's on-going engagement in maternity services in order to receive optimal pregnancy care for both mother and baby.

Unless there is an emergency, the process of multi-disciplinary consultation and documentation should come before a decision to report to CYF and/or the Police. Referral may be made by any staff member after appropriate consultation, but is best made by a staff member familiar with the referral process below.

Note that the Auckland DHB CYF Liaison Practice Leader is available for consultation and assistance where there are challenges associated with engaging or effective partnering with CYF when there is a mutual client.

A Report of Concern to CYF must follow this process:

- Complete a written Report of Concern. You can find this under Clinical Forms on the Intranet (<http://adhb.intranet/ClinicalForms/>). Click on Forms Library, click on Search, enter CR2692 and download the document template onto your computer.
- For Auckland DHB community and mental health services, the CR2692 can be completed online through HCC
- Email the CR2692 to the CYF Contact Centre CyfCallCentre@cyf.govt.nz with a copy to the Te Puaruruhau administrator TEP@adhb.govt.nz. This enables audit of Auckland DHB referrals to CYF and also enables linkage (where appropriate) to the Child Protection Alert System
- In urgent or complex cases, consider following up the CR2692 with a phone call to the CYF Contact Centre (0508 FAMILY). Ask to speak to an intake social worker
- Document in the clinical record that this has been done, including the date and time and the response received (if appropriate);
- A copy of the CR2692: Report of Concern to Child Youth and Family must remain in the clinical record (whether electronic or hard copy)

Decide during consultation on whether referral to both CYF and the Police is required. Referral to the Police, except in emergency, is best done through the Auckland Police Call Centre, 302 6400. In an emergency, phone 111, along with a Code Orange for inpatient areas (777). Where possible, notify the duty manager prior to calling the Police.

The Auckland DHB staff members making the referral should try to make themselves available to review the case in an appropriate multi-disciplinary forum.

5.2 Child at risk

If you have concerns about risk, but there has been no disclosure, and no definitive signs or symptoms, consult with others as set out in [Section 7](#).

“This may be a situation where early intervention initiated by a healthcare provider may prevent abuse or neglect in a family at risk. Therefore, whether or not a formal report of concern to CYF is made:

- *leave the door open for further contact with the child and the child’s caregivers*
- *look for further indicators at the next consultation, or consider raising your concerns with others within the health system (eg with the patient’s primary care provider, Plunket), so that additional follow-up and support can be offered, if required*
- *Consider if there are other health, social, or community agencies where you can refer the family, to reduce stressors, and/or promote health. These may include Children’s Teams under the Children’s Action Plan, non-health agencies, such as educational or social support agencies (for the child or caregiver), or agencies that provide support that may alleviate other risks (eg budgeting advice, community alcohol and drug services, community mental health services)” (FVAIG, p49).*
- Consider a referral to Tu Tangata Tonu for children with a parent or caregiver under an adult mental health service

5.3 Follow-up in all cases

Following a Report of Concern to CYF and/or the Police, Auckland DHB must continue to provide appropriate healthcare services where possible. CYF involvement does not reduce the responsibility of Auckland DHB to provide the child, young person or pregnant woman with appropriate ongoing care and follow-up for the issues which led to referral.

8.6 Step 6: Documentation

“Thorough documentation of all steps of the health consultation is necessary. Always include the date and time that you saw the child or young person, and when you wrote your notes (if different from the time you saw the patient). Always include a legible signature and practice designation. Clearly and thoroughly document the behaviours, signs and symptoms you observed” (FVAIG, p48).

“Children’s health records are private to them. Parents ... are not automatically entitled to them. Withholding grounds may apply, and one of these is when the healthcare provider believes that it is not in the child’s best interests to give the parents access. Therefore, your service must have a process where the primary clinician reviews a child’s file whenever a parent requests access to it” (FVAIG, p51).

The following aspects are described in more detail in the FVAIG, p49-51. Note that if a child has any marks or injuries, and you have any reason to suspect that these were

caused by CAN, you must discuss them with Te Puaruruhau. The child may need formal examination, documentation on body diagrams, photographs and xrays.

6.1 History

6.2 Examination

6.3 Photographs

6.4 Document the results of your health and risk assessment

6.5 Document the consultative process you undertook

6.6 Document the support agencies, referrals and follow- up plan agreed to

6.7 Confidentiality of abuse documentation on the medical record

9. Case review

Auckland DHB tracks the source and number of Reports of Concern made to CYF, in order to guide policy development and facilitate quality improvement processes. Cases of CAN are often complex, and may be highly stressful both for families and for professionals, particularly when referral to the statutory authorities is required.

If staff debriefing is required after a critical incident, the policy on Critical Incident Stress Management should be followed. If a reportable event occurs (see Reportable Events policy), this must be reported through Risk Monitor Pro. Cases of serious CAN (including child deaths) may be reviewed by the “Inter-Agency Serious Abuse Review Committee”, a collaborative process between Auckland DHB, the Police and CYF (terms of reference are available in the Puawaitahi Operational Guidelines). All teams are encouraged to engage in regular case review following critical incidents, and where possible to review positive examples of practice.

All situations within Auckland DHB where a Report of Concern for child or young person or pregnant woman is made to CYF must be reviewed in a multi-disciplinary forum (in relation to a pregnant woman, involving the woman’s lead maternity carer/midwife).

9.1 Case review process steps

- a. The CR2692 is copied to Te Puaruruhau (see Section 8, [5.1](#))
- b. Te Puaruruhau maintains a record of children referred to CYF by each service. If required, this can be made available to each service to facilitate case review
- c. Ideally, review should occur within a month of referral. Possible forums include:
 - Te Puaruruhau Peer Review (weekly)
 - Paediatric Child Protection Meeting (weekly)
 - National Women’s Health Child Protection Meeting (fortnightly)
 - Wahine Ora Vulnerable Pregnant Women’s Meeting (fortnightly)
 - Community Child Health and Disability Services Child Protection Referral Review Meeting

- Other multi-disciplinary team meetings, where staff members with child protection expertise are available
- d. The procedure to follow for dissatisfaction with the outcome of a referral to CYF is outlined on page 9 of the MOU between Auckland DHB, CYF and Police 2011. Note that the CYF Auckland DHB Liaison Practice Leader is available for consultation and help when there are issues concerning liaison with CYF
- e. Specific complex case reviews can be requested by consultation with Te Puaruruhau and the Auckland DHB child protection coordinator.

10. Supporting evidence

- [Child Youth and Family practice guidelines](#)
- [Family Violence Assessment and Intervention Guideline – Child Abuse and Intimate Partner Violence MOH June 2016](#)
- [Memorandum of Understanding between ADHB, CYF and Police 2011 and the associated Schedules](#)
- Puawaitahi Operational Guidelines 2014
- [Whanau Ora MoH 2009](#)
- www.childrensactionplan.govt.nz

11. Legislation

- [Care of Children Act 2004](#)
- [Children Young Persons and their Families Act 1989 \(and Amendments 1994, 2016\)](#)
- [Crimes Act 1961 & Amendments](#)
- [Domestic Violence Act 1995](#)
- [Health Act 1956 \(and Amendments 1993\)](#)
- [Health Information Privacy Code 1994](#)
- [New Zealand Bill of Rights 1990](#)
- [Privacy Act 1993](#)
- [Vulnerable Children’s Act, 2014](#)

12. Associated Auckland DHB documents

- [Abuse and Neglect Starship Clinical guideline](#)
- [Child Protection Alerts](#)
- [Child Protection Asking Children about Abuse](#)
- [Child Protection Suspected Child Abuse Siblings Assessment](#)
- [Clinical Record Management](#)
- [Code of Rights](#)

- [Critical Incident Stress Management](#)
- [Informed Consent](#)
- [Legal Issues Relating to Children](#)
- [Partner Abuse intervention – Family Violence](#)
- [Recruitment & Selection](#)
- [Referral - Child Youth & Family](#)
- [Reportable Events](#)
- [Social work initial assessment \(Policy\)](#)
- [Te Puaruruhau Consultation Process within ADHB](#)
- [Tikanga Best Practice](#)
- [Treaty of Waitangi \(Te Tiriti o Waitangi\)](#)
- [Trespass Notice - ADHB](#)
- [Watch Policy for Inpatient Children at Risk from Possible Child Abuse or Neglect](#)
- [Witnesses - Giving Evidence](#)

Other links

- [Auckland Sexual Health Service](#)
- [Child Youth and Family Practice Centre](#)
- [Learning and Development](#)
- [Supporting Parents – Health Children. Supporting parents with mental illness and or addiction and their children: A guideline for mental health and addiction services](#)

Clinical forms

- [CR2692: Report of Concern to Child Youth and Family](#)

13. Disclaimer

No guideline can cover all the variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

14. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed **before** the scheduled date, they should contact the owner or the [Clinical Policy Facilitator](#) without delay.