

Vulnerable babies, children and young people at risk of harm

An intervention guide

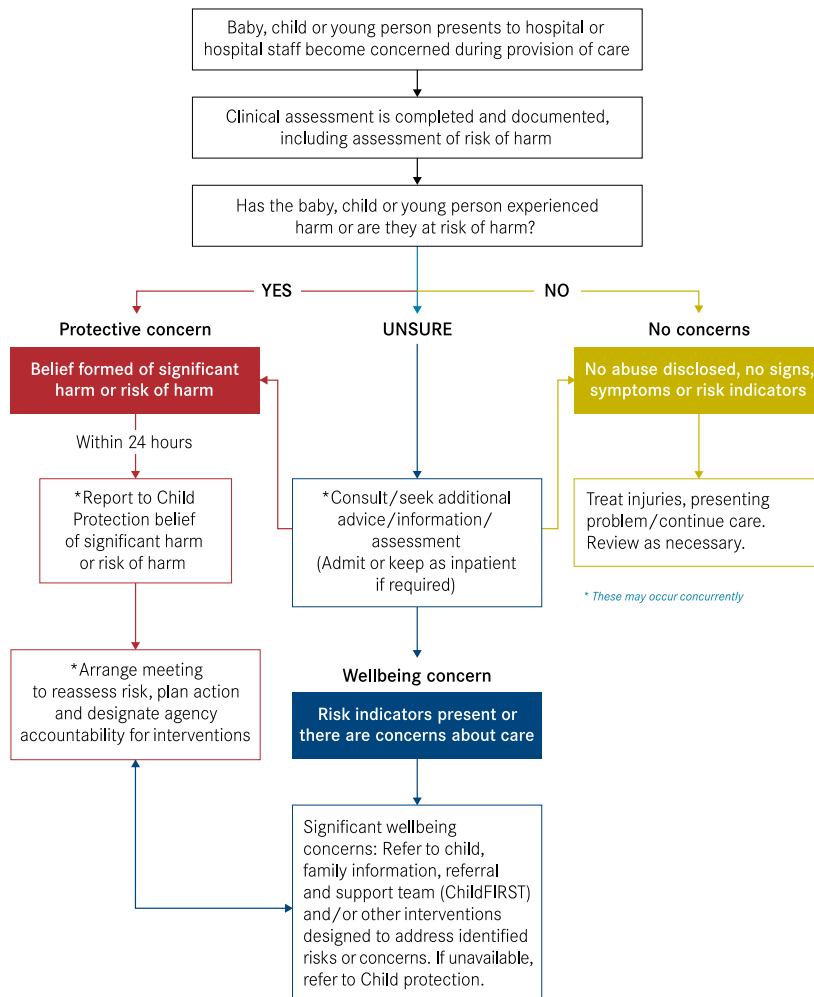
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Intervention flowchart...



Taking action

The flowchart on the opposite page sets out the steps for health professionals in considering and acting on the suspicion of non-accidental harm in a baby, child or young person.

Acute Health services should use the steps described to develop processes for their own organisation (or adapt existing processes).

The steps in this chart may take only minutes or occur over days or weeks, depending on the level of urgency or assessed risk.

The range of measures involved in an intervention will depend on the severity of the situation, the risk of harm to the baby, child or young person, and the parent's capacity and willingness to protect the child from harm.

Regular ongoing liaison between health services, local Child Protection Offices, Child FIRST or other community based child and family services, is encouraged to facilitate communication and improve coordination of care for vulnerable babies, children and young people.

Step 1 Consider the possibility...

Consider the possibility of non-accidental harm in:

- high risk groups
- those with signs and symptoms suggestive of abuse or neglect

Note

- **Always consider the possibility** that harm to a baby, child or young person may be non-accidental (see the tables on the following pages for signs and symptoms):
 - Is the child at risk of or subject to physical or sexual abuse or ill treatment?
 - Have the parents/caregivers behaved in such a way that the child is at risk of or subject to serious psychological harm?
 - Are the child's basic physical and psychological needs not being met, or at risk of not being met?
 - Does the child live in a household where there is family violence? Does this place them at risk of serious physical or psychological harm?
- If the child requires medical care, have the parents failed to arrange for this care? Are they unable or unwilling to do so?
- **Act promptly and decisively** to investigate any suspicions, and **diagnose accurately** to confirm or exclude abuse or neglect. A child may suffer harm if:
 - child abuse is not recognised or professionals fail to act decisively when a child is at risk or when a diagnosis of child abuse is wrongly made or there are long delays in excluding such a diagnosis.

Action

- Treat any presenting medical problems.
 - Complete and document a thorough physical, developmental and psychosocial history (may require referral to a paediatrician, senior colleague or other health professional experienced in child abuse and neglect).
 - Identify any immediate concerns about safety and activate appropriate internal/external processes.
The child's safety is paramount.
 - Review any old notes and previous presentations or admissions. Multiple presentations for illnesses may indicate risk.
 - Consider the risk of self-harm or suicide.
 - Assess for family violence and risk to siblings.
 - If uncertain, or if clinical findings are unusual or puzzling, consult a senior colleague, paediatrician or other health professional experienced in child abuse and neglect.
 - Provide appropriate clinical treatment and referral for the presenting problem.
- Seek multidisciplinary input/expertise to ensure that:
 - evidence of child abuse and neglect is not lost (expert medical assessment may be required with collection of forensic evidence)
 - trauma to the child from multiple assessments and questions is minimised.
 - When doctors offer an opinion about the likelihood that a child's condition might be due to child abuse or neglect, a comprehensive appraisal of the uncertainties must be included.
 - Refer all vulnerable children to the hospital social worker, or suitably experienced staff member, for a psychosocial assessment.

Assessing for signs and symptoms associated with harm

- The presence of one of these signs does not always mean that abuse or neglect is occurring and the absence of signs does not necessarily rule out abuse or neglect. Child abuse may present in many different ways, and may be mimicked by accidental trauma or some medical conditions.
- A belief that harm has occurred or may occur may be based on a number of signs or a single sign.
- Consider each sign or combination of signs in the context of the child's circumstances.
- Take into account the possible cumulative nature of signs/incidents.

Signs in the history
History inconsistent with the injury presented
Parental delay in seeking help
Past abuse or family violence
Disclosure by the child
Exposure of the child to family violence, pornography, alcohol or drug abuse
Severe social stress for the family or parent/s
Parental isolation and lack of support
Parent/s abused as child
Mental illness in a parent, including post-natal depression
Unrealistic expectations of the child
Inappropriate or inconsistent discipline (especially thrashings or any physical punishment of babies)
Terrorising, humiliating or oppressing
Neglecting the child
Promoting excessive dependency in the child
Actively avoiding seeking care or shopping around for care (frequent changes of address)

Physical signs
Multiple injuries, especially of different ages: bruises, welts, cuts, abrasions
Scalds and burns, especially in unusual distributions such as glove and sock patterns
Pregnancy
Genital injuries
Sexually transmitted diseases
Unexplained failure to thrive (FTT)
Poor hygiene
Dehydration or malnutrition
Fractures, especially in infants or in specific patterns
Poisoning, especially if recurrent
Apnoeic spells, especially if recurrent
Retinal haemorrhage
Rapid improvement in hospital

Behavioural and developmental signs
Aggression
Anxiety and regression
Obsessions
Overly responsible behaviour
Frozen watchfulness
Sexualised behaviour
Fear
Sadness
Defiance
Self-mutilation
Suicidal thoughts/plans
Withdrawal from family
Substance abuse
Overall developmental delay, especially if failure to thrive is also present
Patchy or specific developmental delay: motor, emotional, speech and language, social, cognitive, vision and hearing ¹

¹ Ministry of Health. Recommended referral process for GPs. New Zealand. 2001 www.moh.govt.nz.

Step 2 If harm is suspected...

If harm is suspected, ask careful and sensitive questions.

Asking children about possible harm

Talk to children at an age-appropriate level. If children are asked directly about abuse and/or neglect, observe the same conditions of privacy as when asking adults about possible victimisation. Questions might include:

- How are things at home?
- What happens when people disagree with each other in your house?
- What happens when things go wrong at your house?
- What happens when your parents/carers are angry with you?
- Who makes the rules? What happens if you break the rules?

Questions for the parent/carer

- Use open-ended non-judgemental questions about parenting and discipline, for example:
- Do you ever fear for your children's safety?
- Have you ever been worried that someone was going to hurt your children?
- Who looks after your children when you are not home?

Questions if you suspect the parent/carer may be the abuser

- Do you ever worry about your children's safety when they are with you?
- What methods of discipline do you use with your children?
- What do you do when your child misbehaves?
- Are you ever afraid that you might hurt your child?
- Have you ever hurt your child?
- Do you know what practical help is available to assist you?

Asking young people about possible harm

Causes of harm include family, peer violence/bullying, dating violence. Be alert to the possibility of self-harm. Where harm is suspected, a thorough psychosocial assessment is indicated. To determine the most appropriate action/referral, it may be relevant to ask questions about the following (offer the option to 'pass' on a sensitive topic):

Home (family, culture, connections)

Where do you live? Who with? Extended family links and culture? Is home life stable? Who makes the rules and what happens if rules are broken? What happens when you fight at your house? Is there any violence? Who in the family do you get on well with, or not so well? Who do you talk to most?

Education

Do you go to school/training/work?
Which, for how long? If not, how long have you been out of work? Do you have good friends at school/work? Is there a teacher you get on well with? What do you do in/outside classes? Are you bullied?

Activities (eating, sleeping, exercise, risk behaviour)

What do you do out of school? How do you get money? How do you get around? What do you do for a thrill? Do you go to parties? Do you sleep well?

Drugs and alcohol

Do you/your friends/people at your school smoke? Do your friends/parents/you ever drink alcohol? Have you ever used marijuana? What other drugs are people using now? What do you think about it? What have you tried? How much are you using? In what circumstances? What risks are involved?

Sexuality

Do your friends have sexual relations? Do you? What do you know about safe sex? Has anybody ever touched you in a way you don't like, or made you feel uncomfortable or afraid? If this happened, is there anyone you could tell, or ask for advice about sex/relationships? Do you want to talk about anything else about sex/relationships?

Step 3 Provide emotional support...

Provide emotional support for the child or young person

If the child or young person discloses abuse

- **Be aware** that:
 - The child may be feeling scared, guilty, ashamed, angry, powerless, and have been told by the perpetrators the child is responsible for the abuse.
 - You may feel outrage, disgust, sadness, anger, disbelief, but need to remain calm and in control of your feelings.
- **Reassure** the child know that he/she is not at fault, and that something will be done to keep him/her safe. This reassurance one of the most powerful interventions you can provide.
- **Show your care and concern** by:
 - listening carefully to what they are saying
 - telling them you believe them
 - telling them it is not their fault, no one deserves to be hurt or neglected and that they are not responsible for the abuse
 - telling them you will seek help for them and their family/carers
 - letting the child know that you will make a report to the appropriate authorities so that they can help stop the abuse
 - telling the child you are pleased they told you.

When there is no disclosure

- If you suspect abuse, but the child has not told anyone, be aware of the emotional distress the child may be experiencing. Be sensitive and caring, and assure the child that you are willing to listen and to help if there is a problem.
- **Do not:**
 - make promises you cannot keep, such as promising that you will not tell anyone
 - push the child into giving details of the abuse. Your role is to listen to what the child wants to tell you, but not to conduct an investigation
 - indiscriminately discuss the child's circumstances with others not directly involved with helping the child.
- Communicate with the parents or carers about your concerns except where it may place the baby, child or young person or you in danger, and/or the family may seek to avoid child protection staff.

Step 4 Consult, seek advice...

Consult, seek additional advice, information and/or assessment

Be aware that:

- Early multidisciplinary input and case conferencing is the key to providing an appropriate, comprehensive and coordinated response.
- Consultation may be brief – a phone call or, if time and safety permit, more extensive, with multiple referrals and investigations.
- Referral to an experienced paediatrician helps to ensure an adequate investigation of suspected abuse, and an accurate diagnosis regarding suspected abuse².

Seek the advice of:

- your manager or a senior colleague or clinician experienced in this field to discuss your grounds for concerns and how to proceed with the most appropriate support and intervention
- a senior medical officer, nurse manager, paediatrician, social worker or child protection unit staff (if available) to advise on additional assessment or investigations
- where senior/experienced staff are not available (for example, in some rural settings), consider seeking advice from a general practitioner or staff from a community health service with experience in this area

- if expertise or experience is limited internally/locally, seek external specialist advice from the Victorian Forensic Paediatric Medical Service (VFPMS)
- in addition, **consult an Indigenous liaison officer**, if the baby, child or young person identifies as Aboriginal or Torres Strait Islander.

Admit or keep the baby, child or young person as an inpatient, if required to complete the assessment or provide a safe environment.

Seek information from any other agencies currently working with the baby, child, young person, their family or carer.

Forensic paediatric medical assessment

- Consult the Victorian Forensic Paediatric Medical Service to arrange forensic paediatric medical advice and assistance.
- Proformas for forensic paediatric medical assessments are available from the VFPMS website.

² Ziegler DS, Sasmmut J & Piper AC. Assessment and follow-up of suspected child abuse in preschool children with fractures seen in a general hospital emergency department. *Journal Paediatric Child Health* 2005;41:251-255.

Step 5 Notify Child Protection...

Notify Child Protection services of concerns

Making the decision to report

- If you believe the baby, child or young person has suffered, or may suffer, significant harm as a result of abuse or neglect, you must notify Child Protection.
- This may be clear immediately, or only after monitoring a situation over time (for example, initial warning signs in the child's behaviour may not warrant report, but later information – for example, a crisis event – may clarify the situation).
- You do not have to prove that abuse/neglect has occurred. Following a report, the Child Protection worker undertakes a risk assessment based on the information from the reporter and other information, and determines whether significant harm has occurred or may occur. Data and evidence provided by acute health staff can critically inform this risk assessment.

Making the report

- Depending on the urgency of your concerns, you may call Child Protection before you consult or meet with any other staff or agency.
- Gather the information required to complete a '*Protective Intervention Report Form*' (see Appendix E in the framework document).
- Contact your regional Child Protection service (see Appendix C in the framework document)
- Arrange a multidisciplinary, multi-agency case conference within 24 hours (see Step 6).
- Initiate internal reporting/communication processes related to the report, for example:
 - notify your manager/supervisor of the report
 - refer the child to a general or forensic paediatrician for additional examination or investigations
 - refer the child to a social worker or other health professional for assessment of existing social supports, relevant support and welfare services, preventative and early intervention programs.

After making the report

- When Child Protection becomes involved, a family is usually thrown into crisis, and you may also feel guilty about making matters worse. Focus on the child's situation and remember that you have acted correctly.
- Your ongoing roles and responsibilities may include:
 - acting as a support person in interviews with the child or young person
 - attending a case conference relating to the investigation
 - participating in case planning meetings in relation to a child or young person
 - continuing to monitor a child or young person's behaviour in relation to ongoing harm
 - observing/monitoring the conditions on a protective court order that may relate to access or contact with a parent
 - liaising with other professionals and Child Protection workers in relation to a child or young person's wellbeing
 - providing written reports for case planning meetings or court proceedings in relation to a child or young person's wellbeing or progress.
- The child/young person may feel distressed, guilty, ashamed, confused, frightened, and will need support throughout the protective intervention. Professionals involved with the family may be in a position to offer ongoing support, by:
 - liaising with Child Protection workers to ensure they are giving appropriate support to the child or young person
 - providing support to the family where appropriate
 - dealing sympathetically and effectively with changes to the child's behaviour that may occur in response to intervention.

Step 6 Arrange/participate...

Arrange/participate in a meeting/s of relevant agencies and professionals to reassess risk, plan action and assign accountability for interventions

Reasons for a meeting

A multidisciplinary, multi-agency meeting may be held to:

- **help in making the decision** about whether to report

- **plan and manage care following report.**

Sometimes known as a SCAN (Suspected Child Abuse and Neglect) meeting. Case planning will be led by Child Protection and hospital staff will be asked to contribute. SCAN meetings bring together three main professional groups – health professionals, Victoria Police, and Child Protection – to coordinate and exchange information in order to provide early supportive intervention in cases of suspected child abuse and neglect. Hospital staff provide medical input with forensic and psychosocial assessments Victoria Police evaluate whether a criminal offence has been committed and whether charges should be laid and Child Protection investigates the suspected child abuse and neglect

- **plan and manage care where report is not required** – if you do not report as a protective matter case planning with other agencies may still be appropriate, led by hospital staff or you may consider referral to Child FIRST on the basis of significant concerns for the child’s wellbeing. Under these circumstances Child FIRST or other community-based child and family service will lead case planning.

‘**Case planning**’ relates to the safety, welfare and wellbeing of a child and/or family, and should ensure there are no misunderstandings for clients and practitioners about goals or responsibilities. If health professionals are asked by Child Protection services or a registered community based child and family services to attend a case planning meeting they should do so.

Organising the meeting

Bring together an appropriate multidisciplinary and multi-agency group to provide information and input to plan any intervention, including:

- Relevant hospital staff
 - Medical
 - Nursing
 - Social work
 - Other allied health
 - Other relevant specialties, eg mental health service staff
 - Patient liaison
- Other agencies or services involved with the family such as Disability Services
- If Child Protection is involved, include:
 - Child Protection services staff
 - Victoria Police (generally notified by child protection staff as appropriate)
 - If age appropriate, involve the child or young person
 - Involve parents or carers unless it will jeopardise the safety or wellbeing of the baby, child or young person

At the meeting

- Document planned interventions and agency or staff accountability for all actions. Generally the hospital will not be the lead agency for ongoing safety and protective concerns, but will play a key role in provision of health care and information to other agencies.
- Agree any need and timeline for future communication or meeting.
- Agree on any interagency feedback required for future management of the baby, child or young person's case.

Step 7 Follow up...

Follow up and complete additional assessments, investigations, interventions

- **Complete** any additional investigations and assessments related to the risk of harm, as agreed in the consultation process (Steps 4, 5).
- **Complete and follow up** any interventions required to continue clinical care.
- Document steps taken:
 - referrals made
 - support/information provided
 - meetings convened
 - investigations and results
 - plan for care including discharge and return visits or admissions.

Note

- **Meticulous documentation** is of critical importance where there is suspected or actual harm, for a number of reasons:
 - medical notes may be used as evidence in protective legal proceedings (which may occur at a time distant from the time of the report)
 - the need for report may not be clear initially, but result of evidence accumulated over time
 - documentation is critical to future interventions.
- **External referral agencies** are vital in providing support to actual or suspected victims of harm. It is strongly recommended that you or your hospital meet and develop referral relationships with staff from Child FIRST, other agencies and community health services.

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