

<b>DISTRICT HEALTH BOARD</b>	<b>Manual:</b>	Clinical Protocols & Guidelines
<b>Child Abuse and Neglect Policy - Management of</b>	<b>Doc No:</b>	
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## PURPOSE

This policy provides (*name*) District Health Board (DHB) community and hospital -based staff with a framework to identify and manage actual and/or suspected child abuse and neglect. It recognises the important role and responsibility staff have in the accurate detection of suspected child abuse and/or neglect, and the early recognition of children at risk of abuse and adults at risk of abusing children.

This policy also provides guidelines for the development of unit specific policies relating to child abuse and neglect.

## PRINCIPLES

The rights, welfare and safety of the child/tamariki, young person/rangatahi are our first and paramount consideration.

Health services should contribute to the nurturing and protection of children and advocate for them as part of their role to promote and preserve health.

Health services for the care and protection of children are built on a bicultural partnership in accordance with the Treaty of Waitangi.

Maori children/tamariki, young persons/rangatahi are assessed and managed within a culturally safe environment. The Maori Health Unit, is available for cultural support. In the case of mental health clients support and advice is available from Child Adolescent and Mental Health Service (CAMHS)

Wherever possible the family/whanau, hapu and iwi participate in the making of decisions affecting that child/tamariki young person/rangatahi.

All staff are to recognize and be sensitive to other cultures.

(*Name*) DHB provides an integrated service and works with external agencies to provide an effective and coordinated approach to child protection.

Staff are competent in identification and management of actual or potential abuse and/or neglect through the organisation's policy and procedural structures and education programme.

## SCOPE

This policy applies to all cases of actual and/or suspected abuse and neglect encountered by employees, students and people working at DHB under a contract for service.

## TERMS AND DEFINITIONS

All terms and definitions related to this document have been defined (*see Appendix 1*).

## **ORGANISATIONAL RESPONSIBILITIES**

### **Executive Responsibilities**

The (*name*) District Health Board (DHB) is responsible for ensuring it has an organisation-wide policy for the management of child abuse and neglect, regular training for staff in the policy, processes to ensure the policy is adhered to, such as clinical audit, and adequate support and supervision for staff. These activities need to be properly resourced and evaluated.

### **Unit Responsibilities**

All units who provide care for children and youth will have unit level child protection policies based on this policy.

### **Employee Responsibilities**

All employees of (*name*) DHB have responsibility for the management of suspected abuse and neglect. Responsibilities are:

- To be conversant with DHB policy.
- To understand the referral and management of suspected abuse and neglect.
- To take action when child abuse is suspected or identified.
- To attend initial training and regular updates appropriate to their area of work.
- To provide or access DHB Specialist Health Services that may include:
  - Cultural assessments.
  - Mental Health assessments.
  - Diagnostic medical assessments.
  - Social work services, counseling and therapy resources.
  - Paediatric assessment.

This includes situations where child abuse is disclosed but the child may not be present.

### **Human Resource Responsibilities**

(*Name*) DHB recruitment policies will reflect a commitment to child protection by including comprehensive screening procedures.

Where suspicion exists of child abuse perpetrated by an employee or volunteer in the organisation, the matter will be dealt with in accordance with the Disciplinary Procedure and the Protected Disclosure Policy both found in the Personnel Manual.

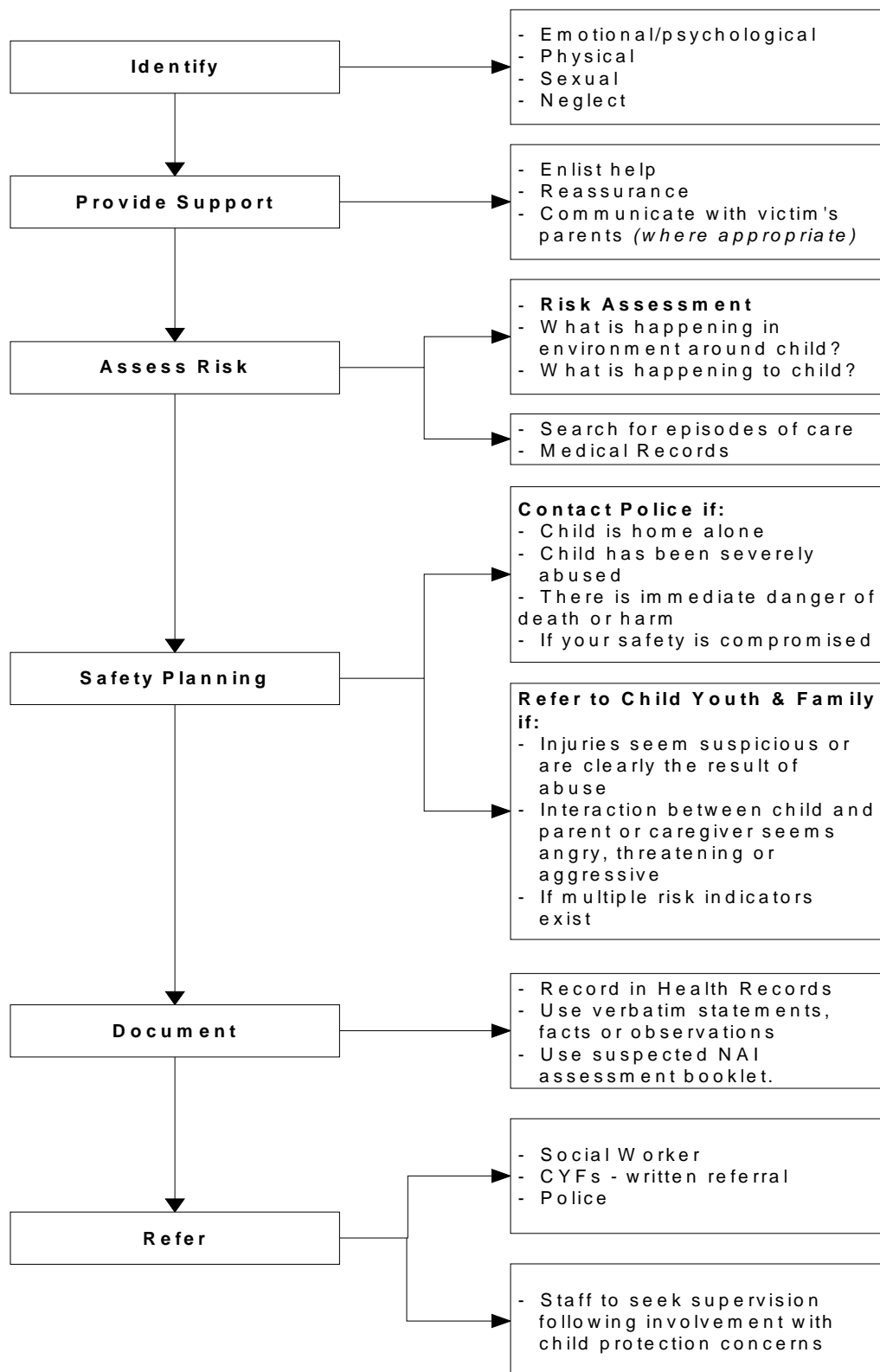
### **Child Protection Co-ordinator Responsibilities**

- To conduct an annual review of compliance to policy.
- Provide monthly analysis of clinical management processes.
- Ensure provision of training in child abuse is available
- To be available to staff for consultation regarding child protection concerns.
- To facilitate communication with Child Youth and Family Services (CYFS).

## **PROCEDURES FOR RESPONDING TO ACTUAL OR SUSPECTED ABUSE**

All situations where recent or ongoing child abuse and/or neglect is disclosed, detected or suspected must be acted on and reported using the following procedure. The following outlines the standard process for assessment and response. Unit level policies will detail specific actions under each heading.

### Procedure for Responding to Actual or Suspected Abuse



**CONSULTATION**

Should occur at least once during this process

**N.B. Consultation should occur at least once. The following staff are available:**

- An experienced colleague
- Paediatrician
- Child Protection Co-ordinator
- Co-ordinator of Family Violence Intervention and Child Protection Programmes

Consultation can occur at any point during the assessment and referral process if concerns exist.

**1. Identify**

Either by disclosure or recognition of signs and symptoms. Always consult if the possibility exists. Refer Appendix 1 for signs and symptoms of each category.

**2. Support and Empower Victims of Abuse**

Enlist Social Work Support in areas where a Social Worker is employed.

If the child is Maori involve the Maori Health Unit during office hours to enlist appropriate cultural supports, or in the case of mental health clients with Child Adolescent and Mental Health Service (CAMHS).

If after hours create a culturally safe environment by contacting Maori health on call personnel. It is important that this does not delay any referral to Child, Youth and Family.

Offer appropriate cultural support where possible. Eg. Pacific Island Resource Centre, DHB Pacific Island Liaison Personnel

**3. Assess Risk**

Refer to Child Abuse Indicators Flip Chart for a comprehensive list of risk indicators – available in most work areas – contact the Child Protection Co-ordinator for a copy.

**Risk Indicators:** environment around the child

- Any **history** previous abuse or suspected abuse
- **Domestic violence**
- Parent **indifferent, intolerant** – view child as particularly troublesome
- **Severe social stress**
- **Severe isolation and lack of support**
- **Parents abused** as children
- **Alcohol and drug abuse**
- **Mental illness** including post natal depression
- **Parent very young**
- **Frequent changes of address**, more than 2 over last year
- At risk **family actively avoids contact** with health care providers or family support agencies

**Assess Risk:** what is happening to the child

- Screen all episodes of care to identify current or previous contact with DHB services
- **Nature** of abuse neglect or risk
- Details of: how, what, where, when, who saw happen
- What is the **trend**? Increasing, decreasing, static.
- Assess safety of **siblings** within the household.

- Are adequate **protectors** available e.g. Adult who will keep the child safe, family, other support people involved with child
- Child's **ability to protect self**, access of perpetrator to child
- Identify other **agencies involved** with the family

### **Red Flags**

- Uncorroborated history
- A discrepancy between the history and injury
- Varying/changing history
- History of repeated trauma
- Delay in seeking medical advice
- Inappropriate parental response
- Sudden change in child's behaviour
- Unusual child/parent interaction

### **Do not further interview child**

#### **Consider:**

- Risk of self-harm or suicide.
- Co-occurrence of partner abuse. If child abuse is suspected assess the mother for partner abuse. Do not ask about partner abuse if another adult or child aged over three years is present.
- Continue to consult.

## **4. Safety Planning/Intervention**

### **A: When a child presents to the DHB with suspected abuse or with abuse and no perpetrator identified**

When abuse is suspected or identified, reporting to CYFS must be made at the earliest opportunity.

- Staff must instigate care and protection processes (report to Police and/or CYFS) if high concerns about child's safety.
- The HBHBD is responsible for keeping the child safe in hospital. Once CYFS is notified then responsibility for the child's safety is shared between HBHBD and CYFS.
- The level of supervision required to keep the child safe will be decided following a comprehensive risk assessment which should be completed at the earliest opportunity.
- The final decision about the level of supervision required will be decided in consultation between Clinical Charge Nurse (out of hours- Duty Manager), the Paediatrician on call and the CYFS Key Worker.
- Continuing assessment and multidisciplinary consultation is essential (refer to Memorandum of Understanding between CYFS and DHB Acute and Elective Services for children under investigation or care of CYFS).
- Security can be called to assist as required when concerns regarding child safety are identified. **For emergency response from a Security Guard or mobile patrol, ring Call Centre on extn: 7777**
- For information regarding visitors policy see flow chart Appendix 4 or Visitor and Support Person Policy (proper reference) (Doc OPM063) on intranet
- CYFS or the Police can obtain a Place of Safety Warrant. This means the child must remain in a named safe location and only persons named by the CYFS Key Worker may visit the child.
- Trespass Orders may also need to be issued if high concerns regarding child safety exist. These are instigated by contacting security.

- Access to the ward is limited at all times through locked doors except during visiting hours (2-8pm). Following the risk assessment staff may further limit access throughout the visiting period if required.
- Supervision options for a child with care and protection concerns include:
  - Place the child in a site visible to staff.
  - Specialising the child.
  - Designated visitors only.
  - Ban all visitors (consider the impact on the child when making this decision).
  - Refer Appendix 5 for Table1: Supervision options for a child admitted with actual or suspected child abuse.

**B: Keep child safe and report to Police if:**

- The child has been severely abused.
- There is immediate danger of death or harm.
- Abuse has occurred and is likely to escalate or recur.
- The child/ren is/are home alone, stay with the child/ren, call the Police and stay until the Police arrive.
- There is immediate risk to the child, or the environment to which the child is returning is unsafe.
- Your safety is compromised.

**C: Report to Child, Youth and Family if the child has:**

- Injuries which seems suspicious, or are clearly the result of physical abuse
- Interaction between the child and parent or caregiver seems threatening or aggressive
- Child states that they are fearful of parent/s, caregiver/s, or have been hurt by parent/s or caregiver/s
- If multiple risk indicators exist, e.g. Partner abuse in the relationship, alcohol/drug use by caregivers, caregivers avoidance of health agency contact

Notify CYFS call centre first (0508 FAMILY / 0508 326 459) followed by a written report using a Child, Youth and Family Referral Document. A report template can be found in the Policies and Procedures section on DHB intranet and beneath the Child Abuse and Neglect Policy

Note that there is **no** issue of breach of confidentiality, where staff report valid child protection concerns to police or CYFS.

The CYP&F Act provides specific protection from legal action to anyone reporting to CYFS in good faith (*see Appendix 6*)

In cases of sexual abuse of children, referral must also be made to the Paediatrician on call who will liaise with the DSAC trained doctor. (See Appendix 7: Guidelines for responding to child sexual abuse).

If a medical examination is required, consent by the competent child (regardless of age) is required before any examination is undertaken (*see Informed Consent Policy - DHB/CPG/038*).

**D: Communicate with victim's patients/caregivers.**

There must be an agreed and documented decision on who will be responsible for any communication with the family/whanau. This may vary between services and cases (see unit specific policies). Ideally communication with family/whanau should not take

place before consulting with senior staff within your practice setting, Paediatrician, Registrar, health Social Worker, or with the duty Social Worker at the Department of Child, Youth and Family. **If the decision is to discuss** concerns or child protective actions with a victim's parents or caregiver, the delegated staff person must understand and acknowledge the sensitivity of the situation.

Concerns or child protection actions DO NOT need to be discussed with a victim's parents or caregivers where it is believed that:

- It will place either the child or you, the health care provider, in danger.
- The family may close ranks and reduce the possibility of being able to help a child.
- The family may seek to avoid protection agency staff.

## 5. Document all observations, process and assessment thoroughly.

In all cases accurate informative documentation is essential and must be recorded in the Health Record with time, date, legible signature and designation.

Document facts and observations as soon as possible after the event or discussion. Wherever possible use the Suspected NAI Assessment Booklet that has many helpful prompts for the history and examination.

- Record only facts and/or observations not "feelings".
- Clearly differentiate between what was seen and heard and what was reported or suspected and by whom.
- Detail who was present at the time.
- Include date and time.
- Where there has been a disclosure, write what was said in quotation marks (verbatim).
- A body diagram can be used to record bruises, cuts and other injuries.

## 6. Reporting or Referral

- If following a comprehensive risk assessment and appropriate consultation abuse is identified or suspected then the child/ren should be reported to the Police and or CYFS as identified in Section 4. The report to CYFS can be by phone but must be followed by a faxed written report. Speed dial number for faxing to CYFS is on the front page of CYFS form.
- DHB Child Protection Co-ordinator must be advised of all notifications made to CYFS by the form on the last page of the notification to CYFS.
- When you are concerned about the child's care, but not to the extent requiring reporting to CYFS then refer to a hospital Social Worker or appropriate community agency to enlist support for the family.

*(Refer Appendix 8 for flowchart: Procedure for Responding to Actual or Suspected Abuse.)*

## DEATH OF A CHILD AND SIBLING ASSESSMENT

In the event that a child is brought into the DHB and is deceased on arrival or the child dies in the DHB and the cause of death is suspicious, then an assessment of the safety of any siblings should be urgently undertaken. The Paediatrician on-call should determine if there are other siblings and if so report to CYFS.

## FAMILY SAFETY AND SECURITY PROCESS

At times it may be necessary to suppress patient details and or provide secure processes at the time of discharge. The guidelines for use when staff assess the safety of a victim of abuse to be high risk are outlined in Appendix 9.

## **STAFF SUPPORT AND SAFETY**

In any case where staff have been involved in the reporting and/or management of abuse or neglect they should seek debriefing, supervision or counselling from an appropriately trained senior colleague. Staff may access Peer Supporter or Employee Assistance Programme and refer to Debriefing Policy following a critical incident PPM054.

## **REFERENCES**

### *Organisation Documents:*

- Debriefing Policy Following a Critical Incident (DHB/ doc)
- Event Reporting Policy (DHB/doc)
- Informed Consent Policy (DHB/doc)
- DHB Unit Specific procedures/policies.
- Privacy – Sending Correspondence by Fax (DHB/doc) Faxing document
- Health Records Policy – Documenting Care and Treatment in the Health Record (doc)
- Privacy – General Guidelines Policy (DHB/doc)
- Privacy – Release of Health Information Policy (DHB/doc)
- Privacy – Collection of Health Information (DHB/doc)
- Tikanga Best practice Policy (OPM/doc)
- Security Policy (DHB/doc)
- Visiting Policy (Visitor and Support Person Policy DHB/doc)

### *Legislation:*

- Health Act (1956)
- Children’s Young Persons and their Families Act (1989) (and Amendments 1994/95)
- Privacy Act (1993) and Health Information Privacy Code (1994)
- Code of Health and Disability Services Consumers Rights (1996)
- New Zealand Bill of Rights (1990)
- Crimes Act (1961)
- Domestic Violence Act (1995)
- Guardianship Act (1968)
- Summary Offences Act (1981)

### *Other:*

- Breaking the Cycle Interagency Protocols for Child Abuse Management. New Zealand CYPS 1996
- Breaking the Cycle An Interagency guide to Child Abuse New Zealand CYPS 1997
- Children’s Commissioner. Safety of Children in Hospital. Wellington: Office of the Commissioner for Children, 2006.
- Family Violence. Guidelines for Health Sector Providers to Develop Practice Protocols. Ministry of Health 1998
- Fanslow, J. Family Violence Intervention Guidelines. Wellington, Ministry of Health, 2002.
- DHB and Eastern Service Centre Child Youth and Family Service. Memorandum of Understanding between Children & Youth Acute and Elective services and the Eastern Service Centre Child Youth and Family Service. 2006.

***For further information contact the Child Protection Co-ordinator.***

## APPENDIX 1

### TERMS AND DEFINITIONS

<b>Child</b>	In this document the word child refers to child/tamariki and young person/rangatahi ages 0-16 inclusive.
<b>Child Protection</b>	Means the activities carried out to ensure the safety of the child/tamariki, young person/rangatahi in cases where there is abuse or risk of abuse.
<b>Child Abuse</b>	Refers to the harming (whether physically, emotionally, or sexually), ill treatment, abuse, neglect, or serious deprivation of any child/tamariki, young person/rangatahi (Section 14b Children, Young Persons and their Families Act 1989). This includes actual, potential and suspected abuse.
<b>Physical Abuse</b>	Child physical abuse is any act or acts that may result in inflicted injury to a child or young person.
<b>Sexual Abuse</b>	Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not.
<b>Emotional/ Psychological Abuse</b>	Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person.
<b>Neglect</b>	Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person.
<b>DSAC</b>	Doctors for Sexual Abuse Care. National organisation advancing knowledge and improving medical care for those affected by sexual abuse. Only DSAC trained practitioners should perform medical examinations for child sexual assault.
<b>Department of Child Youth and Family Service (Child, Youth and Family)</b>	Government agency that carries out the legislative requirements of the Children, Young Persons, and their Families Act 1989. Responsibilities are: <ul style="list-style-type: none"><li>▪ To investigate cases of actual and suspected child abuse and/or neglect</li><li>▪ To complete diagnostic interviews</li><li>▪ To complete evidential interviews in cooperation with NZ Police</li><li>▪ To provide care and protection for children found to be in need.</li></ul>
<b>NZ Police</b>	Government agency responsible for: <ul style="list-style-type: none"><li>▪ Working cooperatively with Child, Youth and Family in child abuse and/or neglect protection work</li><li>▪ Investigating cases of abuse and/or neglect where an offence has or may have been committed</li><li>▪ Prosecuting offenders where an offence has been committed</li><li>▪ Accepting reports of suspected abuse and or neglect and referring these to Child, Youth and Family.</li></ul>

## APPENDIX 2

### FOUR RECOGNISED CATEGORIES OF CHILD ABUSE

These frequently overlap in individual cases. Refer to the “Recognition of Child Abuse and Neglect” published by the Risk Management Project, Children, Young Persons and Their Families Agency 1997.

#### 1. Physical Abuse

Child physical abuse is any act or acts that may result in inflicted injury to a child or young person. It may include, but is not restricted to:

- Bruises and welts
- Cuts and abrasions
- Fractures or sprains
- Abdominal injuries
- Head injuries
- Injuries to internal organs
- Strangulation or suffocation
- Poisoning
- Burns or scalds
- Non organic failure to thrive
- Fabricated Or Induced Illness By Carers (formerly Munchausen Syndrome by Proxy)

#### 2. Sexual Abuse

Child sexual abuse is any act or acts that result in the sexual exploitation of a child or young person, whether consensual or not. It may include, but is not restricted to:

##### Non-contact abuse

- Exhibitionism
- Voyeurism
- Suggestive behaviours or comments
- Exposure to pornographic material
- Inappropriate photography

##### Contact abuse

- Touching breasts
- Genital/anal fondling
- Masturbation
- Oral sex
- Object or finger penetration of the anus or genitalia
- Penile penetration of the anus or genitalia
- Encouraging the child or young person to perform such acts on the perpetrator
- Involvement of the child or young person in activities for the purposes of pornography or prostitution.

### **3. Emotional/Psychological Abuse**

Child emotional/psychological abuse is any act or omission that results in impaired psychological, social, intellectual and/or emotional functioning and development of a child or young person. It may include, but is not restricted to:

- Rejection, isolation or oppression.
- Deprivation of affection or cognitive stimulation.
- Inappropriate and continued - criticism, threats, humiliation, accusations, expectations of, or towards, the child or young person.
- Exposure to family violence.
- Corruption of the child or young person through exposure to, or involvement in, illegal or anti-social activities.
- The negative impact of the mental or emotional condition of the parent or caregiver.
- The negative impact of substance abuse by anyone living in the same residence as the child or young person.

### **4. Neglect**

Child neglect is any act or omission that results in impaired physical functioning, injury, and/or development of a child or a young person. It may include, but is not restricted to:

- Physical neglect - failure to provide the necessities to sustain the life or health of the child or young person.
- Neglectful supervision - failure to provide developmentally appropriate and/or legally required supervision of the child or young person, leading to an increased risk of harm.
- Medical neglect - failure to seek, obtain or follow through with medical care for the child or young person resulting in their impaired functioning and/or development.
- Abandonment - leaving a child or young person in any situation without arranging necessary care for them and with no intention of returning.
- Refusal to assume parental responsibility - unwillingness or inability to provide appropriate care or control for a child or young person.

## APPENDIX 3

### GUIDELINES FOR ACCESSING INFORMATION

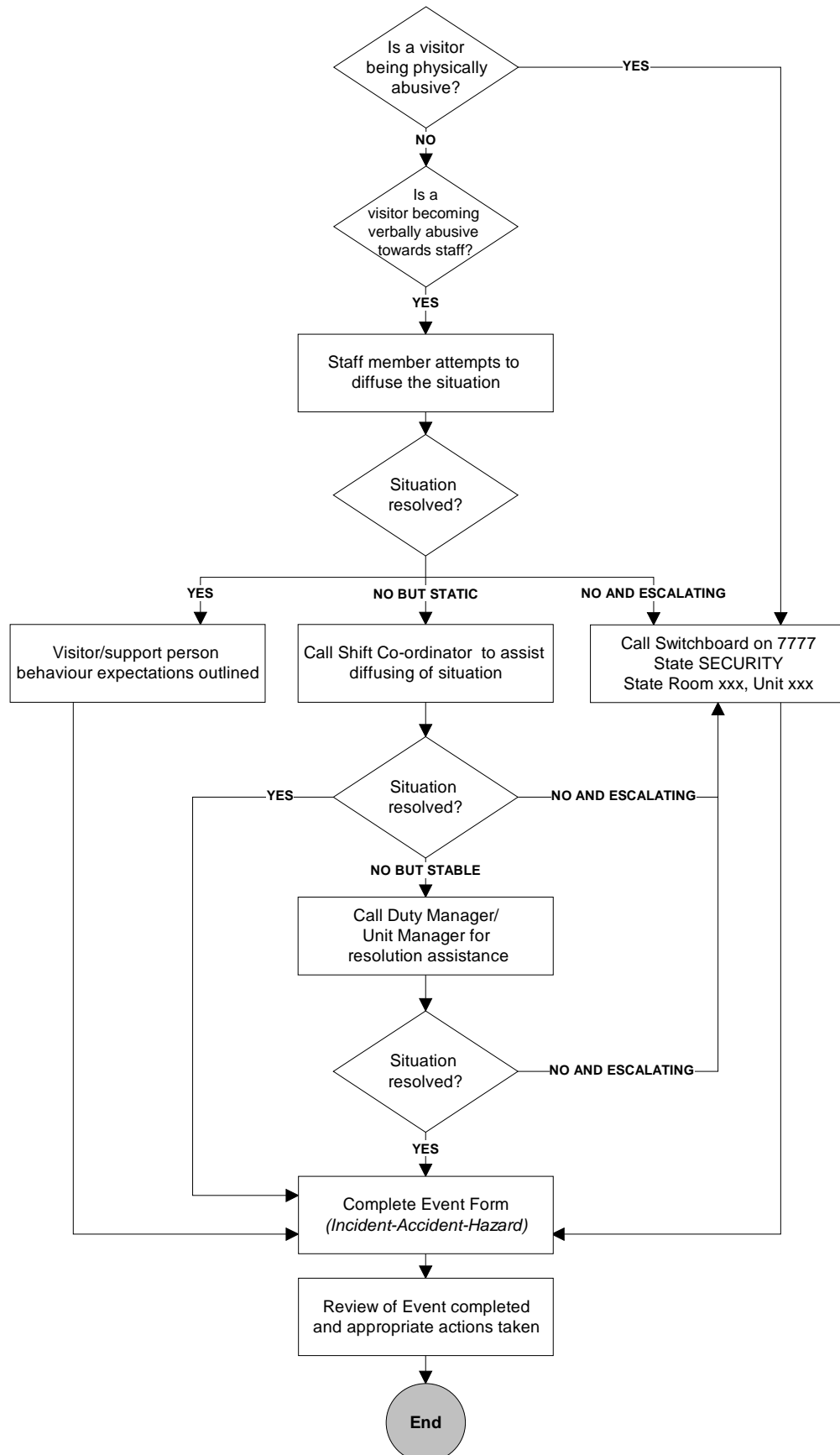
Where there are any concerns regarding actual or suspected abuse all available information must be accessed.

- Track health records for location of relevant information.
- Search for episodes of care:
  - If there is an inpatient or ED file contact medical records office or duty manager after hours.
  - If there is a Community Health file, contact appropriate DHB service.
  - If there is a Mental Health file contact Mental Health Service or Access Centre.

If more detail is required contact other hospitals for relevant data. The search can be done at the same time of reporting. It is important that the reporting should not be delayed.

**APPENDIX 4**

**Flowchart: Visitor policy**



**APPENDIX 5**

**Table 1: Supervision options for a child admitted with actual or suspected child abuse**

	<b>Visits</b>	<b>Supervision</b>
Child admitted to ward, with suspected Non-accidental injury (NAI): Assessment ongoing	Options include: <ul style="list-style-type: none"> <li>▪ Place child in a site visible to staff</li> <li>▪ Designated visitors only</li> <li>▪ Visits supervised</li> <li>▪ Visitors banned</li> </ul>	If supervision is required: <ul style="list-style-type: none"> <li>▪ By arrangement with ward staff in consultation with Clinical Charge Nurse/shift co-ordinator</li> <li>▪ Responsibility of <i>(name)</i> DHB until CYFS notified</li> <li>▪ Once CYFS notified then responsibility for the child's safety is shared between DHB and CYFS.</li> </ul>
Child admitted to ward, suspected NAI. Notified to CYFS: Perpetrator identified		
Child admitted to ward, suspected NAI. Notified to CYFS: Perpetrator not identified		
Child admitted to ward, under care of CYFS	The Child Protection Plan (CPP) is communicated to the inpatient Team Leader. Visits are in accordance with the plan.	If supervision is required: <ul style="list-style-type: none"> <li>▪ By arrangement with ward staff</li> <li>▪ Responsibility of DHB to ensure visits are supervised</li> <li>▪ Responsibility of CYFS to provide supervision in accordance with CPP</li> <li>▪ DHB should provide supervision in the event that CYFS are unable provide supervisor or the visit should not occur.</li> </ul>

## APPENDIX 6

### LEGAL AND PRIVACY ISSUES

Since the introduction of the Privacy Act (1993) and the Health Information Privacy Code (1994), agencies and individuals have become concerned about how much information can be given to statutory social workers or the Police. Both documents make provision for the disclosure of information necessary to prevent harm to any individual.

As well, all privacy restrictions are over-riden by certain sections of the Children, Young Persons and their Families Act (1989). These provide for the reporting of child abuse, protection of an individual from proceedings when disclosing child abuse to either a statutory social worker or police, and government agency obligations

DHB encourages good communication between DHB staff and CYFS or the police to keep children safe. Requests for information should be referred directly to unit managers, who are responsible for ensuring such requests are dealt with promptly and appropriately. Information must only be released to a CYFS social worker, police officer or care and protection coordinator (s66 CYF Act: see below).

Health workers therefore, are able to give information to the Child, Youth and Family or police Both by reporting abuse or when requested by either agency.

### CHILDREN, YOUNG PERSONS AND THEIR FAMILIES ACT

#### ***S15 Reporting of ill treatment or neglect of child or young person***

Any person who believes that any child or young person has been, or is likely to be, harmed (whether physically, emotionally, or sexually), ill-treated, abused, neglected, or deprived may report the matter to a social worker or a member of the police.

#### ***S16 Protection of person reporting ill treatment or neglect of child or young person***

No civil, criminal, or disciplinary proceedings shall lie against any person in respect of the disclosure or supply, or the manner of the disclosure or supply, by that person pursuant to section 15 of this Act of information concerning a child or young person (whether or not that information also concerns any other person), unless the information was disclosed or supplied in bad faith.

#### ***S66 Government Departments may be required to supply information***

- (1) Every Government Department, agent, or instrument of the Crown and every statutory body shall, when required, supply to every Care and Protection Co-ordinator, CYFS social worker, or member of the police such information as it has in its possession relating to any child or young person where that information is required -
  - (a) For the purposes of determining whether that child or young person is in need of care or protection (other than on the ground specified in section 14 (1)(e) of this Act): or
  - (b) For the purposes of proceedings under this part of this Act.

Section 66 means that where a care and protection coordinator, CYFS social worker or police officer requires information about a child/young person for the purposes of determining whether the child/young person is in need of care and protection, or for proceedings under the CYF Act, DHB staff must provide that information. A staff member may be asked to provide this information in an affidavit. DHB recommends that the staff member seeks the support and advice of the unit manager, DHB's child protection coordinator and/or DHB's legal adviser.

## **PRIVACY ACT**

### ***Principle 11 (f) (ii)***

An agency may disclose information if that agency believes, on reasonable grounds that the disclosure of the information is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another individual

## **HEALTH INFORMATION PRIVACY CODE**

### ***Rule 11 subsection 2 (d) (ii)***

An agency that holds personal information must not disclose the information to a person or body or agency unless – the disclosure of that information is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another individual

## **HEALTH ACT 1956**

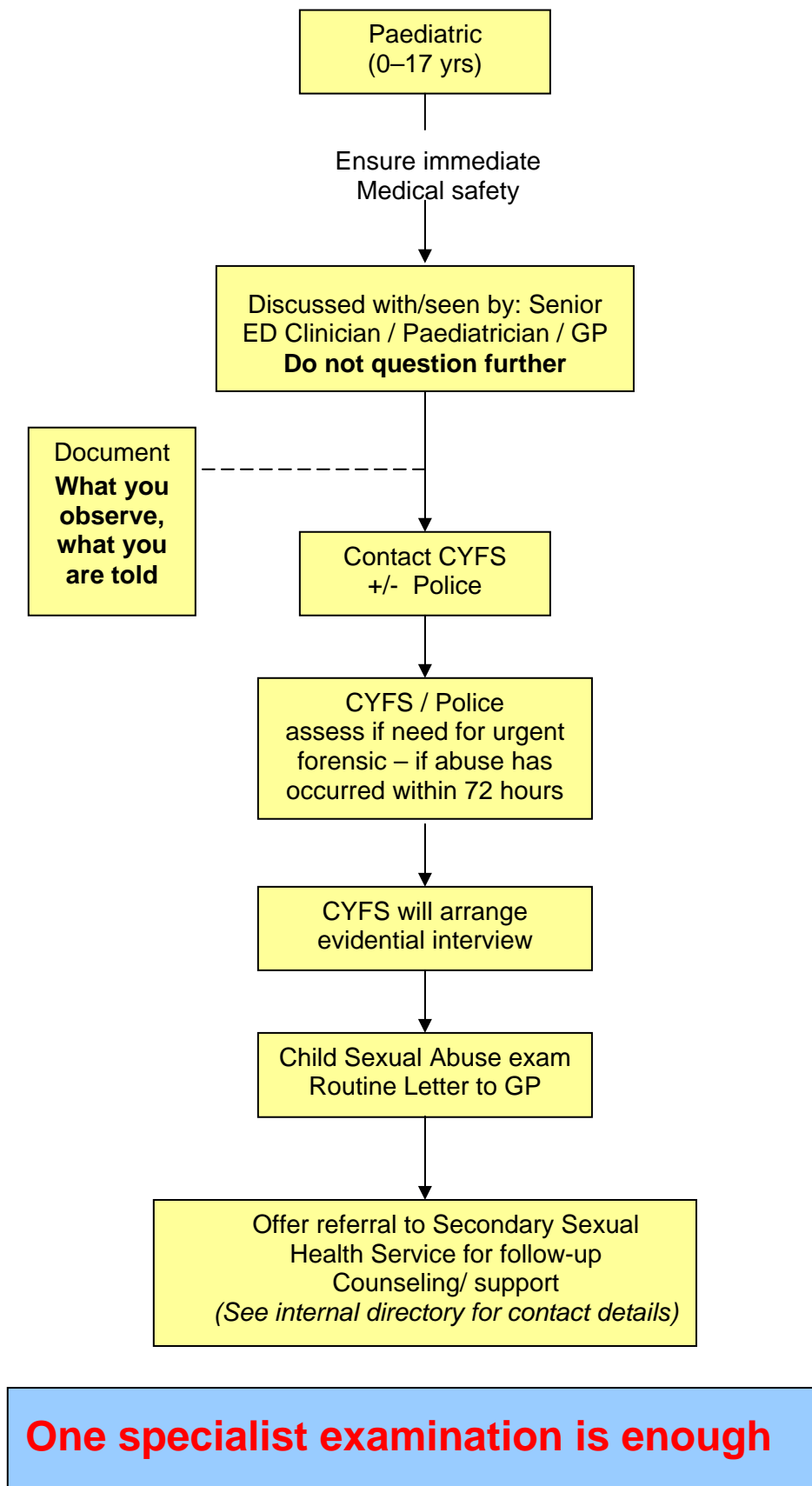
### ***Section 22 (2) (c) Disclosure of health Information***

Any person being an agency, that provides health services or disability services...may disclose health information... to a social worker or a Care and Protection Co-ordinator within the meaning of the Children Young Persons and their Families Act (1989), for the purposes of exercising or performing any of that person's powers under that Act.

Always seek advice prior to release of information (*refer to Privacy policies in the Operational Policy Manual in the first instance and/or the Risk Manager*).

**APPENDIX 7**

**Guideline for responding to Child Sexual Abuse**



## APPENDIX 9

### SAFETY AND SECURITY GUIDELINES

This guideline sets out the Hawkes Bay District Health Board's (DHB) procedures for staff when there is a need to access support to optimise the safety for victims of family violence when the risk to the victim's safety is assessed to be a high risk. These guidelines will provide information to support staff to:

- Ensure persons making public enquiries about the victim are given no details by suppressing all details on the hospital computer
- Use a safe process to discharge the family to an advocacy agency, e.g. women's refuge. This may include informing an inquirer that the patient has left the hospital before this is so and/or denying knowledge of where the patient has gone.

Procedures outlined in this policy should be discussed with the patient/client who is the victim of abuse and their consent obtained.

The safety of the patient is the paramount consideration. If a patient who is a victim of violence expresses fear of the perpetrator or others s/he is likely to be correct. It is defensible in this case for hospital staff to refuse public access to patient details and to facilitate the patient leaving the hospital for a place of safety.

#### **1. Procedure to establish name suppression for victims of abuse in the DHB computer system ensuring persons making public inquires are given no details about the victim.**

- 1.1. The guardian of/or victim of abuse identifies that s/he is concerned that the perpetrator may trace them to the hospital.
- 1.2. The staff discuss with the victim/guardian the potential to place name suppression on the patient's details. The victim/guardian consents to this name suppression being actioned.
- 1.3. The Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse is informed and s/he directs the Unit Receptionist to place the "No details to be released" flag against the patient details on the patient inquiry screen. Only the Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse may direct this action.
- 1.4. The patient's name is replaced with a pseudonym on all patient details boards in the department/ward.
- 1.5. The following staff are informed of this name suppression being actioned:
  - 1.5.1. Duty Manager
  - 1.5.2. Switchboard staff
  - 1.5.3. Security
  - 1.5.4. All relevant staff within the department. This information transfers if the patient is admitted to a ward
- 1.6. This directive against the patient details is valid for the duration of the patient's hospital visit or until appropriate personnel remove the directive.
- 1.7. Complete the name suppression documentation form (available on Nettie under forms and templates)

- 1.8. The Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse responsible for the patient's care and/or Duty Manager will remove the name suppression at discharge or when the patient requests this.

## **2. Procedure for staff to follow when name suppression has been granted.**

When any staff member (including switchboard, clinical staff and volunteers) receives an enquiry about a patient for whom a "No details to be released" flag is active s/he will:

- 2.1 Ask for the caller's name and write this down (if provided).
- 2.2 Inform the caller s/he is unable to provide any information.
- 2.3 Notify the Shift Co-ordinator/ Team Leader/ Clinical Charge Nurse responsible for the patient's care.
- 2.4 Notify security (e.g. if the caller is the suspected perpetrator of an assault and police charges are likely).

## **3. Process used to discharge a victim of abuse in a safe manner from a department or ward setting when there are high-risk safety issues.**

- 3.1. Arrange the discharge plan in consultation with the guardian/ patient and the discharge agency concerned, e.g. ensure the guardian speaks to the agency concerned and that all parties are in agreement with the discharge plan.
- 3.2. Complete the name suppression process as above if appropriate.
- 3.3. Ensure that the following people are informed of the discharge plan process:
  - 3.3.1. Duty Manager
  - 3.3.2. Security +/- The NZ Police (if risk is considered high by department staff and security)
- 3.4. The discharge plan may include the leaving the ED / ward or other department by a safe route, in consultation with security staff.
- 3.5. Document the discharge plan. N.B. Complete an Event Reporting Form if any unexpected outcomes occurred.
- 3.6. Advise the Duty Manager of the discharge outcome.