NEW ZEALAND COLLEGE OF MIDWIVES (INC)

Child Protection Policy Appendices

August 2016

Appendix 1: Definitions

	Definition
Child	A boy or girl under the age of 14 years
Young person	a boy or girl over the age of 14 years but under 17 years
Midwife	A person who has completed the necessary educational requirements, has been admitted into the Register of Midwives and holds a current Annual Practising Certificate
Lead Maternity Carer midwife	A midwife who has been selected by the woman to provide her lead maternity care

Domestic Violence	**Domestic violence**, in relation to any person, means violence against that person by any other person with whom that person is, or has been, in a domestic relationship.
	Violence means—
	• (a) physical abuse
	• (b) sexual abuse
	• (c) psychological abuse, including, but not limited to:-
	  ○ (i) intimidation
	  ○ (ii) harassment
	  ○ (iii) damage to property
	  ○ (iv) threats of physical abuse, sexual abuse, or psychological abuse
	  ○ (v) financial or economic abuse (for example, denying or limiting access to financial resources, or preventing or restricting employment opportunities or access to education)
	
	a person psychologically abuses a child if that person:-
	• (a) causes or allows the child to see or hear the physical, sexual, or psychological abuse of a person with whom the child has a domestic relationship; or
	• (b) puts the child, or allows the child to be put, at real risk of seeing or hearing that abuse occurring
	
	If a person suffers abuse themselves, they are regarded as having caused or allowed the child to see or hear the abuse, or, as the case may be, as having put the child, or allowed the child to be put, at risk of seeing or hearing the abuse.
	
	Domestic violence may be:
	• a single act or
	• a number of acts that form part of a pattern of behaviour, even though some or all of those acts, when viewed in isolation, may appear to be minor or trivial.

Child Abuse	Child abuse may be physical , sexual or psychological / emotional **Physical abuse** Physical abuse is a non-accidental act on a child that results in physical harm. This includes, but is not limited to, beating, hitting, shaking, burning, drowning, suffocating, biting, poisoning or otherwise causing physical harm to a child. Physical abuse also involves the fabrication or inducing of illness. **Sexual abuse** Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities (penetrative and non-penetrative, for example, rape, kissing, touching, masturbation) as well as non-contact acts such as involving children in the looking at or production of sexual images, sexual activities and sexual behaviours. **Psychological / emotional abuse** Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effect on the child's emotional development. This can include a pattern of rejecting, degrading, ignoring, isolating, corrupting, exploiting or terrorising a child. It may also include age or developmentally inappropriate expectations being imposed on children, the negative impact of substance abuse by anyone living in the same residence as the child or young person, or the negative impact of the mental or emotional condition of the parent or caregiver.
Neglect	**Neglect** Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, causing long term serious harm to the child's heath or development. It may also include neglect of a child's basic or emotional needs. 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 2 Legislation and professional frameworks relevant to midwifery practice

The following Acts / frameworks and legislative documents are relevant for midwives in relation to their practice in relation to family violence or vulnerable children.

Document / Act	Relevance
Children Young Persons and their Families Act 1989 http://legislation.govt.nz/act/public/1989/0024/latest/DLM147088.html?src=qs	Defines a Child and Young Person, the Paramountcy Principle and the conditions under which midwives may share information about concerns about a child's well-being without consent
Children, Young Persons, and Their Families (Vulnerable Children) Amendment Act 2014 http://www.legislation.govt.nz/act/public/2014/0041/latest/DLM6110540.html?search=ts_act_children_resel_25_a&p=1	Sets out the requirement for a social worker to assess the suitability of a person who has had a child or children removed from care (or committed murder, manslaughter or infanticide) to care for a subsequent child.
Domestic Violence Act 1995 http://legislation.govt.nz/act/public/1995/0086/latest/DLM371926.html?search=ts_act%40bill%40regulation%40deemedreg_domestic+violence+act_resel_25_a&p=1	Defines Domestic Violence as physical, psychological and sexual. Also defines children witnessing domestic violence as violence against children Defines what is considered a domestic relationship
Crimes (Substituted Section 59) Amendment Act 2007 http://legislation.govt.nz/act/public/1961/0043/latest/DLM328291.html?search=ts_act%40bill%40regulation%40deemedreg_Crimes+act_resel_25_a&p=1	Defines parental control and when a parent or caregiver is justified in using force to prevent or minimise harm to a child
Health information privacy code 1994 https://www.privacy.org.nz/the-privacy-act-and-codes/codes-of-practice/health-information-privacy-code/	Informed consent information sharing is best practice however the Code sets out the reasons why midwives might share information without consent • disclosure of the information is directly related to one of the purposes in connection with which the information was collected • there is a risk of serious harm

Midwifery Council Code of Conduct https://www.midwiferycouncil.health.nz/images/stories/pdf/midwifery%20code%20of%20conduct%20feb%202011.pdf	Sets out requirement for midwives to maintain privacy of health information except "when there is an imminent risk of serious harm or the midwife is required to provide information under law NB: the Privacy Code has been updated since the Council published the Code of Conduct and the word "imminent" has been removed – council will updated its Code to be consistent with the Privacy Code
Standards of Midwifery Practice As set out in the New Zealand College of Midwives Handbook for Practice www.midwife.org.nz	The word "woman/wahine" used throughout includes her baby/ tamaiti, partner, family/whanau – although we are women centered we acknowledge the baby and partner as integral to the woman's well being Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk
Code of ethics As set out in the New Zealand College of Midwives Handbook for Practice www.midwife.org.nz	Midwives hold information in confidence in order to protect the woman's right to privacy. Confidential information should be shared with others only with the informed consent of the woman, unless otherwise permitted by law
Vulnerable Children's Act 2014 http://legislation.govt.nz/act/public/2014/0040/latest/DLM5501618.html?search=ts_act%40bill%40regulation%40deemedreg_vulnerable+Childrens+Act+2014_resel_25_a&p=1	Sets out requirements for worker "safety checking" and development of Child Protection Policies
Sharing personal information of families and vulnerable children – a guide for interdisciplinary groups" https://privacy.org.nz/how-to-comply/sharing-information-about-vulnerable-children/	The Privacy Commissioner's reference document to guide information sharing practice for professionals

Appendix 3 – Identifying and responding to child abuse and neglect

Identification and signs and symptoms

- Following attendance at a family violence education workshop it is recommended that midwives incorporate routine enquiry about the presence of partner abuse into their practice, (including enquiry about the safety of children when partner violence is disclosed).
- As child abuse and neglect (Appendix 1) can occur in the absence of partner abuse midwives need to familiarise themselves with the signs and symptoms of child abuse and neglect.

- Risk factors alone have poor predictive value for child abuse. Children may be experiencing abuse or neglect where no known 'risk factors' are present, and may not be experiencing abuse or neglect in families with multiple 'risk factors'. (Appendix 4).

- If child abuse and neglect concerns are present, it is recommended that midwives ask the woman open ended non-judgemental questions to further assess for possible child abuse or neglect. (Appendix 6). Midwives are not expected to seek information directly from older children about abuse or neglect that they may be experiencing.

Validation and support

- Communication with caregivers or parents about possible or actual child abuse or neglect concerns needs to be sensitive, non-judgemental, and supportive.

    - Midwives are not expected to diagnose abuse, formally assess severity of injuries, or accuse a parent or caregiver of child abuse or neglect. A midwife's role is to identify and document concerns or possible concerns, and refer to specialist services which can carry out a more detailed assessment.
    - Midwives are encouraged to share their concerns about child abuse or neglect with the women who they are working with, discuss who they will be sharing information with and what they will be documenting in order to practice with transparency.
    - It is recognised that in exceptional circumstances midwives may need to share information without women's consent when there is a risk of serious harm or when informing women of the intention to share information may increase the risk to children or cause concerns for the midwife's own personal safety. (Appendix 2).

Health and Risk assessment

- When abuse is disclosed, midwives are advised to undertake a preliminary risk assessment, seeking advice from experienced colleagues and / or specialist services as necessary when concerns about actual or possible abuse or neglect are present.
- Risk assessment should determine the likelihood of recurrence of victimisation, including the seriousness of the abuse.
- When partner abuse is also present, it is important that joint risk assessment (for the woman and children) occurs.
- Risk assessment will occur in the context of the wider family / whanau health and social context as these factors will inform the level of concern and risk.

Intervention / safety planning, referral and follow up

- Risk assessment will inform safety planning and referral pathways. Midwives are encouraged to seek advice from experienced colleagues and / or specialist services when undertaking safety planning and determining referral options.
- Be aware that actions to keep the child safe (such as referral to other services) may increase risks to the woman. Always consider the safety of the mother and her child in any assessment, safety planning and referral. A referral to child protection services may need to be accompanied by a referral to family violence advocacy services for the woman.
- LMC midwives child protection role occurs within a continuity of care model. When a referral to Child Youth and Family is warranted, midwives will use their professional judgement to determine if it is in the woman's and children's best interests for her or a colleague (such as CYFS Liaison Social Worker) to make the referral.
- When a family who a midwife is providing care to a woman who has a previous child or children currently in CYFS care, the midwife should discuss the need for referral to CYFS for the current pregnancy. The Children, Young Persons, and Their Families (Vulnerable Children) Amendment Act 2014 requires a social worker to assess the suitability of a person who has had a child or children removed from care (or has committed specific crimes) to care for a subsequent child.

Appendix 4 Signs of child abuse or neglect (Ministry of Health, 2016)

Physical abuse: injuries that don't make sense

If you're worried about physical abuse, always remember that if in doubt, it is always safer to consult. Seek a second opinion from a more experienced colleague or local paediatrician. Some signs may include the following (Maguire 2010).

 Unexplained head injuries – even an apparently trivial bruise to the head of a baby or young infant with no evident signs of concussion may be reason for concern (Ingham et al 2011; Jenny et al 1999).

 Unexplained bruises, welts, cuts and abrasions – particularly in unusual places (face, ears, neck, back, abdomen, buttocks, inner arms or thighs, back of the leg), clustered, patterned or in unusually large numbers (Labbe and Caouette 2001; Maguire and Mann 2013; Pierce et al 2010).

 Any unexplained bruise or injury in a baby who is not yet independently mobile – especially if they are not yet pulling to stand, crawling or walking (Pierce et al 2009). Fractures in babies are often not clinically obvious, and may present as reluctance to use one limb or to crawl, or with non-specific irritability.

 Unexplained fractures – many children get accidental fractures, but always consider whether the history is consistent with the fracture type. This depends entirely on the quality of the history you take (Flaherty et al 2014; Maguire et al 2013; Pierce 2006).

 Unexplained burns anywhere on the body. Burns may be difficult to interpret, and if you are concerned they should be referred early to a doctor with expertise in burns or child protection (Kemp, Jones et al 2014; Kemp, Maguire et al 2014).

 The child or their parent can't recall how the injuries occurred, or their explanations change or don't make sense. While there may be innocent explanations for this, 'no history of trauma' is a common feature of child abuse (Hettler and Greenes 2003).

Sexual

The signs, symptoms, and history described below are not diagnostic of abuse. However in certain situations, contexts and combinations they will raise the practitioner's suspicion of abuse. It is better to refer on suspicion. If you wait for proof, serious harm can occur.

From: Recommended Referral Processes for GPs: Suspected Child Abuse and Neglect, Ministry of Health, RNZCGPS, NZMA, CYF, 2000.

Behaviour changes after sexual abuse may not be evident and if they do occur they may be highly variable (Kellogg 2010). Concern may exist if there is:

 age-inappropriate sexual play or interest and other unusual behaviour, like sexually explicit drawings, descriptions and talk about sex. However, this does not necessarily indicate sexual abuse, and should be discussed with clinicians experienced in child behaviour or child sexual abuse

 fear of a certain person or place. Children might try to express their fear without saying exactly what they are frightened of, so listen carefully, and take what they say seriously. They may display other behavioural change suggesting emotional disturbance (see below).

However, never jump to conclusions

Emotional abuse

Most forms of abuse, exposure to violence or neglect are accompanied by emotional effects, which may or may not cause behavioural changes. The changes in behaviour noted below are not however specific for the emotional consequences of abuse or neglect.

- **sleep problems** like bed-wetting or soiling – with no medical cause, nightmares and poor sleeping patterns.
- **frequent physical complaints** – real or imagined, such as headaches, nausea and vomiting, and abdominal pains
- **signs of anxiety**
- **other altered behaviour**. Children who are abused may withdraw, present as sad and alone, or consider hurting themselves or ending their lives. Some children may develop conduct disorder, such as oppositional or aggressive behaviour, acting out or deteriorating school performance.

Neglect

Neglect is one of the most common forms of child maltreatment, with serious long-term consequences for children (Stoltenborgh et al 2013), but can be very difficult to define. It is useful to consider (DePanfilis 2006):

- do the conditions or circumstances indicate that a child's basic needs are unmet?
- what harm or risk of harm may have resulted?

These questions cannot be answered without sufficient information. This includes the pattern of caregiving over time, how the child's basic needs are met (or not met) and whether there have already been specific examples when an omission of care has led to harm or the risk of harm (DePanfilis 2006).

Neglect can consist of (Fong and Christian 2012):

- **physical neglect** – not providing the necessities of life, like a warm place enough food and clothing. In babies or young children, this may present as poor growth ('failure to thrive')
- **neglectful supervision** – leaving children home alone, or without someone safe looking after them during the day or night
- **emotional neglect** – not giving children the comfort, attention and love they need through play, talk and everyday affection
- **medical neglect** – the failure to take care of their health needs (Jenny et al 2007)
- **educational neglect** – allowing chronic truancy, failure to enrol children in school or inattention to special education needs.

(Ministry of Health, 2016)

Appendix 5 Identifying the risk of child abuse when partner abuse has been disclosed

The following list of questions offers suggestions for midwives to ask when determining the risk of child abuse or neglect when partner abuse has been disclosed.

- Does the abuser have access to the child / children?
- Has the abuser threatened to hurt the child / children?
- Have the child / children witnessed the abuse (physical or verbal) occurring?
- Has the abuser ever hit the children, touched or spoken to them in a sexual way?
- Have the children tried to intervene when trying to protect the victim from abuse? Were they injured as a result?
- When women are experiencing abuse, it can affect their ability to parent in the way they would if they were free from abuse. Is this true for you?
- Are you afraid you may hurt your children?
- Have you ever hurt your children?
- Do you know what help there is to assist you?

Caregivers of children who have been abused may be reluctant to seek medical care for injuries. There may be a pattern of repeated injuries or lack of information sharing between services – or seeking care from different health care services to avoid pattern of injuries being noticed. The description or history of how the injury occurred may not match the appearance of the injury. It is important to take a good history of what happened.

The following questions offer some suggestions for midwives to consider asking if they are concerned that child abuse or neglect being present,as they have observed injuries or behaviour that may indicate that a child is being abused or neglected **(see Appendix 4)**

- Do you ever fear for your child's safety?
- Have you ever been worried that someone was going to hurt your children?
- Who looks after your children when you aren't?
- That looks like a nasty (bruise / burn / injury / rash). Can you tell me what happened?
- Have you taken (your child) to anyone to get it looked at?

Appendix 6 Referral and follow up

Midwives are expected to be aware of the local referral agencies and pathways, relevant colleagues and resources in their region and have their contact details readily available in order to refer and support children and families as necessary.

National Referral agencies

Name of Agency	Telephone number
CYFS	0508 326 459
Women's Refuge	0800 733 843
Victim Support	0800 842 846
Police	111 in an emergency or local station
SHINE	0508 744 633

Local referral Agencies – ***individual LMC responsible for local agency contact information***

Referral Agency	Contact details
DHB Maternal wellbeing care and protection group	
DHB maternity social worker	
CYFS DHB Liaison social worker	
DHB Child Protection Co-ordinator	
Children's team	
Barnardo's	
Early Start	
Women's Refuge	
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References:

Ministry of Health. (2016). Family Violence Assessment and Intervention Guidelines. from http://www.health.govt.nz/publication/family-violence-intervention-guidelines-child-and-partner-abuse

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DePanfilis D. 2006. *Child neglect: A guide for prevention, assessment and intervention*. URL: www.childwelfare.gov/pubs/usermanuals/neglect/chapterfive.cfm (accessed 15 October 2015).

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