NEW ZEALAND COLLEGE OF MIDWIVES (INC)

New Zealand College of Midwives

Child Protection Policy

August 2016

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1.0 Scope of policy

1.1 This Policy applies to all midwives who are claiming for maternity services provided under the Section 88 Primary Maternity Services Notice and complies with the requirements of the Vulnerable Children's Act 2014.

1.2 This policy will be reviewed every two years.

2.0 Purpose of Policy

2.1 This policy provides guidance for Lead Maternity Carers (LMC) midwives to assist them to identify and respond to child abuse and neglect.

2.2 The policy should be interpreted in the context of LMC midwifery practice, which is women centred, practiced within a continuity of care model, governed by all relevant legal and professional frameworks, community based and integrated with a range of other health and social services.

3.0 Background / context

3.1 The development of a loving relationship with a mother, father and/or a primary caregiver in the first three years of life, is essential for the healthy development and wellbeing of children (Rowley 2015).

3.2 Intimate partner violence is associated with child abuse and neglect with co-occurrence rates estimated between 30 and 60% (Edleson, 1999). Child abuse and neglect can also occur in the absence of intimate partner violence. Midwives need to understand their responsibilities and response to each type of abuse, as they occur, either on their own or concurrently.

3.3 LMC midwives work in a continuity of care model, often within family homes and are well placed to identify and respond to family violence in the course of their practice.

3.4 When women are experiencing intimate partner violence, it may impact on their ability to love and nurture their children. Children living in homes where intimate partner violence is present are likely to be affected by witnessing the abuse, even if they are not being directly abused themselves.

3.5 Vulnerability to child abuse – whether physical, sexual or through neglect – depends in part on a child's age. Fatal cases of physical abuse are found largely among young infants. Shaking is a prevalent form of abuse seen in very young children. The majority of shaken children are less than 9 months old. (Krug & Zwi, 2002).

3.6 Women who are experiencing intimate partner violence are less likely to successfully breastfeed (Cerulli 2010, Lau 2007, Misch 2014). These women may need additional midwifery support to establish and maintain breastfeeding. Breastfeeding has the potential to reduce the risk of infants being abused or neglected as breastfed infants need to be in close proximity to their mothers the majority of the time. Breastfeeding also improves the cognitive development of babies (Kramer et al 2008) and will provide the mother with exposure to hormonal influences which may support her to bond with, care for, nurture and protect her baby.

3.7 Midwives are autonomous registered health professionals who will identify where they need to seek further education, information or advice to enable them to meet their obligations under this policy.

4.0 Related Documents / Acts

Document	Legislation
• New Zealand College of Midwives Handbook for Practice • NZCOM Family Violence Consensus Statement • Midwifery Council Code of Conduct • Midwifery Council Cultural Competence Framework • New Zealand College of Midwives: Safety of midwives resource • New Zealand College of Midwives: Family Violence Screening resource • Family Violence Intervention Guidelines: Child and Partner Abuse. Ministry of Health • Sharing personal information of families and vulnerable children: A guide for interdisciplinary groups. Office of the Privacy Commissioner https://privacy.org.nz/assets/InteractiveEscalationLadder/Escalation-Ladder-FINAL-HiRes.pdf • Code of Health and Disability Services Consumers' Rights	• Health and Disability Commissioner Act 1994 • Children Young Persons and Their Families Act 1989 • Crimes (Substituted Section 59) Amendment Act 2007 • Vulnerable Children's Act 2014 • Privacy Act 1993 • Human Rights Act 1993 • Children, Young Persons, and Their Families (Vulnerable Children) Amendment Act 2014 • Health Practitioners Competency Assurance Act 2003 • Domestic Violence Act 1995 • Care of Children Act 2004

5.0 Principles of the Policy

5.1 When midwifery refers to a woman under this policy this includes her baby / tamaiti. (New Zealand College of Midwives, 2015).

5.2 Midwives recognise the principle of maternal autonomy and that an unborn child doesn't have a legal status until he or she is born.

5.3 The primary means through which midwives support optimum outcome from pregnancy for the woman and her baby is through their professional relationship with the mother, to encourage women's self-determination, engagement in health care and healthy lifestyle behaviour.

5.4 The woman (or mother)/ family's primary role in caring and protecting the child should be supported, valued and maintained whenever possible. However children's safety and wellbeing must have priority in situations where families are unable to ensure the safety of their children, either their newborn or older children.

5.5 LMC Midwives work and practice in relation to family violence, including child abuse and neglect, takes place within a continuity of care model and the broader cultural, health and social context for women. Midwives apply their unique body of knowledge, critical and holistic assessment skills to their practice in relation to child abuse and neglect.

5.6 Children are a Taonga / treasure who represent our future. Each child deserves to be loved and nurtured and to have his or her emotional, physical and psychological needs met.

5.7 Midwives have a responsibility to respond to concerns about actual or possible abuse or neglect in newborns for whom they are caring (within their scope of practice) and also in older children or young people for whom they are not directly providing care but who they may encounter in the course of practice. This will usually require the involvement of other professionals whose scope of practice directly includes the care of these older children or young persons.

5.8 Child protection work is complex and challenging. Midwives are fully accountable for their actions and work collaboratively with other professionals when they identify the need to seek further education, advice or involve other agencies or professionals to ensure the safety and well-being of children.

6.0 Responsibilities

6.1 Midwives take responsibility for their professional development by accessing the necessary ongoing education through either New Zealand College of Midwives (The College) Family Violence workshops or the District Health Boards (DHB) Violence Intervention Programmes (VIP). This education is based on the Ministry of Health Family Violence Assessment and Intervention Guidelines (Ministry of Health, 2016).

6.2 Midwives are considered to be core children's workers under the Vulnerable Children's Act 2014. This requires all practising midwives to be periodically "safety checked". LMC midwives take responsibility for completing the necessary safety checking procedures within the required timeframes, pending the development of a national agency to facilitate this and national resourcing of safety checking requirements.

6.3 The 6 step process set out in the Ministry of Health Family Violence Assessment and Intervention Guideline violence is:

- Identification of signs and symptoms
- Validation and support
- Health and risk assessment
- Intervention/safety planning
- Referral and follow-up
- Documentation

Appendix 3 sets out in more detail examples and responses midwives can consider and implement to identify and support victims and undertake risk assessment and safety planning.

6.4 Intervention / Safety planning

Given the high level of co-occurrence of both child abuse and intimate partner violence, joint safety planning and referral processes need to be implemented when both intimate partner violence and child abuse are identified.

Any concerns about the safety of the children should be discussed with the abused partner, unless you believe that doing so will endanger the child, another person or yourself. If you or your colleagues decide to notify CYF, the abused partner should be informed, unless the same concerns apply.

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. See Appendix 6.

6.5 Referral pathways

Referral response to actual or suspected abuse or neglect will be informed by the midwife's assessment of the risk to the child / children.

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.

Always consider the safety of the woman if you are involving agencies involved in child protection. If the woman is at risk of intimate partner violence, a referral to child protection agency may increase the risks to her. Joint safety planning is necessary. Seek advice from specialist agencies as necessary.

1.	**There are clear concerns that the child is being harmed or,** **there are concerns about immediate safety of children (or the midwife's own) or a high risk of re-victimisation or,** **if there are no concerns about immediate safety but there are significant present concerns about caregivers ability to cope**	Seek advice from a multi disciplinary team or experienced colleagues Consider referral to: ▪ Police ▪ Paediatrician (if injuries are present that need to be assessed) ▪ Child Youth and Family ▪ Health social worker or DHB Child Protection Co-ordinator ▪ Local Children's Team (if these exist in your area)
2.	**When there isn't clear evidence of child abuse or neglect, but it is suspected and you are uncertain what to do**	Seek advice from a multi disciplinary team or experienced colleagues Consider referral to: ▪ Local Children's Team (if these exist in your area) ▪ Child Youth and Family ▪ Health social worker or DHB Child Protection Co-ordinator ▪ DHB Maternity Care, Wellbeing and Child Protection Group ▪ A paediatrician or GP
3.	**If you are concerned about the child's care or parents ability to cope but not about abuse or neglect**	Seek advice from a multi disciplinary team or experienced colleagues Consider referral to: ▪ Social services ▪ Community NGO (such as Barnardos, Early Start) ▪ Other universal health services who midwives handover care to such as Well Child Services, General practice ▪ Whanua ora / iwi providers ▪ Other relevant services such as mental health, drug and alcohol services, parent line, ▪ DHB Maternity Care, Wellbeing and Child Protection Group

6.6 Documentation

- All documentation should be; legible, objective, factual, dated and signed as per all clinical documentation.
- Document in the usual clinical record unless doing so will place the women and / or her baby at risk, in which case keep a separate record that should be kept in secure place as per usual practice for clinical record storage.
- Record the size, appearance, colouration and site of any injuries objectively. Note the stated cause of injuries including when and how they allegedly occurred. Specify what aspects were seen or heard, and which were reported or suspected. Use the caregivers own words as much as possible.
- If documenting concerns or injuries about an older child or young person not in midwives direct care, document in a separate record, noting the child's name and / or parent or caregivers name on the record. Keep the record in a secure place.
- Note the risk assessment and any action taken, referral information offered, referrals made and follow up arranged.
- Always seek the advice of the College Legal Advisor if you are asked to provide information or a copy of your notes to the Police or another agency in relation to a care and protection cases.

7.0 References

Cerulli, C., Chin, N,. Talbot, N., Chaudron, L, (2010) Exploring the Impact of Intimate Partner Violence on Breastfeeding Initiation: Does It Matter? Breastfeeding Medicine Volume 5, Number 5

Edleson, J., L. . (1999). The Overlap Between Child Maltreatment and Woman Battering. *Violence Against Women, 5*(2), 134-154. doi: 10.1177/107780129952003

Klaus, P. (2010) The Impact of Childhood Sexual Abuse on Childbearing and Breastfeeding: The Role of Maternity Caregivers. Breastfeeding Medicine Volume 5, Number 4, 2010

Krug, E., Dahlberg, L., Mercy, J., , & Zwi, A. L., R. (2002). World Health Report on Violence and Health

Kramer, M. S., Aboud, F., Mironova, E., Vanilovich, I., Platt, R. W., Matush, L., Shapiro, S. (2008) Breastfeeding and child cognitive development. Archives of General Psychiatry, 65 (5), 578-584

Lau, Y., Chan, K.S., 2007 Influence of Intimate Partner Violence During Pregnancy and Early Postpartum Depressive Symptoms on Breastfeeding Among Chinese Women in Hong Kong Journal of Midwifery & Women's Health Volume 52, Issue 2, March–April, Pages e15–e20 doi:10.1016/j.jmwh.2006.09.001

Misch, E., Yount, K. (2014) Intimate Partner Violence and Breastfeeding in Africa. Maternal and Child Health J (2014) 18:688–697 DOI 10.1007/s10995-013-1294-x

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

New Zealand College of Midwives. (2015). *Midwives Handbook for Practice* (5th ed.). Christchurch: New Zealand College of Midwives.

Rowley, S. (2015) Wiring the Brain. Brainwave Trust Aotearoa http://www.brainwave.org.nz/wp-content/uploads/wiring_brain1.pdf