Government of **Western Australia**
Child and Adolescent Health Service

Guidelines for Protecting Children 2020

Healthy kids, healthy communities

Compassion | Excellence | Collaboration | Accountability | Equity | Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

The *Guidelines for Protecting Children 2020* provides information on the sensitive topic of child abuse. No one is immune to the emotional impact of responding to children who have been harmed or who are at risk of harm.

If you require support to address issues arising from accessing the Guidelines, it is important you seek assistance and support from your colleagues, manager or contact the Employment Assistance Program available through your employer.

ACKNOWLEDGEMENT OF COUNTRY AND PEOPLE

The Child and Adolescent Health Service acknowledges the Aboriginal people of the many traditional lands and language groups of Western Australia. We acknowledge the wisdom of Aboriginal Elders both past and present and pay respect to Aboriginal communities of today.

Using the term Aboriginal

Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national context and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

Contents

Introduction

Every child has the right to be safe and to live without fear, abuse or violence in their family and community. We have an obligation to ensure children are protected, cared for and given the opportunity to develop to their full potential.

The role of the WA health system (the Department of Health, Health Service Providers and contracted entities) is to promote and protect the health status of the community, of which the safety and wellbeing of children is implicit.

The purpose of the *Guidelines for Protecting Children 2020* is to provide WA health staff with information to appropriately address child abuse concerns they identify through the provision of health services.

All WA health system staff need to be able to manage concerns of child abuse. Child abuse occurs across all cultures, religions, geographical locations and socio-economic communities. All children are at risk of child abuse and at any given time some children who access the WA health system are experiencing child abuse.

The *Guidelines for Protecting Children 2020 (Guidelines)* use the World Health Organisation's[1] definition of child abuse:

> *'All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power'.*[1]

In this document, child abuse is divided into the following categories:

- Physical Abuse
- Sexual Abuse
- Emotional Abuse (including exposure to Family Violence), and
- Neglect (including medical neglect).

Child abuse is a sensitive issue that many health staff find challenging to address in their work role. To date there has not been a methodologically rigorous national study of the prevalence of child abuse and therefore estimates of reported incidence and prevalence vary. However, it is widely recognised that child abuse is common, significantly underreported and has serious long-term consequences. Therefore, it should be expected that child abuse concerns will be identified when working with children, adults and families.

[1]World Health Organization. Child maltreatment [Internet].Geneva: World Health Organization; 2016; cited 2020 May 12]. Available from: https://www.who.int/news-room/fact-sheets/detail/child-maltreatment

From the evidence available, with the exception of child sexual abuse, children are most likely to be abused by parents or caregivers. Child sexual abuse is perpetrated by a wider group of people including parents, other relatives, siblings, friends and others known to a child. Many children experience chronic and multiple types of abuse.[2]

Cumulative harm

Cumulative harm is the outcome of multiple episodes of abuse experienced by a child and refers to the effects of patterns of circumstances and events in a child's life which diminish their sense of safety and wellbeing.

Although each episode of child abuse has an impact on a child, when considered cumulatively, the impact on developmental, social, psychological, relational and educational dimensions of a child's life may be profound, and can have both short and long-term consequences.[3] The more adverse experiences a child has, the higher their risk of long-term issues such as heart disease, cancer, respiratory diseases, mental health issues and addiction in adulthood.

Overarching Principles

The *United Nations Convention on the Rights of the Child* was ratified in Australia in 1990 and emphasises that due to their youth and vulnerability, children need extra protection. Australia formally recognises children have a right to

- protection from exploitation and abuse
- be cared for and have a home
- have a say in decisions that affect them.[4]

These principles underpin the Council of Australian Governments (COAG) endorsed National Framework for Protecting Australia's Children 2009–2020.

Legislation

The Children and Community Services Act 2004 is the key legislation in Western Australia (WA) to confer functions in relation to the provision of social services, the provision of financial and other assistance, and other matters concerning the wellbeing

[2] Who abuses children? Child Family Community Australia Resource Sheet - September 2014; Australian Institute of Family Studies. Available from: https://aifs.gov.au/cfca/publications/who-abuses-children

[3] Victoria. Department of Human Services. Cumulative Harm: A conceptual overview. Best Interests Series. Melbourne: Victorian Government: 2007.

[4] https://humanrights.gov.au/our-work/childrens-rights/about-childrens-rights

of children, other individuals, families and communities.

Under the *Children and Community Services Act 2004*, a child means 'a person who is under 18 years of age, and in the absence of positive evidence as to age, means a person who is apparently under 18 years of age'.

Staff in the WA health system are confronted daily with children and young people who have suffered harm. Harm, under the *Children and Community Services Act 2004*, in relation to a child, includes harm to the child's physical, emotional or psychological development.

When it is suspected that this harm may, or has been, caused by child abuse, this should be reported to the Department of Communities. Given the cumulative nature of harm, it is important to consider current and historical information on a child and the interrelated impacts on their health and other aspects of life in order to determine the best response.

Department of Communities

The Department of Communities (Communities) has the statutory authority under the *Children and Community Services Act 2004* to assess and respond to allegations of harm and take actions when necessary to safeguard or promote a child's wellbeing. Communities have previously been known as the Department of Child Protection (DCP) and the Department of Child Protection and Family Support (CPFS).

Royal Commission into Institutional Responses to Child Sexual Abuse

Whilst abuse more commonly occurs in a child's family or community, children may also be vulnerable to experiencing abuse through institutions/organisations they are involved with. The Royal Commission into Institutional Responses to Child Sexual Abuse (Royal Commission) was established in 2013 by the Australian Government in response to allegations of the sexual abuse of children in institutions over many years. The purpose of the Royal Commission was to:

> *'focus on systemic issues, be informed by an understanding of individual cases, and make findings and recommendations to better protect children against sexual abuse and alleviate the impact of abuse when it occurs.'* (p.7)[5]

[5] Royal Commission into Institutional Responses to Child Sexual Abuse. Final report: Preface and executive summary, December 2017.

The Royal Commission found that sexual abuse of children occurred in almost every type of institution, including health care settings. The final report of the Royal Commission, published in December 2017, consists of 17 volumes with 409 recommendations to reform policy, legislation, administration and institutional structures. The Final Report and its recommendations can be accessed via https://www.childabuseroyalcommission.gov.au/final-report.

Given the number and breadth of the Royal Commission recommendations, implementation is expected to take a number of years. The Department of Health and Health Service Providers are each responsible for implementing recommendations relevant to the WA health system.

As System Manager, the Department of Health is providing the strategic leadership required to support implementation across the WA health system. The Child and Adolescent Health Service (CAHS) are leading the implementation of recommendations at the Health Service Provider level with support from the Statewide Protection of Children Coordination (SPOCC) unit. The Department of Health has partnered with CAHS to support and streamline implementation within other Health Service Providers through sharing resources and processes.

Child Safe Organisations

The Royal Commission found that factors that contributed to the abuse occurring in organisations / institutions, and remaining undetected, included:

- poor professional practices
- inadequate governance structures
- failures to record and report complaints or understand the seriousness of complaints and
- a culture where the best interests of children were not a priority.[6]

It recommended ten standards, which were later incorporated into a National Statement of Principles for Child Safe Organisations, endorsed in 2019 by the Council of Australian Governments, the Prime Minister and state and territory First Ministers. They incorporate the Child Safe Standards as recommended and extend beyond sexual abuse to include other forms of abuse or potential harm to children.

[6] Child Safe Organisations. Child Safe Organisation project. Sydney: Australian Human Rights Commission; 2019a. Available from https://childsafe.humanrights.gov.au/about/child-safe-organisations-project

Figure 1. National Principles for Child Safe Organisations

National Principles for Child Safe Organisations, Australian Human Rights Commission – childsafe.humanrights.gov.au

Implementing the National Principles across sectors and industries throughout Australia, including the WA health system, is a significant but necessary undertaking to create a Child Safe culture which prevents children being abused in Australian institutions and organisations. The National Principles will be implemented across the WA health system in coming years.

Actions recommended throughout the *Guidelines for Protecting Children 2020* align with findings and recommendations from the Royal Commission.

Reporting Responsibilities

All WA health system staff have a professional, ethical and at times legal duty to respond when they believe a child is, has been or is likely to be, abused. Actions and decisions should centre on the child's wellbeing and best interests being paramount.

Under the common law principle: duty of care, all health professionals have an obligation to report a reasonable suspicion of child abuse. This legal principle requires all clinical staff to exercise proper professional care in their duties and responsibilities, as well as to take all reasonable and practical steps to prevent harm.

All doctors, nurses and midwives are legally obliged to comply with the mandatory reporting of child sexual abuse under the *Children and Community Services Act 2004*. The WA health system requires that all Australian Health Professional Regulation Agency (AHPRA) registered doctors (including Visiting Medical Practitioners), nurses and midwives employed in the WA health system in their clinical capacity (whether casual, full time, part-time, permanent or contracted basis, or providing consultancy or sessional services) complete the mandatory reporting of child sexual abuse online eLearning module, that is available through each Health Service Provider.

Information must be reported with Communities and in case of emergency, the WA Police. WA health system staff are unlikely to have all knowledge or access to all information relating to a child. Each piece of information received by Communities allows a more accurate assessment of a child's safety.

Regardless of the nature or level of child abuse concern, WA health system staff should continue to engage and support the parent/carer to understand the likely impact of their actions/inactions on the health, safety and wellbeing of the child and to strengthen their capacity to provide adequate care and protection for that child.

CAHS Child Safety and Protection Policy

The CAHS '**Child Safety and Protection Policy'** outlines requirements to promote the health and wellbeing of children when there are concerns about child abuse. The policy can be found at https://healthpoint.hdwa.health.wa.gov.au/policies/Policies/CAHS/CAHS.PM.ChildProtection.pdf

Managing child abuse concerns

Child abuse concerns are complex and require comprehensive responses beyond recognising and/or reporting child abuse concerns. WA health system staff also need to also fully respond and record concerns to ensure the best interests, safety and wellbeing of children is prioritised.

The Guidelines for Protecting Children 2020 have adopted a new framework to assist WA health system staff to manage child abuse concerns. The 4Rs are:

- **Recognising**
- **Responding**
- **Recording**
- **Reporting**

The 4Rs are typically implemented in the order above. However, given the ongoing nature of working with children and addressing child abuse concerns, any or all of the 4Rs may need to be addressed multiple times in relation to a particular child or children.

Recognising child abuse

Recognising *means you have identified through observations of physical, behavioural and other indicators that you are concerned that a child is being, or has been, abused.*

Content Topics

Co-existence of multiple forms and episodes of abuse

Typically, child abuse is perpetrated by adults who have caring responsibility for the child (parents, carers or guardians), with the exception of child sexual abuse, which is perpetrated by a wider group of people including parents, other relatives, siblings, friends and others known to a child. Most child abuse is not identified based on a single event or indicator and is rarely an isolated incident. Many children are subject to multiple and ongoing forms of abuse and WA health staff should consider this in their assessments and responses, e.g. if a child has been physically abused, they should consider whether the child is also experiencing emotional abuse.

Parental risk factors

Substance misuse, mental health problems and domestic violence are key risk factors for child abuse. There is substantial research documenting the association between these parental behaviours, engagement with child protection services and poor outcomes for children.

Recognising that an increased risk of child abuse is associated with parental/carer risk factors require WA health system staff to be mindful of parental issues when assessing the wellbeing of a child being. It does not mean that all children being raised by parents with one or more of these factors are inevitably being abused.

Parents/carers behaviours

- having difficulty controlling their emotions
- having rapid or extreme mood swings
- being withdrawn, apathetic and emotionally unavailable
- having trouble recognising children's needs and responding to cues
- struggling to set and maintain safe and appropriate boundaries
- making children feel very responsible for their parent's wellbeing
- believing a child is to blame for their problems
- struggling to develop and maintain routines
- struggling to meet their children's physical needs, including hygiene
- not seeking medical or dental care for their children
- struggling to keep their homes clean, buy food and clothes and pay essential household bills.
- engaging in criminal behaviours in order to obtain money to purchase alcohol and other drugs.

Children are at increased risk of

- being born prematurely/with a low birth weight
- developing behaviour problems such as physical aggression by the time they reach school age
- developing mental health difficulties at an early age
- having problems sleeping and be irritable
- have insecure attachment
- have delayed intellectual, emotional, social and psychological development.

Children are more likely to

- take on an emotional and practical caring role for parents and other family members
- put the needs of their family first
- feel constantly worried about their parent or carer's health and wellbeing
- have to cope with frightening situations such as a parent attempting to take their own life or displaying extremely volatile behaviour
- experience social stigma attached to their parent's condition which limits their friendships and social support network.
- experience bullying and social isolation.
- be separated from parents being treated for current mental health problems
- be taken into the care of the CEO of Communities.

Recognising risk for unborn children

As with increased risks associated with parental behaviours, maternal and paternal behaviours may also raise concerns of harm while a child is in utero. The following

table provides indicators of parental attitudes/behaviour and environments that could prompt consideration of possible, or risk, of harm to the unborn child. This list is not definitive, and an unborn child may be harmed without any of these risk factors being present. Additionally, a child born to parents with numerous risk factors may not be abused. However, as the number of risk factors increase so too may the level of concern held by health staff for the unborn child.

Indicators of risk to unborn or newborn child

Parental attitude/ behaviour towards unborn baby	Parenting History	Family, environmental and medical
• Unwanted/concealed pregnancy • Lack of awareness of baby's needs • Unattached to unborn baby • Unrealistic expectations • Inappropriate parenting plans • Different/ abnormal perceptions of the baby • Inability to prioritise baby's needs • Poor/nil antenatal care.	• Negative childhood experience • Childhood abuse • Denial of past abuse • Multiple carers • Substance abuse • Family and Domestic Violence • Abuse of previous children • Very young parent(s) • Mental health issues • Learning difficulties • Physical disabilities • Ill health • Unable/unwilling to work with professionals • Postnatal depression.	• Family and Domestic Violence • Unsupportive partner • Isolation • High mobility/transience • No or little commitment to parenting • Relationship difficulties • Multiple relationships • Lack of community support • Poor engagement with professional services • Premature births • Baby has extra care needs.

Indicators of child abuse

Tables 1 - 4 contain definitions and indicators relating to each category of child abuse to support the recognition of child abuse by health staff. The indicators included in the tables are not exhaustive. Indicators can be subtle and need to be considered in the context of the child's age, development and situation. Staff need to use their professional judgement when looking at indicators of child abuse. Staff may have concerns that a child is being abused and not have any of these indicators present.

Table 1. Physical abuse - also be referred to as Inflicted injury or Non Accidental Injury (NAI)	
Definition	**Possible harm experienced by child**
Physical abuse occurs when a child is severely and/or persistently hurt or injured through behaviours including, but not limited to, beating, shaking, excessive discipline or physical punishment, inappropriate administration of alcohol or drugs, attempted suffocation.	The physical harm that a child may experience as a result of physical abuse can include, but is not limited to, injuries such as cuts, bruises, burns, bites and fractures.

Indicators of physical abuse (include, but are not limited to)		
Physical Indicators in child	**Child's behaviour**	**Parent/Carer behaviour**
• Any injury/bruising in pre-mobile infants • Unexplained bruising to the cheeks, ears, neck, buttocks or genitals • Imprint bruises (showing the shape of an object or hand) • Imprint burns that show the shape of the object including cigarette burns • Immersion burns • Retinal haemorrhages • Ingestion of substances including alcohol, drugs or poisonous substances • Bite marks • Fractured bones in children under the age of two years • Injuries of different ages • Evidence of female circumcision/cutting.	• Drowsiness, lethargy or seizures in small babies (that may indicate a head injury) • Appears fearful in the presence of the parent/carer • Shows little or no emotion when hurt • Overly compliant during medical examination • Becomes startled when an adult makes a sudden movement • Moves or holds body in a way that indicates physical discomfort • Arms and legs are covered by clothing in hot weather • Frequent absences from school.	• Unable to provide any history for injury • Provides an explanation that is not consistent with the child's injury • Appears unconcerned or minimises the child's injury or medical condition • Attempts to conceal child's injury • Non-attendance or avoids medical appointments • Delay in bringing the child to hospital with an injury that requires medical attention.

Tattooing or branding

Under the *Children and Community Services Act 2004* it is an offence to tattoo or brand any part of the body of a child who has not reached 16 years of age (other than for medical or therapeutic services.)

A child aged over 16 years may be tattooed or branded with written consent of the parent to tattoo or brand a child, naming the manner of tattooing or branding, and the part of the child's body the branding can occur.

There is additional information about skin penetration procedures and the law at: https://ww2.health.wa.gov.au/Articles/S_T/Skin-penetration-procedures-and-the-law

Table 2. Sexual abuse	
Definition (reminder, a child is anyone aged under 18)	**Possible harm experienced by child**
Sexual abuse occurs when a child has been exposed or subjected to sexual behaviours that are exploitative and/or inappropriate to their age and developmental level and that the child does not comprehend or to which she/he is not able to give informed consent. It includes behaviours where: • the child is subject to bribery, coercion, threats, exploitation or violence; or • the child has less power than the other person involved in the behaviour; or • there is a significant disparity in the developmental function or maturity of the child and other person involved in the behaviour.	Harm that may result from sexual abuse may include significant emotional trauma, physical injury, infections and impaired emotional, social and sexual development.

Indicators of sexual abuse (include, but are not limited to)		
Physical Indicators	**Child's behaviour**	**Parent/Carer behaviour**
• Sexually transmissible infections • Unexplained bruising or injury to the breasts, genital area or thigh • Bleeding from genital area (not related to menstruation) • Complaining of pain to genital area • Neglecting bodily hygiene • Pregnancy. **There may also be no physical injuries or indicators present. This does not mean that sexual abuse has not occurred.**	• Disclosure of sexual abuse • Displaying a degree of sexual knowledge (through talk/actions/drawings) above an age appropriate level • Lack of appropriate boundaries when physically interacting with other children and/or adults • Engaging in harmful sexual behaviours • Regression in development, such as loss of toileting control previously gained by younger children • Wearing oversized clothes or several layers of clothing that conceal the body (in warm weather) • Contact with a known child sex offender.	• Exposing a child to pornography • Intentional exposure of a child to sexual behaviours or activities of others • Coercing a child to engage in sexual behaviour • Parental prostitution in the home.

Table 3. Emotional abuse (including family violence - see further information on next page)	
Definition	**Possible harm experienced by the child**
Emotional abuse occurs when an adult harms a child's development by repeatedly treating and speaking to a child in ways that damage the child's ability to feel and express their feelings. Examples include threatening, isolating, withholding of emotional nurturance and closeness, discrediting, belittling, teasing, humiliating, bullying, confusing, ignoring and inappropriate encouragement. Emotional abuse also includes being exposed to family violence.	• Lack of emotional nurturance • Significant emotional trauma • Bullying • Humiliating or shaming • Belittling • Exposure to the child to family violence.

Indicators of emotional abuse (include but are not limited to)		
Physical Indicators	**Child's behaviour**	**Parent/Carer behaviour**
• Unexplained delays in speech development and/or speech disorders • Unexplained delays in physical development • Failure to thrive • Disordered eating • Abnormal weight gain.	• Repetitive and compulsive behaviours in attempts to self-soothe, e.g. rocking, sucking, head-banging • Flat and superficial way of relating, lacking a sense of genuine interaction • Lowered capacity to engage appropriately with others • Expressions of deep loneliness, anxiety and/or despair • Bullying, disruptive or aggressive behaviours towards peers • Displaying a lack of connectedness or empathy experiences of self or others • Self-harming and/or self-destructive behaviours, e.g. cutting, physical aggression, reckless behaviour showing a disregard for self and safety, drug taking. • Withdrawn/disassociation • Depressed, suicidal ideation.	• Unrealistic expectations of the child • Persistent hostility towards the child • Belief that the child is 'bad' • Expressing resentment towards the child's dependency on them • Prioritising their own needs above the need to parent their child adequately • Scapegoating one or more children and actively demonstrating favouritism to other children.

Family and domestic violence

The Restraining Orders Act 1997 (WA) Section 5A(1) defines Family and Domestic Violence (FDV) as '*violent, threatening or other behaviour by a person towards a family member that coerces or controls the family member or causes the family member to be fearful.'*

Impacts of FDV on children

Under the *Restraining Orders Act 1997* s6A(1): *'A child is exposed to family violence or personal violence if the child sees or hears the violence or otherwise experiences the effects of the violence.'* [7] Examples of a child's exposure to FDV include:

- overhearing threats of death or personal injury to a person
- seeing or hearing an assault of a person
- comforting or assisting a person who has been assaulted
- cleaning up after property damage
- being present when police or ambulance officers attend an incident involving violence.

Even if children are not physically harmed by FDV, emotional harm results from exposure to family violence. 'Infants, children and adolescents experience serious negative psychological, emotional, social and developmental impacts to their wellbeing from the ongoing traumatic experiences of domestic violence' (Sety, 2011).

FDV often commences or intensifies during pregnancy and impacts unborn children. It is associated with increased rates of miscarriage, low birth weight, premature birth, foetal injury and foetal death.

Table 4 contains information from the *Clinical Practice Guideline: Responding to Family and Domestic Violence.*[8] This table demonstrates some of the indicators that clinicians might see in children living in households where there is FDV.

[9] *Restraining Orders Act (WA) 1997*. pt1 s6A(2). Referred to in the *Children and Community Services Act 2004*.pt1 s3.
[8] North Metropolitan Health Service, Women and Newborn Health Service. Clinical practice guideline: Responding to family and domestic Violence; 2020.

Table 4. Indicators of family and domestic violence

Stage of development	Impacts of family and domestic violence
Infants	Infants living in a home where there is FDV may: • have disturbed sleeping and eating patterns • show continuous and distressed crying • have disruption to healthy feeding and sleeping routines • show early signs of maternal deprivation if the mother is too traumatised to respond effectively to her baby's needs • be underweight • have delayed mobility • be very demanding or alternatively very passive • acquire physical injuries from being held in a mother's arms while the mother is being assaulted • show increased separation anxiety from their mother • demonstrate a high level of aggression towards other infants.
Pre-schoolers	Pre-school aged children living in a home where there is FDV may: • display difficulty in playing alongside others without exerting control over the game or other children. This is often done aggressively by hitting, biting, screaming or hair pulling • exhibit distrust of any new adult, and show reluctance to participate in ordinary social experiences • not relate to the activities or interests of their age group • show hypervigilance for conflict and may cower at raised voices • exhibit frequent illness, severe shyness and low self-esteem • experience adjustment problems, e.g. when moving from kindergarten to school • boys tend to demonstrate aggressive behaviour more than girls • girls tend to internalise their stress by becoming clinging, anxious, withdrawn, passive and overly compliant.
Primary School age	Primary school aged children living in a home where there is FDV may: • see violence as acceptable to gain control over a situation • be more likely to be able to express their fears and anxieties regarding the violence occurring however, may lack the trust in others to do so safely • have problems with schoolwork, difficulty concentrating and lowered performance in class • display bullying behaviour and poor social skills • display depression, withdrawal and anxiety in new situations • avoid peer relations • self-harm.
Adolescents	Young people living in a home where there is FDV may: • see violence as an acceptable and usual part of relationships which can increase in aggressive behaviour including assaulting their family members (mimicking the perpetrator's behaviour) • experience depression, anxiety • be at higher risk of being homeless (running away from home to avoid conflict) • experience substance abuse • seek solace in a relationship outside the family; maybe abusive • not finish their 12 years of education.

Adolescent intimate partner violence

Children are most likely to experience Family and Domestic Violence (FDV) within family relationships. However, if adolescents begin dating and engaging in sexual relationships, they may experience FDV in these relationships, known in these circumstances as intimate partner violence, (IPV). Some adolescents can simultaneously experience FDV in their home and IPV within a relationship. IPV can go unnoticed as adolescents may be reluctant to disclose abuse and/or even the existence of the relationship or minimised as relationships involving adolescents may be viewed as less significant than adult intimate partner relationships. The level and impact of the abuse on the victim may be poorly recognised and understood.

Only recently has research evidence begun to emerge on adolescent IPV. However, it highlights that the majority of victims of FDV sexual assault are females less than 19 years of age with the perpetrator an intimate partner in 26 to 53 per cent of cases.[9]

As with FDV in the home, IPV involves the physical, sexual and emotionally abusive behaviours, including verbal, physical and sexual aggression and violence, and coercive and controlling behaviours such as:

- reproductive coercion (e.g. condom refusal)
- stalking and monitoring
- digital dating abuse (e.g. using technology to harass, monitor, control, pressure or coerce)
- imaged-based abuse (e.g. threatening to distribute intimate photos)
- coercion through threats of disclosure e.g. threats to disclose a sexual relationship to parents/caregivers or 'out' partner if in a LGBTQI+ relationship.
- economic abuse.

[9] Australian Bureau of Statistics. Recorded crime—victims, Australia.(No. 4510.0). Canberra. 2018b.

Table 5. Neglect (including medical neglect - see further information on next page)	
Definition	**Possible harm experienced by child**
Neglect occurs when a child does not receive adequate food or shelter, medical treatment, supervision, care or nurturance to such an extent that their development is damaged or they are injured. Neglect may be acute, episodic or chronic.	• Slow growth • Persistent hunger • Frequent illness • Inadequate or hazardous shelter • Poor standards of hygiene • Injuries from a lack of supervision.

Indicators of neglect (include, but are not limited to)		
Physical Indicators	**Child's behaviour**	**Parent/Carer behaviour**
• Non-organic failure to thrive • Delay in achieving developmental milestones • Loss of hair bloom/poor hair texture • Persistent skin and/or ear infections • Poor standard of hygiene including unwashed body/clothes/teeth not cleaned, inappropriate clothing for age/weather/social conditions • Untreated dental caries/severe tooth decay • Obesity.	• Self-comforting behaviours e.g. rocking, thumb-sucking, head-banging • Flat and superficial way of relating, lacking a sense of genuine interaction • Expressions of deep loneliness, anxiety and/or despair • Scavenging for, or stealing food • Sporadic school attendance • Developmentally inappropriate over-dependence on self to fulfil parental responsibilities, such as caring for self, siblings and household.	• Delay in seeking treatment for injury or illness to child without adequate explanation • Known history of significant postnatal depression of mother • Itinerant lifestyle • Depriving or withholding physical contact or stimulation.

Medical neglect

Medical neglect includes:

- failure to seek medical attention for apparent signs of serious illness
- failure to follow health professional instructions once medical advice has been sought.

Medical neglect can lead to serious disability or death

Medical neglect may occur for a variety of reasons and requires health staff to undertake a comprehensive assessment of the child's needs, parent/carers' resources and efforts to provide medical care for the child.

The following factors are necessary for a diagnosis of medical neglect:

- the child is harmed or is at risk of harm because of a lack of health care
- recommended health care offers a significant benefit to the child
- the benefit of treatment outweighs morbidity so that a reasonable carer would choose treatment over non-treatment
- access to health care is available, and
- the carer understands the medical advice.

It is important to recognise the impact of the neglect on the child, both short- and long-term effects. For example, a child that has hearing loss and not being brought to health appointments or adhering to the treatment plan. The short-term impact of hearing loss is that their speech and language development might be affected. Without intervention, this can impact their ability to communicate with peers, form friendships and impact their learning and education outcomes.

Child obesity as a medical neglect issue

Management of obesity in childhood is complex and requires a sensitive response involving a multidisciplinary health professional team and parent/carer engagement. However, a concern of medical neglect may arise if parents are unwilling to engage in or unable to adhere to the agreed strategies to support weight loss for their morbidly obese child.

Professional judgement is required to determine balance of immediate and longer-term risks which indicate that a child's best interests are served by notifying Communities of the concerns. Factors to consider include:

- the child is morbidly obese and continues to gain weight despite intensive contact with health services
- the child has or is at risk of developing obesity-related complications
- other professionals have concerns about whether the parent/carer has consistently acted in the child's best interests

- observed behaviours in a parent/carer that actively promotes treatment failure
- parent/carer is unable or unwilling to support the treatment program or blames the child for obesity or treatment failure
- presence of indicators of neglect or emotional abuse such as poor school attendance, family violence, poor hygiene.

Consultations with the Perth Children's Hospital Child Protection Unit (CPU) and Healthy Weight Management Service, both located at Perth Children's Hospital, are available to provide support for decisions and processes.

Table 6. Medical Child Abuse		
Definition	**Possible harm**	
'Child receiving unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker.'[10] Medical child abuse has been previously referred to as Fabricated or Induced Illness or 'Munchausen syndrome by proxy', wherein parents or carers exaggerate, invent or induce symptoms in their children and seek unnecessary medical care for them'.[11] The term medical child abuse gives greater congruence with definitions of other forms of abuse by focusing on the harm to the child rather than the motivation of the caretaker.	Medical child abuse often results in the child being harmed through unnecessary investigations and treatment and emotional trauma from falsely being told that they are ill or unwell.	
Indicators of Medical Child Abuse (may include)		
Physical Indicators in child	**Child's presentation**	**Parent/Carer behaviour**
• Reported symptoms which do not correlate with any recognisable disease or with the child's disease • Signs which do not correlate with any disease • Signs which do not correlate with reported symptoms • Investigations which do not correlate with signs • Treatment for an agreed condition which does not produce the expected effect	• History of unexplained illnesses, deaths, multiple surgeries in parents or siblings • Limitation in daily life and the adoption of a 'sick role' or lifestyle as a disabled person • Characterisation as being disabled, through the receipt of disability benefits or special educational provision • The child becomes anxious about their state of health • Repeated presentations to a variety of doctors and with multiple issues	• In over 90% of cases, the child's mother is involved • Medical child abuse needs to be distinguished from excessive, genuine parental anxiety and from major parental psychiatric illness (e.g. parent with delusions of child's health) • Often, they are the only person to witness the onset of the child's symptoms • They often have detailed and extensive knowledge on the medical condition and may also claim a medical or nursing background • They often form close relationships with hospital staff • They may have a history of exaggeration, fabrication of induction or symptoms in themselves

[10] Jenny, C., Metz J., (2020) Medical Child Abuse and Medical Neglect *Pediatrics in Review 2020;41;49*
[11] Ibid

What to do if you suspect medical child abuse?

Do not confront the parent or carer if you are concerned that a parent or carer may be exposing a child to unnecessary investigations or treatments through the fabrication or induction of illness.

Confronting the parent or carer can significantly increase the risk of further harm to the child. Parents do not necessarily stop their behaviour towards the child when under suspicion or when medical child abuse is identified, but may:

- change health providers
- deny all or part of what they have done, despite overwhelming evidence
- accuse or shift blame onto those who are aware of their behaviour.

The staff member should:

- document the concerns they have and why they believe the presentation could be fabricated or induced illness by a parent or carer.
- consult with your manager to decide on the appropriate response. This may include consulting with the Perth Children's Hospital Child Protection Unit (CPU) and/or reporting your concerns to Communities.

Recognising harmful sexual behaviours in children

WA health system staff working with children generally have a sound knowledge of child development, including sexual development. Sexual development is a normal part of a child's development. Harmful sexual behaviours in children (under 18 years) includes behaviours that fall across a spectrum of sexual behaviour which is problematic to the child's development, as well as those that are coercive, sexually aggressive and predatory towards others (see figure 5 below for behaviours).

The term 'harmful sexual behaviours' recognises the seriousness of these behaviours and the significant impact on victims. However, research supports not labelling children who exhibit harmful sexual behaviours towards another child or person should as 'perpetrators' or 'offenders'[12] as is used in the adult context. The large majority of children who exhibit harmful sexual behaviours do not go on to become sexual offenders as adults when they receive appropriate treatment and therapeutic support[13].

There are several frameworks available to assist workers in recognising sexual behaviours in children that are normal and also behaviours that can be assessed as problematic and harmful. Figure 5 has been adapted from the National Society for the Prevention of Cruelty to Children (NSPCC) in the UK (with their permission) to assist with recognising which sexual behaviours are normal and which are problematic or harmful.

[12] Caldwell, M.F. (2010). Study characteristics and recidivism base rates in juvenile sex offender recidivism. International Journal of Offender Therapy and Comparative Criminology. 54: 197-212.

[13] Centre of expertise on child sexual abuse, Key Messages, https://www.csacentre.org.uk/resources/key-messages/harmful-sexual-behaviour/

Figure 5. Responding to children who display sexualised behaviour

This chart has been adapted and used with the permission of the National Society for the Prevention of Cruelty to Children (NSPCC UK)

It's important to be able to distinguish normal sexual behaviours from those that may be inappropriate, problematic or harmful, to ensure the appropriate support is provided to a child. This guide identifies the level of concern arising from different sexualised behaviour in a child and the appropriate response.

Normal

- Developmentally expected and socially acceptable behaviours
- Consensual, mutual and reciprocal
- Decision making is shared.

Inappropriate

- Single instances of developmentally inappropriate sexual behaviour
- Behaviour that is socially acceptable within a peer group
- Generally consensual and reciprocal
- May involve an inappropriate context for behaviour that could be considered normal.

Problematic

- Developmentally unusual and socially unexpected behaviour
- May be compulsive
- Consent may be unclear and the behaviour may not be reciprocal
- May involve an imbalance of power
- Doesn't have an overt element of victimisation.

Abusive

- Intrusive behaviour
- May involve a misuse of power
- May have an element of victimisation
- May use coercion and force
- May include elements of expressive violence
- Informed consent has not been given (or the victim was not able to consent freely).

Violent

- Physically violent sexual abuse
- Highly intrusive
- May involve instrumental violence which is physiologically and/or sexually arousing to the perpetrator
- May involve sadism.

How to respond

- Although green behaviours are not concerning, they still require a response
- Listen to what children and young people have to say and respond calmly and non-judgementally
- Talk to parents about developmentally typical sexualised behaviours
- Explain how parents can positively reinforce messages about appropriate sexual behaviour and act to keep their children safe from abuse
- Make sure young people know how to behave responsibly and safely.

How to respond

- Amber behaviours should not be ignored
- Listen to what children and young people have to say and respond calmly and non-judgementally
- Follow your organisation's child protection procedures and make a report to Department of Communities if required.
- Consider whether the child or young person needs therapeutic support and make referrals as appropriate.

How to respond

- Red behaviours indicate a need for immediate intervention and action
- If a child is in immediate danger, call the police on 000
- Follow your organisation's child protection procedures and make a report to Department of Communities
- Refer the child or young person for therapeutic support.

For further information and consultation on responding to children who display sexualised behaviour, please speak with your manager. Alternatively, consult with the Perth Children's Hospital Child Protection Unit (T 6456 4300 or emailing CPUDuty.PCH@health.wa.gov.au) . There is a duty Social Worker available 8:30am to 5.00pm Monday - Friday. You can also contact your local Department of Communities office.

Online safety

Behaviour considered unacceptable offline should not be tolerated or enabled within an online environment. Inappropriate online behaviour includes bullying, aggression, image-based abuse, and attempts or exposure of children to inappropriate content (e.g. pornography, violent material).

WA health system staff who recognise inappropriate online behaviour or receive information about online activity that may cause harm to a child should, in addition to any decision to report the behaviour to Communities, encourage making a complaint to the eSafety Commissioner. This can be lodged anonymously if required. The eSafety Commissioner is empowered by the *Enhancing Online Safety Act, 2015* to respond to complaints, conduct investigations and prosecute illegal behaviour. The eSafety Commissioner deals with reports associated with cyber-bullying, image-based abuse (sharing intimate images without consent) and offensive and illegal online content. The eSafety Commissioner's webpage provides information and advice on issues such as sexting, grooming and other forms of inappropriate online content and conduct.

The WA Police can also provide support in addressing eSafety issues when a criminal offence has occurred. The WA Police Force website provides information about the law, responding to, and reporting eSafety issues.

Expectations around appropriate online behaviour for children, parents/carers, staff and visitors should be promoted to all users of online environments in WA health system facilities. If the inappropriate online behaviour involves WA health system staff or information technology systems used to access inappropriate content, the behaviour must be reported following the Health Service Provider's reportable conduct policies.

Mature minor

There is no specific age that of itself determines if a child (someone under 18) is a mature minor.[14] A mature minor is a child (i.e. under 18 years) who is assessed by a professional as being capable of making decisions about their care.

In a healthcare context, children may be considered competent to make decisions about their medical care when they have sufficient maturity and cognitive competence to fully understand a proposed course of action and its consequences. A child who is assessed as mature in relation to one proposed health care decision

[14] WA Health Consent to Treatment Policy. WA Department of Health; 2016.

may not be assessed as a mature minor in relation to another health care decision. Examples of decisions by mature minors include matters such as confidentiality and disclosure and consent to treatment.

Points to consider when assessing a child as a mature minor

This information is from the 'Working with youth: a legal resource for community based health workers'.[15]

- Age of the child.
- Nature of the clinical or other problem.
- Ability of the child to explain the clinical or other problem by providing an appropriate history.
- Nature and purpose of the proposed health care or other action.
- Ability of the child to understand the gravity and complexity of the proposed health care or other action.
- Ability of the child to understand and rationalise health care or other relevant options.
- Consequences of the proposed health care (including side-effects of proposed treatment) or other action.
- Ability of the child to understand fully the nature, consequences, risks and implications of the proposed health care or other action and of non-action.
- Emotional impact on the child of either accepting or rejecting the proposed health care or other action.
- Child's general maturity of expression.
- Child's level of functioning in other aspects of his or her life.
- Child's level of schooling.
- Child's level of independence from parental care.
- Any moral and family issues involved.
- Health worker's prior knowledge of the child.
- Reason the child came to see the health worker about the clinical or other problem without parental involvement.
- Whether the child is acting freely in attending the health worker and making his or her decision.

The above list is provided for general guidance only, is not exhaustive and will not apply to every circumstance. Other factors may need to be considered in individual circumstances. Health workers must assess each child's circumstance on a case-by-case basis.

[15] Department of Health Western Australia. Working with Youth – A legal resource for community-based health workers. Perth: Department of Health Western Australia; 2007. (Revised 2013.)

Responding to child abuse concerns

Responding refers to how you react to a concern of child abuse. This includes what you say, who you say it to and any decisions or action you take.

Content Topics

The appropriate response to a child abuse concern depends on the nature and level of concern you have. In order to promote and protect the health, safety and wellbeing of a child, it’s vital that sufficient information is gathered to determine the appropriate response.

General Dos and Don’ts of Responding

- You do need to undertake a response if you have concerns about child abuse and neglect.
- You do need to liaise with internal and external staff.
- If you receive a disclosure of abuse, you do need to respond from the premise that the disclosure of the abuse is true.
- You do need to follow up your response with appropriate reporting and recording (see Section 3 and 4 for further information)
- You do not need to have proof or evidence of your concerns (though sometimes you may have medical or other evidence).
- You do not need to determine innocence or guilt of possible perpetrators of child abuse or neglect.

Disclosures of child abuse

In order for children to be safe within the WA health system staff need to actively listen and respond appropriately to children's concerns. This is especially important when a child is disclosing, or attempting to disclose, they have been abused.

The manner in which a staff member responds to a disclosure of abuse will have significant impact on the child's ability to process the abuse in the short, medium and long term. It provides the opportunity for immediate support and comfort and to identify actions required to protect the child from further abuse. Additionally, an appropriate response, particularly from the first person the child discloses to, is more likely to result in the child's preparedness to participate in further discussions, including telling their story to statutory agencies (Communities/WA Police Force).

Children may disclose abuse at any time. A child may disclose while the abuse is happening when this is ongoing, immediately after it has ended or many years later. A disclosure of abuse from a child is rarely straightforward and overt and is more commonly indirect or seemingly accidental. WA health system staff need to be alert to attempts to disclose abuse via more subtle methods including changes in behaviour, vague statements (e.g. "something happened" or being shown a story or a picture by a child. A child might not be comfortable speaking about what happened to them or may not have the words to describe what happened. They may provide clues about what happened as a test to see how the staff member is likely to respond to a more direct disclosure of abuse.

Barriers for a child making a disclosure of abuse

Children face a number of barriers to disclosing abuse. These can lead to delays in a child disclosing abuse. Barriers include (but are not limited to):

- feeling ashamed and embarrassed
- not understanding that what is happening to them is child abuse
- believing it is their fault that they were abused (which may have been reinforced by the person perpetrating the abuse)
- be fearful of not being believed
- fear of what will happen to them, family, friends, pets or the perpetrator (particularly when the perpetrator is a family member or close friend).

How to respond to a disclosure of abuse from a child

If a child discloses abuse to you, respond calmly and with age appropriate language, tell them:

- you believe them
- they did the right thing in telling you
- it is not their fault
- to use their own words and take the time they need
- you cannot keep this information to yourself
- what will happen next, including who you will speak to
- you will be honest with them, and that includes not keeping secrets or making promises you cannot keep.

Key messages that a child needs to hear

- That they are believed
- What happened is not their fault
- They did the right thing disclosing the abuse
- What is going to happen next. Explain this will almost always involve others, as this is what is going to be needed to keep them safe.

Professional Boundaries

Professional boundaries must be central to your approach when you are working with children who have experienced, or who are experiencing abuse. The involvement with, and consideration of the family and/or their carers may present you with professional dilemmas and challenges in maintaining appropriate professional boundaries. It is important to know your professional and personal support systems and access them as required.

Despite your possible distress to a child or young person's abusive experience, it is important your care, response, treatment and support remain within the parameters of your professional boundaries and responsibilities. Expressions of anger, pity and outrage have no place in the provision of professional health care to the victims and possible perpetrators of child abuse.

What difference does the response of the WA health system staff member make to a child who discloses abuse?

Consider the difference a WA health system staff member can make to a child's journey of disclosure and healing from abuse by comparing the likely impact of the following responses to a child who tells you they have been abused:

✓ **Response type 1:** "Thank you for telling me." "I believe you." "I didn't quite understand what you just said, tell me more about that." "You are not to blame." "I know you said you don't want me to tell anyone, but I need to and I will tell you who I am going to talk to." "Do you have any questions about what I'm going to do?" "I'm sorry that happened." "You did not deserve that abuse."

X **Response type 2:** "Why are you telling me?" "Are you lying again?" "(Alleged perpetrator) would never do that." "I'm too busy to talk to you, tell me about it later." "I don't understand what you are telling me, speak up." "Don't use dirty words." "You probably deserved it." "What were you wearing?" "Were you drunk?" "If you are so worried about (alleged perpetrator) then you shouldn't have been alone with them." "I'm sure the (alleged perpetrator) was only trying to help you." "I'm going to speak to (alleged perpetrator) and see what they have to say about this." "I promise you will be safe now," (you cannot guarantee this).

Responding to Parents/Carers

It is important to communicate clearly and openly with parent/carers when collecting information to support an assessment. Things to consider include:

- communicate in a non-judgemental and helpful manner
- do not ask leading or direct (yes/no) questions as this may prejudice any subsequent investigation by relevant officers
- avoid emotional expressions or responses (anger, pity, outrage or taking sides)
- empathise with expressed coping problems, but do not support the abusive behaviour
- keep parents/caregivers informed about their child's medical condition and treatment needs.

Consultation

Consultation with colleagues and others is a common practice for health staff and encourages ethical and considered decision-making, particularly where issues are complex or there is uncertainty about the best course of action to take.

When managing child abuse concerns, there are often complexities in relation to keeping families engaged with health services and risks that need to be managed in order to keep the child's best interests at the centre of decisions and actions. Factoring in other expertise and perspectives, together with mindful consideration of confidentiality issues are vital aspects of the decision-making process. You may wish to consult with:

- your line manager
- a colleague
- a local paediatrician identified as having expertise in child abuse
- Perth Children's Hospital Child Protection Unit (T 6456 4300)
- Statewide Protection of Children Coordination Unit (SPOCC) (T 6456 0030)
- Perth Children's Hospital Emergency Department (T 6456 2222)
- Communities

Responding to physical abuse

Examination and documentation of physical injuries

The physical examination for possible physical abuse should include:

- assessment of the child's general physical condition
- measurement of height and weight with reference to percentile charts
- measurement of head circumference. Large or increasing head circumference may be a sign of a medical condition or possibly an intracranial injury in a child less than two years
- general physical examination, including assessment of nutrition and illness
- developmental assessment – brief assessment of the child's gross motor and language development
- examination of the injury (with the child's consent). Some investigations are to be performed by a medical practitioner / doctor (see below).

It is important to:

- describe bruises, abrasions, lacerations and burns in terms of number, size, shape (e.g. linear, circular, rectangular), pattern (e.g. handprint, the shape of an object), orientation (e.g. horizontal, vertical, circumferential) and location
- describe the actual colour and appearance of bruises as they cannot be aged
- make notes on whether every injury appears old or new (e.g. healing abrasion, scar) if possible
- measure injuries with a tape measure and, if obtaining photographs, place a ruler adjacent to the injury (see Section on Documentation)
- document the explanation given by the child and parent/carers for each injury
- use an official work camera to take photographs of injuries. Please refer to the individual Health Service Provider policies for further information. Do not use personal mobile phones.

Specific investigations to be performed in a site with paediatricians and/or referral to Perth Children's Hospital Child Protection Unit

- X-rays. Description of fractures should conform to standard medical description of orientation of bone involved and site along particular bone
- full blood count and coagulation screen for all cases involving bruising
- skeletal survey for all infants under 2 years
- head CT scan and/or MRI scan for acute neurological symptoms
- eye examination by an ophthalmologist for identification of retinal haemorrhages as early as possible for infants less than12 months, especially if there are neurological symptoms or multiple fractures and/or skeletal injury
- urinalysis, liver function, renal function, amylase and abdominal imaging for abdominal injury.

Appendix A of the Guidelines for Protecting Children 2020 includes body maps to assist in the recording of physical injuries.

Emergency department child injury assessment

A 'Child Injury Assessment' form has been introduced into Emergency Departments in many WA hospitals. This proforma is used by doctors to improve the identification of physical abuse in young children who present to an Emergency Department with a fracture, head injury, poisoning or burn.

Safety net meetings

In conjunction with the injury assessment, some hospitals have implemented Safety Net Meetings. These meetings provide additional scrutiny to children presenting with physical injury to minimise the risk that identification of physical abuse is missed by auditing injury assessments that were not referred for further action. Actions from the meeting may include seeking further information from a child or school health nurse and/or previous presentations to health services.

Power to keep a child under six years of age in a hospital

The 'officer in charge' of the hospital (Chief Executive/Executive Director) can invoke Section 40 (2) Children and Community Services Act 2004 to safeguard a child under 6 years of age in hospital for 2 working days for observation, assessment and/or treatment whether or not the parent consents to that action.

Section 40 does not alter any guardianship rights, and it does not deny parents' access to their child, it only determines that the child needs to remain in hospital.

Responding to sexual abuse

Assessment of child sexual abuse concerns are important to establish:

- the timing of the last known incident of abuse
- the presence of any injuries or symptoms and any medical treatment the child may require
- whether a forensic assessment is required
- whether a safety and risk assessment is required – including assessing if the child would be at risk after leaving the health setting
- If there is any risk to any other children relating to the alleged sexual abuse.

This may include documentation of physical, behavioural or emotional indicators that become apparent through discussions with a child or their family. Information comes from many sources, including parents, family members or medical records. Disclosure from a child is not required to report concerns to Communities.

Important

There may be no physical symptoms in most instances of child sexual abuse. The absence of physical, medical or forensic evidence does not mean that sexual abuse has not occurred and should not override professional judgement regarding the health and safety needs of the child.

Forensic assessment of acute child sexual abuse

Forensic assessment of acute child sexual abuse ideally occurs within 72 hours of the (latest) sexual abuse/assault that involved bodily contact between child and abuser, e.g. vaginal, anal, oral penetration, any skin-to-skin contact.

If the (latest) abuse/assault occurred more than 72 hours but less than 7 days ago, then a medical examination should be performed as soon as practically possible, to maximise the possibility of capturing any fading physical or forensic evidence. If the (latest) abuse/assault occurred within the preceding 7–14 days, then a forensic examination is not usually indicated as it is likely that any possible forensic evidence is lost.

If, from the information gathered, it appears there may be forensic evidence, a forensic medical examination should take place as soon as possible, in consultation with the Perth Children's Hospital Child Protection Unit (CPU) or local paediatrician.

- Early evidence ‘wee and wipe’ kits can be used by all regional medical and nursing staff to collect any physical evidence of sexual abuse at the earliest opportunity.
- A more comprehensive medical examination and the collection of microbiological specimens may be performed by specially trained medical doctors or gazetted nurses on follow-up after the initial presentation.

Four initial samples are required: urine, buccal, labial/perineal, clothing.

1. Pass urine: collected in a yellow-lid specimen jar (to look for spermatozoa). It is also useful for drug screens.
2. Buccal wash: instruct the patient to rinse their mouth with sterile water, then spit the wash into a yellow-lid specimen jar.
3. Labial/perineal gauze: wipe over the labia/perineum, then place the gauze into a yellow-lid specimen jar. Wipe the gauze over any fluid stains on the body.
4. Clothing: place clothing into the brown paper forensic bag. If clothing is wet, allow it to air dry before placing into a paper bag.

The specimens should be handed to the WA Police Force immediately or immediately placed in a locked cupboard/drawer to maintain the chain of evidence.

Important
Forensic specimens should not be placed into culture media.
Place in plain containers.

Metropolitan Area

If you are in the Perth metropolitan area, use the specialised clinical service for suspected child abuse at Perth Children’s Hospital CPU:

T 6456 4300 8.30am to 5:00pm Monday to Friday
T 6456 2222 8.30am to 10:00pm Saturday and Sunday
5.00pm to 10:00pm weeknights

Refer children aged 16 years and over to the Sexual Assault Resource Centre (SARC) 24-hour service medical/forensic and counselling service T: 9340 1828.

WA Country Health Service

The WA Country Health Service has a Responding to Sexual Assault Policy that outlines the requirements for all WACHS staff members in regional areas.

Intimate body piercing

It is an offence to pierce intimate body parts, i.e. the genitals, anal area, perineum and nipples, of people less than 18 years of age, irrespective of the consent of the child or their parent under the *Children and Community Services Act 2004*. Any intimate piercing of a child should be reported to Communities for further assessment.

Other forms of body piercing are prohibited for children unless written parental consent is provided, with the exclusion

- ear piercing in a child aged 16 years and over
- body piercing required for medical or therapeutic purposes.

Responding to emotional abuse

All children are negatively impacted by the persistent lack of emotional nurturance and warmth. Health assessments for possible emotional abuse can include:

Child medical assessment - gathering information that may indicate emotional abuse as a possible contributor to, e.g. abnormal weight gain or loss, unexplained listlessness, selective mutism, self-harming.

Parent/carer medical assessment - mental health, alcohol/drug, or intellectual disability assessment of parents/carers needs to consider the extent to which the presenting behaviour may impact on a parent's capacity to provide a consistent and appropriate level of emotional care and nurturing to any dependent children.

Non-physical assessment - gathering information, often over time, from others close to the child that may indicate the child's emotional health and development is being compromised through emotionally abusive parenting.

Responding to family and domestic violence

Health assessments for children exposed to FDV are frequently initiated through observations/information from parents/carers including both those who perpetrate and those who are the victims of the violence.

Responding to child abuse that is occurring in the context of FDV may require reporting against the wishes of the adult victim (usually the mother of the child/ren).

The decision to report the impacts of FDV must be made with the best interests of the child as the paramount consideration. If your assessment is that a child is experiencing significant harm or risk of harm as a result of FDV, then a report should be made to Communities.

As with all types of abuse if there is an immediate threat to safety WA Police should be called before a report is made to Communities.

A parent's resistance to reporting may reflect fear for themself and their children if the perpetrator of FDV discovers a report has been made to Communities. The process of reporting must include actions to alleviate or minimise any risk to the adult victim and any children. Whenever possible, WA health system staff should consult with professionals who are experienced in working with victims of FDV to enable safe and sensitive responses.

The key resource for WA health system staff to FDV is the Clinical Practice Guideline: Responding to Family and Domestic Violence.[16] This document outlines principles of screening for family and domestic violence and abuse, intervention and standard information applicable to varied health settings.

Communities have a range of responses to link victims to FDV services, including women's and men's helplines:

Women's Domestic Violence Helpline
Telephone (08) 9223 1188 or Free call 1800 007 339

Men's Domestic Violence Helpline
Telephone (08) 9223 1199 or Free call 1800 000 599

[16] North Metropolitan Health Service, Women and Newborn Health Service. Clinical practice guideline: Responding to family and domestic Violence. 2020.

Responding to neglect

If a staff member is concerned that a child is being neglected, they should document their concerns at every contact with the child and family, including an assessment of:

- whether the situation is the same, better or worse
- any acute issues making it difficult for the parents/carer to meet the needs of the child.

Documentation recorded over time identifies whether there is a pattern of neglectful behaviour that is maintaining, decreasing or increasing over time and assists in determining the type and level of action needed to respond to concerns of neglect.

The Child Wellbeing Guide is a resource that has been developed to clarify what aspects of parental care are of concern and track changes over time.

WA health system staff addressing concerns of possible neglect should be working with parents and carers to support the development of knowledge and skills to improve the health and wellbeing of their child.

Ongoing health service provision

The presence and referral of child protection concerns do not alter the ongoing provision of health services. Health staff have a significant role in ongoing support for children and their families, even after referrals have been made to Communities and/or other government or non-government agencies.

Health staff are in an important position to:

- monitor the physical, developmental and psychosocial wellbeing of the child(ren) and family
- provide feedback to the family on their efforts to address concerns.

If a WA health system staff member receives new information on a child that indicates there are new or increased child abuse concerns, a new report to Communities must be made. Openness and transparency in communicating with a child and their carers, including advising them if a report is made to Communities (if it is safe to do so), signifies in a respectful way that protection concerns will be addressed alongside the continued provision of health services.

Recording child abuse concerns

Recording a concern of child abuse includes any documentation you undertake throughout the process of managing a child abuse concern.

Recording concerns of child abuse

WA health system staff members must record any concerns of child abuse. The record should use respectful language, be concise, factual, understandable and comprehensive. It must be recorded as soon as possible after interaction with the child/family. The content should be written to inform any person who reads the report, regardless of how soon it is read after writing.

Records can be subpoenaed or be included in a Freedom of Information requests.
The record must include:

- the information that led to the concern
- dates, times and details of the contact with the child/family or any other person who provided information or reason to be concerned for the child
- information about any other child or family member who may be relevant to the concern
- any relevant verbatim quotes from the child/parent or any other relevant person
- any action taken, (including if a report was made to Communities and/or the police)
- details of any observations related to the concern
- details of anyone you consult with about the concerns.

Recordkeeping

Relevant records must be accurately maintained and securely stored. The record must be reliable and document any allegations/ concerns, the course of action taken, consultations made and advice provided. *Guidance for identifying and retaining records which may become relevant to an actual or alleged incident of child sexual abuse*[15] provides information on the creation of records as part of a response to an allegation of any child abuse.

With regards to documenting an allegation of child abuse by a staff member in a Health Service Provider (inpatient or outpatient), advice should be obtained from Human Resources as part of the coordinated response to the situation.

The State Records Office of Western Australia states:
'*Institutions must create and keep full and accurate records. These records provide evidence of the actions, decisions and advice of that institution. For a record to be trusted and reliable an institution must ensure that it remains a true and accurate account of what occurred, that the record has not been altered without authorisation, that the record's authenticity can be assured and that it is accessible'.* [17]

Please refer to the Health Service Provider's record-keeping policies for more details.

[17] State Records Office. Guidance for identifying and retaining records which may become relevant to an actual or alleged incident of child sexual abuse. Government of Western Australia; October 2019.

Retention of records

The Royal Commission recommended institutions keep records relating to child sexual abuse for a minimum of 45 years, potentially longer. Records must be accessible many years after the abuse had occurred. The Royal Commission recognised that many people did not disclose child abuse until years after the abuse occurred. Records retained for a long period of time, gives the victim/survivor access to their records. This is particularly important for the purposes of pursuing a criminal investigation, accessing support services and accessing any financial support, including criminal injuries compensation following redress.

Records in relation to any allegations of sexual abuse do not just pertain to individual medical records. Information can include supporting information relevant to the incident or allegation (e.g. staff rosters, attendance records).

A Disposal Freeze for government records relating to children is currently in force for Western Australian State and Local government. Relevant disposal authorities are currently being reviewed to address the records retention requirements. The disposal freeze relates to records documenting, or that may be relevant to, actual or alleged incidents of child sexual abuse.

Further information on the retention of documentation can be found at http://www.sro.wa.gov.au/state-recordkeeping

Reporting child abuse

A report is any formal notification of a concern of child abuse to Communities and/or WA Police Force, in consultation with your Manager/Supervisor

Content Topics

In all instances where a WA health system staff member has recognised that a child may have been harmed or is at current risk of harm through child abuse, a report should be made to Communities.

Communities
Telephone: (08) 9222 2555 Country free call: 1800 622 258 Fax: (08) 9222 2776
International: +61 8 9222 2555 T +61 8 9222 2555
Street address: 189 Royal Street, East Perth WA 6004
Postal address: PO Box 6334, East Perth WA 6892

For contact details for Communities district offices and country offices: https://www.dcp.wa.gov.au/Organisation/ContactUs/Pages/ContactUs.aspx

Department of Communities

Written reports

Written reports are the preferred process for reporting all forms of suspected child abuse to Communities. There are two main ways this may occur depending on who is making the report and the type of report:

1. Child Protection Concern Referral form (Form 441 via email to cpduty@communities.wa.gov.au; Use this form for reporting:
   - physical abuse, emotional abuse, FDV and neglect by any reporter
   - sexual abuse by non-mandatory reporters
2. Mandatory reports of child sexual abuse by doctors, nurses and midwives through the secure portal www.mandatoryreporting.dcp.wa.gov.au

There are considerations in regard to information security and confidentiality with sending written reports. These are detailed later in this section.

Verbal reports

Verbal reports are appropriate in certain circumstances, mainly when there is urgency or uncertainty regarding the required actions. **A verbal report will need to be followed with a written report as soon as practicable, preferably within 24hours.** It is essential to record the content of any verbal reporting to Communities.

Crisis Care (After Hours)

To verbally report urgent concerns for a child after hours, please contact Crisis Care. Crisis Care is the 24 hour crisis service of Communities. Crisis Care provides a state wide telephone information and counselling service for people in crisis needing urgent help.

Telephone (08) 9223 1111 Country free call 1800 199 008

Reporting child abuse concerns to WA Police Force

WA Health system staff report to WA Police in instances of immediate, significant risk and harm.

- Most reports of child abuse concerns to WA Police are verbal.
- It is essential to record the content of any verbal reports to WA Police.

If WA Police are called to make an urgent report of child abuse, concerns must also be reported to Communities when safe to do so. Although these agencies work closely together and are likely to communicate in cases of emergency responses to child abuse concerns, it is still essential for WA health system staff to make an independent report to Communities.

Code Black (Personal Threat)

A code black is called when there is an immediate personal threat to any person in a WA health system workplace. This could include a child, a patient, a visitor, staff or any other person physically in the workplace.

Code Black, Alpha

A Code Black Alpha is called when child is abducted from the hospital by someone other than the custodial parent or carer. It does not apply to the removal of a child by a custodial parent or carer against medical advice.

The following information about reporting immediate threats to safety in WA health system workplaces is also conveyed in the Figure 6 reference flowchart below.

Code Black: Role of hospital security

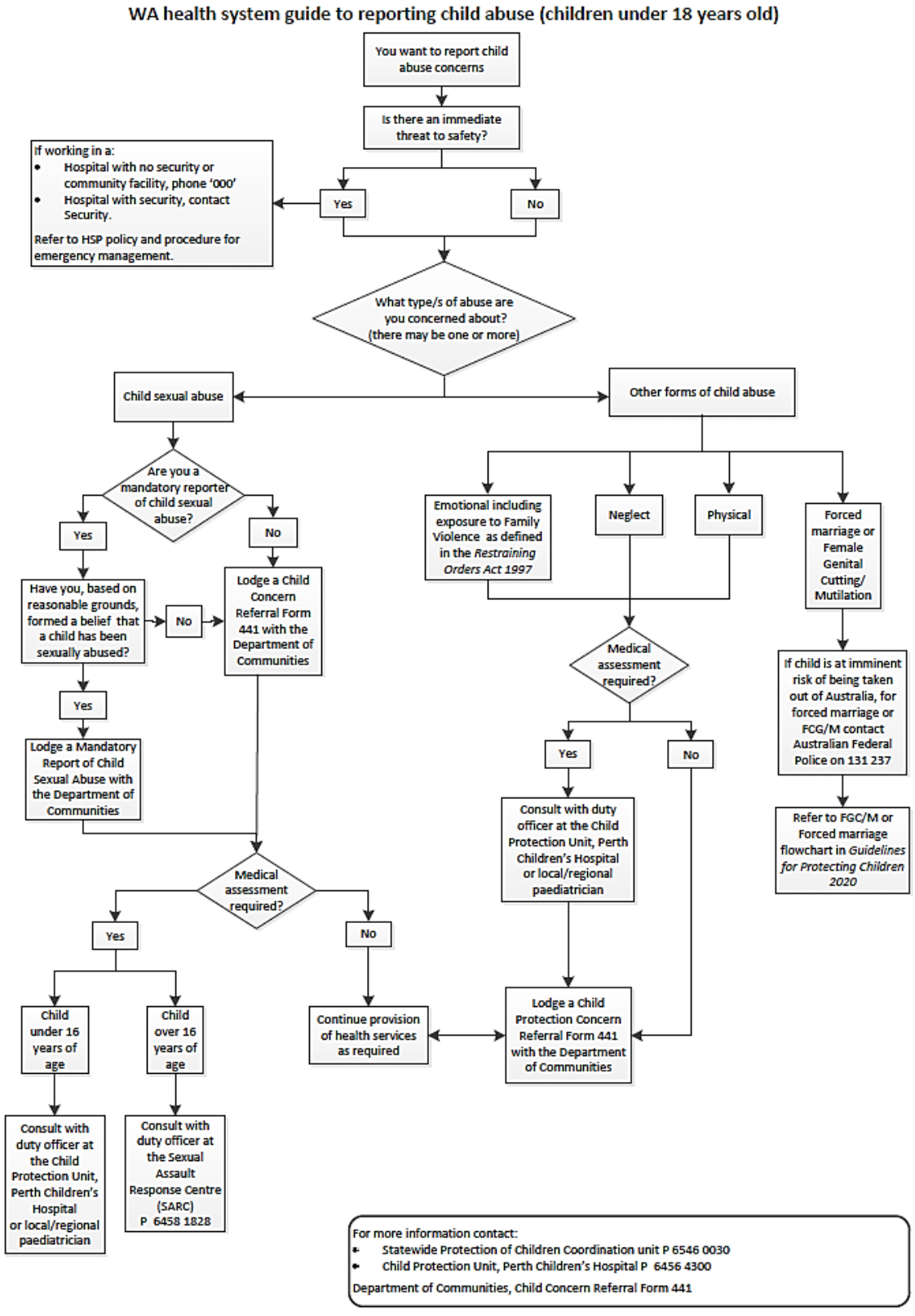
Staff working in hospitals with security accessible via dialling 55 should dial 55 in circumstances of a Code Black or any other immediate threat to personal safety.

Staff working in Hospitals or other workplaces where there is a process other than dialling 55 to call security to a Code Black should follow the correct process for that workplace.

Code Black (including Alpha and Bravo) in environments where there is no security staff. If there is no security staff in a workplace, or if they are currently unavailable, WA Police should be called on 000.

The relevant processes incorporating the above-mentioned actions in the Figure 6 reference flowchart below.

Figure 6. WA health system guide to reporting child abuse (children under 18 years old)



Emailing confidential client information

When information is transmitted outside of the WA health domain or system network (e.g. sent via email, SMS or social media over the internet, public switched telecommunications networks or unsecured wireless networks), it is considered unsecured information in transit unless encrypted. Confidential or health information must not be transmitted through unsecured channels without the use of appropriate encryption or where necessary, specific approvals. Any media containing information must be protected against unauthorised access, misuse or corruption during transportation.

Data transfer via secure file transfer (MyFX or MyFT)

HSS provides secure file transfer services to enable Health Service Providers to send and receive data electronically and safely via My File eXchange (MyFX) and My File Transfer (MyFT). Both systems provide comprehensive enterprise security of health information that is sent or shared, as data is secured by user authentication upon opening attached information. The use of these programs is set out in Department of Health Information Security Policy.

Decisions about transmitting confidential information should include consideration of the impact of not sharing information. Relevant information should be shared when a child is being abused or at risk of being abused. If the process of sharing information does not meet the email and secure file transfer criteria above due to lack of access to these systems, WA health system staff should consult with their line manager and document the rationale and medium of sharing information.

Informing families when making a report to Communities

The best outcomes for children are based on open and transparent practices that facilitate a trusting professional/patient relationship. It is important to support a parent/carer to remain engaged with health services whilst accepting referrals to additional services to address concerns that may be impacting their parenting and child.

WA health system staff should discuss any child protection concerns they have with a child (if appropriate) and their parent/carer. This includes, where possible, informing them when making a report to Communities.

However, there are situations where it is not appropriate to inform family members of the intention to make a referral, including where:

- discussion would put a child at risk of harm
- there is information to suggest that advising parents/carers would impede an assessment made by Communities or any police investigation
- fabricated or induced illness is suspected
- there are concerns about a possible forced marriage
- the family present as a flight risk
- it might compromise the safety of the health staff member or others in the service
- it is not possible to contact parents/carers, and this is causing unnecessary delay in making the referral.

Protection from liability for making a report

If a WA health staff makes a report to Communities they are protected under the *Children and Community Services Act 2004*. If you are acting in good faith then the person making the report or giving information to Communities:

- does not incur any civil or criminal liability; and
- is not to be taken to have breached any duty of confidentiality or secrecy imposed by law; and
- is not to be taken to have breached any professional ethics or standards or any principles of conduct applicable to the person's employment or to have engaged in unprofessional conduct.

Restrictions on disclosing notifier's identity

With some exceptions, your identity must not be disclosed without your consent and penalties apply if notifier identifying information has been disclosed.

Identifying information of a notifier means information that:

- identifies the notifier or
- that is likely to lead to the identification of the notifier or
- from which the identity of the notifier could be deduced.

Section 240 of the *Children and Community Services Act 2004* provides a list of exceptional circumstances when a notifiers identity can be disclosed.

Figure 7. Information to include in a report to the Department of Communities

The following is a guide for WA health system staff

Adapted with permission from the Territory Families. *Professional Reporters Guide: Reporting Child Harm or Exploitation;* 2019

Demographic Information

Notifier/Reporter

- Full name
- Profession/Position title
- Contact number (preferably mobile)
- Email address
- Your relationship to the child/family
- How long you have been working with the family?

Child/Children

- Full name, including any other names they are known by
- DOB
- Address
- Details of any siblings
- Contact numbers
- Any special needs or medical conditions
- Ethnicity e.g. Aboriginal or CALD
- Primary language spoken
- School/Childcare centre they attend

Parent/Carer

- Full name, including any other names they are known by
- DOB
- Address
- Contact numbers
- Does the parent/carer have disabilities, mental health conditions, history of substance use or medical conditions?
- Primary language spoken, incl ethnicity, e.g. Aboriginal or CALD
- Are there any Family Law Court or custody issues?
- Any current or history of family violence?

Details of your concerns

What

- What are you concerned about?
- What discussions have you had with the family in relation to your concerns?
- What has the family said in relation to your concerns?
- What action do you think needs to be taken to reduce your concerns?
- Does the child require further medical attention?

When

- When did you first become worried about the child?
- How often do you think the harm has occurred?
- Is the harm worse than before, or has it stayed the same?
- Do you think this is likely to occur again?

Where

- Where was the child when the harm occurred?
- Where were the parents/carers when the harm occurred?
- Where is the child at the time of making the report?

Who

- Who do you think has caused the harm to the child?
- Will the child have any further contact with this person?
- Does this person live with the child?
- Does this person have any other children in their care?

Information specific to type of child abuse

Physical abuse

- Does the child have any current physical injuries? If so, document using a body map diagram. (Appendix A, pp85-90)
- Are you aware of any previous physical injuries? If so, describe.
- What is the parent/carer's explanation for the injury?

Sexual abuse

- Document any disclosures using the words used by the child.
- Was a STI screen done? If so, provide results
- Does the child have any current physical injuries? If so, document using a body map diagram.

NB: sexual abuse may have no physical indicators

Emotional abuse

- Are there behavioural changes that support your concern?
- Is the child showing physical signs of distress?
- What have your observed in interactions between the child and their carer?
- Does the child have a reliable support person? Provide contact details

Neglect

- Are there concerns about how much supervision is given to the child by caregivers?
- Is this occurring often? How often?
- Are there any medical/behavioural indicators that support your concern?

Other issues to consider when writing a report to Communities

When writing a report to Communities, the information must be

- Objective
    - show fairness and balance, avoid potential biases that may relate to a child, young person, parent or caregiver's age, gender, race, ethnicity, religion, sexual orientation, disability, cultural/community child rearing practices, or socio-economic status

- Accurate
    - factual, considered, objective and up-to-date account of your concerns, consultations, contacts, actions and plans

- Credibility
    - relates to the quality of the information collected and assessment of concern, e.g. relevant, professionally sound and accurate data
    - is reliant on the report being impartial, factual and free of any possible interpretation or judgement of an individual's values, morals or religious or cultural beliefs
    - in reporting suspicions of child abuse maximises opportunities for the safety, wellbeing and development of children who have been harmed or are at risk of harm

The reports made to Communities form the basis for any intervention or assessment of harm for a child.

Making a mandatory reporting of child sexual abuse

Under the *Children and Community Services Act 2004*, a mandatory reporter has a duty to report to Communities Mandatory Reporting Service. Within the WA health system doctors, nurses and midwives are mandatory reporters of child sexual abuse.

According to the *Children and Community Services Act 2004* (s124A) "...sexual abuse in relation to a child, includes sexual behaviour in circumstances where —

(a) the child is the subject of bribery, coercion, a threat, exploitation or violence; or
(b) the child has less power than another person involved in the behaviour; or
(c) there is a significant disparity in the developmental function or maturity of the child and another person involved in the behaviour;"

Section 124B of the Children and Community Services Act 2004 states:
A person who —

*(a) is a **doctor, nurse, midwife**, police officer, teacher or boarding supervisor; and*

(b) believes on reasonable grounds that a child —

*(i) has been the subject of sexual abuse that occurred on or after *commencement day or*

(ii) is the subject of ongoing sexual abuse;

and

(c) forms the belief —

*(i) in the course of the person's work (whether paid or unpaid) as a **doctor, nurse or midwife**, police officer, teacher or boarding supervisor; and*

*(ii) on or after *commencement day,*

must report the belief as soon as practicable after forming the belief.

** (1/1/2009 –commencement day);*

A mandatory reporter of child sexual abuse does not need proof or evidence that a child is or has been sexually abused but they need to be able to describe how they formed the belief by applying the definition of sexual abuse in section 124A and following the steps in Section 124B. If assistance is required to assess the information gathered or clarify concerns, support can be sought from:

- a colleague or supervisor
- Communities Mandatory Reporting Service, 1800 708 704 (24 hour service)
- Perth Children's Hospital, Child Protection Unit T 6456 4300 and/or
- Statewide Protection of Children Coordination (SPOCC) unit 6456 0030.

Submitting a mandatory report of child sexual abuse

Online reporting

Encrypted online reporting via Communities Mandatory Reporting form on their online portal is available at www.mandatoryreporting.dcp.wa.gov.au.
This is the preferred method for lodging a Mandatory Report.

Communities' secure online portal, the Mandatory Reporting Web System guides reporters thorough the process of making mandatory report of child sexual abuse. Once the mandatory report is submitted through this portal, a receipt number is generated and sent back to the mandatory reporter. If the report was not submitted online, a receipt number will be provided via email.

NOTE: The Mandatory Reporting online portal will "time-out" if there is no data entered for 58 minutes, resulting in the loss of any previously entered information. If you are likely to be interrupted during the process of writing the online report, you could write

the key information into a Word document to cut and paste into the MR Web online form as soon as possible (within 24 hours). The temporary record you create as a Word document must be deleted after cutting and pasting content to your online report.

Other methods of lodging a report

If internet access is unavailable a mandatory report can be lodged by:

- Fax 1800 610 614
- Email mrs@dcp.wa.gov.au
- Post PO BOX 8146 Perth BC WA 6849

If the report is urgent due to immediate safety concerns for a child(ren) then you can telephone Communities Mandatory Reporting Service on 1800 708 704. This verbal report must be followed with an online or written mandatory report as soon as practicable, within 24 hours.

As in other circumstances, if a child or anyone else is in immediate danger, call WA Police.

Communities may require further information from a reporter, and it is essential that after-hours telephone (preferably mobile) contact details are included in the information provided.

Reporting Sexually Transmitted Infections (STIs) in children under 14 years

An Operational Directive (OD) 0296/10 Interagency Management of Children Under 14 Years who are Diagnosed with a Sexually Transmitted Infection (STI) is under review. Currently, this Directive establishes parallel processes for the sharing of information between the WA health system, Communities and the WA Police Force for a coordinated response to children under 14 years of age who have a diagnosed STI. For all such children Communicable Disease Control Directorate will report to the central office of Communities when there is laboratory confirmation of an STI. To avoid any potential for delayed reporting that might place a child at ongoing and serious risk, the WA health system staff member is also required to make an independent referral to Communities on laboratory confirmation or on clinical diagnosis.

Where appropriate, discuss the notification with the child. This provides an opportunity for the child to raise any concerns they may have, including, telling parents/carers and addressing any issues that may affect their treatment and safety.

If a doctor, nurse or midwife has formed a belief on reasonable grounds that sexual abuse is occurring to a child (someone under 18, whether or not they have an STI), then a mandatory report of child sexual abuse must be made to Communities Mandatory Reporting Service: https://mandatoryreporting.dcp.wa.gov.au

Sharing information for the protection of children

Content Topics

The general principles regarding patient confidentiality and the seeking of consent to share information are set out in the mandatory policy 0010/16 Patient Confidentiality Policy.[18] However, under the *Children and Community Services Act 2004*, confidential information may be provided without the consent of the parent and/or child. Staff are encouraged to use their professional judgement in deciding whether or not to seek permission to share information in relation to concerns of child abuse. If a staff member is unsure, they should seek guidance from their manager.

The Health Services Act 2016

The Health Services Act (HSA) 2016 supports the sharing of information. The HSA authorises disclosure of relevant information in certain circumstances, provided that the collection, use or disclosure of information is authorised and if the information is collected, used or disclosed in good faith.

WA health system staff must:

- act within the limits of this legislation
- use open and accountable processes and procedures, and
- align work practices with the policies of their employing Health Service Provider.

[18] WA Department of Health. Mandatory policy MP0010/16 Patient Confidentiality Policy; 2016.

Key Principles for effective sharing of information when it relates to the protection of children

- **The paramount consideration is the best interests of the child**
  Information sharing should be considered within the context of balancing competing interests of the community and agencies but not to the detriment of safeguarding children. Health staff must respond to issues with the best interests of the child as paramount. When working with adults who have children, the safeguarding of children should still be a priority.

- **Improving outcomes for patients**
  WA health system staff should share information with the relevant investigative authorities (Department of Communities and/or WA Police Force) when a concern is raised about a child who has been or is at risk of abuse.

- **Better coordination of services**
  Whilst patient/client confidentiality is a priority, relevant information should be disclosed with or without consent (via appropriate processes) to promote the safety of a child/ren.

Information sharing between the Health Service Providers and Communities

Communities

Section 23 of the *Children and Community Services Act 2004* permits the sharing of relevant information between Health Service Providers and Communities if it is in the interest of the 'wellbeing of a child or a class or group of children'.

Section 23 of the *Children and Community Services Act 2004* enables the Chief Executive Officer, or an authorised officer, of Communities to disclose or request relevant information from a public authority applicable to the wellbeing of a child or class or group of children.

How is the purpose for sharing information defined?

The sharing relevant information with Communities enables:

- better informed assessments
- assessments and planning to occur to keep children safe
- provide families with the services they need. For example family support/referral share information for the wellbeing of a young person who was previously in care
- support care planning for children in care.

What is relevant information?

According to the *Children and Community Services Act 2004* ***relevant information*** means —

(a) information that, in the opinion of the CEO, is, or is likely to be, relevant to —

(i) the wellbeing of a child or a class or group of children; or

(ii) the wellbeing of a person who under section 96 qualifies for assistance for the purposes of Part 4 Division 6; or

(iii) the safety of a person who has been subjected to, or exposed to, family violence; or

(iv) the performance of a function under this Act;

or

(b) other information of a kind prescribed by the regulations for the purposes of this paragraph.

For example, WA health system staff can share information with Communities staff that relates (but is not limited) to:

- immediate safety concerns for child/ren indicating harm
- reporting a concern for the wellbeing of a child or family
- protecting a child/ren from family and domestic violence

- sharing information to inform assessments, including any known events or history of the child suffering harm
- support care planning for children in care or exiting care
- the impact of a parent's mental illness, substance misuse, disability or history of the family.
- a person in a household who may pose a risk to a child
- any period when the child has been cared for by other people
- any significant issues relating to the child's sibling/s.

Section 23 of the *Children and Community Services Act 2004* also permits WA health staff members to seek relevant information from Communities in relation to the safety and wellbeing of a child whom a health service is or has been provided.

Each Health Service Provider may have different processes for requesting or responding to requests for information under Section 23 of the Children and Community Services Act 2004. Please refer to individual Health Service Providers for further guidance.

Declining a request for information from Communities

There may be occasions when health staff may determine that information requests from Communities do not follow the proper processes and/or are not relevant to the decisions being made for the wellbeing of the child.

If a staff member decides not to provide some or all of the information requested by Communities, they should consult with their manager and possibly the legal section of their Health Service Provider. The rationale and process for making the decision should be recorded and communicated to Communities. It should be emphasised that the decision is not intended to impede a child abuse assessment.

Escalation of concerns between the WA health system and Communities

Communities and the WA health system have an agreed dispute resolution process and pathway. Any issues or concerns held by WA health staff members with Communities should, in the first instance, be negotiated at the lowest and most informal level practicable.[19] This means that the staff member should be contacting the caseworker for a child, or the intake team.

If the issue remains unresolved, the concern should be raised (in consultation with your line manager) with the team leader at either the Central Intake team (if the child does not have an allocated caseworker) or the local district office of Communities.

[19] Bilateral Schedule between the Department of Child Protection and Family Support (CPFS) and WA Health for collaborative responses to: child abuse and neglect identified by WA Health; and children in care.

If the issue remains unresolved, the matter must be escalated through your manager to the local Communities District Director.

If the issue continues to be unresolved, then the line manager should complete an online Complaints Form from the Complaints Management Unit Communities. Senior management should also be advised that a formal complaint has been made to determine if further action is required.

WA health system staff member seeks further information/feedback from Communities in order to be able to continue delivering the most appropriate health service to the child/family

If issue is not resolved

Provide an explanation to Communities (if verbal follow up with written confirmation) of the ways in which the specific information sought will enhance health service provision to the child/family. Document.

If issue is not resolved

If not responded to within timeframe nominated, contact Communities Team Leader at Local office (if verbal follow up with written confirmation) resend all relevant documentation. Document and date actions

If issue is not resolved

Escalate to Health line manager who is to progress with the local Communities office District Director. Line manager to keep health worker informed

If issue is not resolved

Line manager to use formal Communities complaints process. Complete online. Keep copy. Inform senior management of actions. Keep health worker informed

If issue is not resolved

Senior management to determine if the issue requires further escalation

Information sharing between Health Service Providers and other government agencies, schools or non-government social services (other than Communities)

Some key government departments and non-government organisations are classified as 'prescribed authorities under section 28ABC of the *Children and Community Services Act 2004*.

Prescribed authorities (see list below) can share relevant information with each other and do not need Communities as an intermediary for this to occur.

As at time of publication, the following public authorities are prescribed authorities:

- Child and Adolescent Health Service
- Department of Education
- Department of Health
- Department of Justice
- Department of the Premier and Cabinet
- Department of Treasury
- Disability Services Commission
- East Metropolitan Health Service
- Health Support Services
- Housing Authority
- Judges, the Principal Registrar and Registrars, Family Law Magistrates and family consultants in the Family Court of WA
- Mental Health Commission
- North Metropolitan Health Service
- Pathwest
- Quadriplegic Centre
- South Metropolitan Health Service
- State Training Providers
- Teacher Registration Board of Western Australia
- Training Accreditation Council Western Australia
- WA Country Health Service
- Western Australia Police Force.

A current list of approved organisations (prescribed authorities) can be found at the Communities.

Section 28 (a) also refers to ‘Authorised Entities’. This term refers to the governing body of school systems (for example, public, Catholic or Independent schools) AND the Chief Executive Officer (CEO) of non-government organisations.

The Children and Community Services Act provides the same level of protection for workers when sharing information between prescribed authorities and authorised entities as that given when sharing information between the WA health system and Communities.

The legislation states that the Chief Executive Officer (CEO), or delegate, of an authorised entity or prescribed authority, can request or disclose information to the CEO, or their delegate, of another authorised entity or prescribed authority. Information may be requested or disclosed if, in the opinion of the CEO, the information is, or is likely to be, relevant to the:

- the wellbeing of a child or a class a group of children or
- the safety of a person who has been subjected to, or exposed to, family and domestic violence.

Table 7. Information sharing practice guide

Consult and Document	**1**	Review your Policy, Procedures and Legislation	Share information that is consistent with legal obligations and organisational policies and procedures.
	2	Verify the request for information	If you do not know the person seeking information, you need to verify this before providing the information. A request in writing is the preferred.
	3a	Express consent (first approach)	Relevant information can be shared when informed consent has been obtained. The person should understand the purpose for sharing information and who it will be shared with.
	3 b	Express consent not obtained	You are permitted to share relevant information, without express consent, pertaining to the safety and wellbeing of a child/ren. Reasons should be based on: • risk of harm to the child/ren • the security risk to staff other patients/clients • attempt suicide or self-harm • it will interfere with Police or Communities investigations • an assessment of flight risk • after reasonable attempts and unable to locate the patient/client.
	4	Situations when you MUST share relevant information	• Mandatory Reporting of Child Sexual Abuse • Notifying Communities about concerns that a young person is at risk of harm – physical, sexual, neglect, emotional abuse (which includes exposure to family violence). • Assisting police with child protection inquiries • You believe a person poses a serious risk to themselves or others. • Other legislation applies and permits the sharing of relevant information
	5	Record keeping	Document and follow Policy and Procedures. Follow State Records guidance for identifying and retaining records that may become relevant to an actual to an alleged incident of child sexual abuse.
	6	Information disclosed in good faith and is authorised	The **authorised** collection, use or disclosure of relevant information is not regarded as a breach of any duty of confidentiality or secrecy imposed by law or a breach of professional ethics or standards or any principles of conduct applicable to a person's employment or unprofessional conduct.

Vulnerable children and families

Content Topics

All children are inherently vulnerable just due to their dependence on adults to meet their care needs. However, there are some children and families that may face additional challenges and a higher risk of child abuse.

Children with complex and chronic medical needs

Children and young people with chronic medical conditions are at a higher risk of child abuse and neglect, particularly medical neglect. Having a child with a chronic medical condition or illness has been demonstrated to have a negative impact on family functioning through ongoing, additional stress on all family members.

Recognising neglect can be increasingly difficult for health staff as they develop a relationship with the child and family through ongoing and often frequent attendance at health services.

Recognising and responding to concerns of child abuse and neglect for children with complex and chronic medical needs and their families

- Indicators of risk should be considered alongside the presentations of the associated medical condition and professionals should not assume all behaviours and presentations to be part of the medical condition/s.
- It is valuable to include assessment of interactions between the parent/carer and child.
- Ask the parent(s) and the child how they are managing with treatment requirements at home.

- Connect the family to appropriate support services and professionals who can support the family in providing care in the home and adapting parenting skills to the child's unique needs.
- Recognise that visiting children in their home environment is a significant opportunity to assess strengths and needs and acknowledge the commitment and actions of parents/carers.
- Encourage and/or refer parents/carers and children to attend relevant support groups where they can share their experiences with peers.
- Acknowledge the risks and potential additional supports required during the period of transition and integration between child and adult programs. Successful transition between child and adult chronic condition care services is complex.

Children who have a disability and their families

Children with a disability (physical and/or intellectual) experience abuse and neglect at a higher rate than their peers without disability.[20] Reasons for this include:

- the child may not have the language to disclose or describe any child abuse or neglect that they are experiencing or be able to recognise they are being abused.
- some children require assistance with personal care such as toileting and dressing.
- particular behaviours may be interpreted as related to the child's disability or associated medical condition and concerns may be overlooked not recognised as indicators of abuse or neglect.
- Concerns may be minimised by health staff due to not wanting to jeopardise the relationship they have with the family.

Recognising and responding to concerns of child abuse and neglect for children living with a disability and their families

- Disclosures of abuse often occur as a series of subtle or indirect disclosures, rather than a one-off event. Offer multiple and varied opportunities for a child to disclose.
- Be mindful of the child's behaviours (particularly if they are non-verbal) and whether the child may be trying to communicate or make a disclosure through their behaviour.
- Consider the physical environment and other strategies that may assist the child to convey their concerns, including interactions between the parent/carer and child.
- If possible, visit the child in their home environment. This may provide the staff member with further information into how the parents/carers manage the child and their disability on a day to day basis in their own environment. If this is not possible, a referral to a home visiting service may be appropriate.
- Collaborate with a professional who has expertise in that particular disability. They may be able to assist the staff member to distinguish between what are expected behaviours and what may be an indicator of child abuse.
- Assess the interactions between the parent and child as well as the parent's attitude towards the child.

[20] Maclean M.J., Sims S., Bower C., Leonard H., Stanley F.J., & O'Donnell M. (2017). Maltreatment Risk Among Children With Disabilities. Pediatrics. 139(4):e20161817

Child abuse concerns for unborn and newborn children

Where there are concerns for an unborn infant's safety and wellbeing after birth or a newborn infant's safety due to the risk of abuse and neglect, Communities will make efforts to engage the parents and their families at the earliest opportunity.

The Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is identified as at Risk of Abuse and/or Neglect[21] is the agreement between Communities and Health Service Providers (HSPs) for when child protection concerns are identified during pregnancy or shortly after a baby is born.

Roles and responsibilities

HSPs and Communities have a joint role in achieving safe outcomes for infants and parents.

Communities is the statutory agency with the responsibility for assessing and responding to allegations of abuse and neglect of children. They work with pregnant mothers, fathers and their families with a primary focus on increasing the safety and wellbeing of infants within their family system, wherever possible. Whilst Communities considers the health and welfare needs of the mother in planning, their statutory role is to act in the best interests of the child concerned.

HSPs are primarily concerned with the health needs of the pregnant woman and her unborn or newborn infant. The health needs of the mother include her psychological and physical health needs and how these impact on the pregnancy and birth outcome.

Practice principles

- The best interests of the child are the paramount consideration.
- Interagency cooperation that promotes engagement with the parents is essential to encourage access to antenatal care, improve the obstetric outcomes and promote the safety of the newborn infant.
- Cooperative interagency planning on how the unborn or newborn infant's safety and wellbeing to commence as early as possible.
- Consider the significant vulnerability of newborn infants when assessing the capacity of the parents to provide safe care.
- Wherever possible, the newborn infant remains in the care of his or her parent/s.
- Wherever possible, obtain consent before sharing information between the HSP and Communities provided, this does not place a person at risk or breach

[21] Bilateral Schedule between the Department of Child Protection and Family Support (CPFS) and WA Health for collaborative responses to: child abuse and neglect identified by WA Health; and children in care.

mandatory reporting legislation by providing information that could identify the person involved in making mandatory reports.

- Give parents clear and appropriate information to promote transparency and accountability.
- The provision of information to the parents occurs in a manner appropriate to:
    - the parents' literacy and cognitive capacity
    - the newborn and birthing mother's health needs when they are most likely to comprehend the information
    - the safety of the infant and other people.
- Consideration is given to Aboriginal and culturally and linguistically diverse (CaLD) families and their social, economic and family histories. Seek advice on how best to engage and prepare Aboriginal and CaLD families to maximise their participation in the process.
- Parents are involved in planning and participate in decision-making processes.
- Wherever possible, parents have antenatal safety plans identified and adequately resourced.
- Parents are encouraged to engage an appropriate support person throughout the planning continuum. For example, a family member, advocate or lawyer.

Pre-birth planning

The purpose of early interagency assessment and planning is to identify and share the concerns in relation to the mother, father and unborn baby as early as possible and to enable professionals with particular expertise to share information.

This work will include three meetings held before the birth of the infant, involving Communities, HSP, other involved services, the parents and their nominated supports.

These meetings are usually held when the mother is at approximately 20, 26 and 32 weeks gestation. However, the timeframe for meetings can be adapted according to the best interests of the unborn infant or a newborn infant where pre-birth planning has not occurred.

Children in the care of the Chief Executive Officer (CEO) of Communities (formerly known as 'wards of the state')

The *Children and Community Services Act 2004*, administered by Communities, provides for the protection and care of children in circumstances where their parents have not given, or are unlikely or unable to give, protection and care.

If it is determined a child is unable to live safely with their parents, generally when Communities substantiate parental child abuse (physical, emotional or sexual) and/or neglect, they are placed with alternate carers to provide day-to-day parenting. The CEO may assume formal parental authority and responsibility.

Children taken into care often have long histories of serious child protection concerns. The resultant harm from ongoing trauma, neglect and abuse is cumulative and predisposes them to physical, developmental and mental health issues.

Many children in care require timely access to health services to address these health needs. Without early intervention, the impacts of trauma and neglect can persist, influencing whole of life outcomes.

Working with children in the care of Communities

- Section 30 the *Children and Community Services Act 2004* determines the responsibility for decision-making regarding treatment and the exchange of confidential information according to the agreement or order which applies to an individual child. The Act identifies who has legal responsibility for providing consent.
- Where the Chief Executive Officer (CEO) of Communities has parental responsibility, this will be delegated to a case manager who works with a child's carer to support and manage their health (and other) needs.

The WA health system is responsible for providing:

- health services to all children in care to identify and address their health needs
- support to Communities to manage a child's health needs by providing relevant information, guidance on actions and referral for health services required.

A Health Service Provider will not always know that a child presenting for a health service is in the care of the CEO of Communities unless a case manager provides this information (e.g. through a referral) or it is provided by the carer or child.

- Care status is often not recorded in health information systems, and when it is recorded, may be inaccurate as children move in and out of care. Where care status is captured in information systems or notes, care status needs to be verified and/or updated.

- Confidential information regarding a child in care may be provided verbally to their case manager as required to support their wellbeing and care. Case manager details will most likely be provided by the child or carer and can be verified by the Central Intake team at Communities (T 1800 273 889 or email cpduty@cpfs.wa.gov.au or the district office where the child is case managed.
- Information provided verbally and to whom should be recorded in medical/client records, and provided in writing if requested.
- A child in care may be assessed as a mature minor as for any other child (refer to page 27) when considering their maturity in the context of the complexities and issues of a proposed treatment or decision. They can provide consent, on their behalf, to treatment and release of confidential information to their case manager and others, while understanding the limitations of this confidentiality.
- A child in care may disclose past or current abuse, and such disclosures should be handled as outlined in earlier sections. If current abuse is disclosed, the child's immediate safety should be ascertained, the case manager contacted, and the required action identified, including updating the medical/client notes.
- In cases where the health staff member forms a belief about child sexual abuse, they should follow the standard procedure for submitting a mandatory report of child sexual abuse, as it cannot be assumed that the information will already be known to Communities.

Aboriginal children, families and communities

Aboriginal children, families and communities experience significant social and economic disadvantage and resultant health inequity and over-representation in child protection and justice systems.[13]

The legacy from historic forced removal of Aboriginal children from their families (Stolen Generation) continues to impact child abuse and neglect responses and outcomes for Aboriginal children and families. One outcome of the Stolen Generation can be ongoing fear and reluctance to report concerns of abuse and neglect to Communities.

Recognising and responding to concerns of child abuse and neglect for Aboriginal children and families

- Aboriginal Health Workers and other Aboriginal workers are employed in various roles and services throughout the WA health system. They are a vital source of information and support when working with Aboriginal families. WA health system staff should ensure they are familiar with the specific workers, roles and resources in their workplace which may assist them to provide appropriate responses to Aboriginal children and their families.
- Liaison with Aboriginal Medical Services and other service providers (with appropriate permissions from family and/or policy and legislation) may assist in providing a more detailed medical history and further information on the level of care being provided to a child.
- For some Aboriginal families, English is not their first language, particularly if they are from remote communities. WA health system staff may need to determine if an interpreter is required.
- Best outcomes and ongoing engagement occur when any concerns about child wellbeing and abuse are managed transparently with parent/carers (if it is safe to do so).
- WA health system staff can demonstrate awareness and acknowledgement of possible distrust of mainstream health by a child and their family or carers.
- Culture and cultural practices are not a reason to minimise, deny or excuse child abuse or neglect.

Culturally and Linguistically Diverse (CaLD) children and their families

Assumptions about individuals or families should not be based on cultural background. However, some CaLD and refugee families manage a range of unique risk factors and challenges arising from their migration, their cultural history and the complexities of moving to a new country and environment. Some CaLD families may not be aware of support opportunities.

Factors leading to concerns for children may be:
Cultural

- status of the husband/ father as 'head of the household' with women and children designated a lower status can result in gender-based violence including, female genital mutilation/cutting removal of girls from school, forced/early marriages and in extreme cases, honour killings
- child rearing differences including use of physical reprimands, lower levels of parental supervision
- academic pressure and
- those from refugee-like backgrounds, in particular consider the ongoing impact of exposure to trauma, family disruption, cumulative childhood adversity, interrupted education, limited health literacy and psychological concerns including anxiety, stigma and post-traumatic stress disorder. [22, 23]

Migration-related

- limited English proficiency and/or literacy
- lack of awareness about child protection laws and agencies
- lack of extended family support and generational differences
- stressors related to transitioning to new cultures and expectation
- interrupted or low levels of literacy and general education and
- perceived or experienced racism and discrimination.

[22] Hanes G., Chee J., Mutch R., Cherian S. (2019). Paediatric asylum seekers in Western Australia: identification of adversity and complex health needs through comprehensive refugee health assessment. J Paediatr Child Health. doi: 10.1111/jpc.14425

[23] Hanes G., Mutch R., Sung L., Cherian S. (2017). Adversity and resilience amongst resettling Western Australian paediatric refugees. J Paediatr Child Health. 53(9): 882-888

Recognising and responding to concerns of child abuse and neglect for CaLD children and families

Although there may be wide variation in parenting practices between cultural groups, child abuse and neglect is not condoned in any culture. When health staff members are having conversations with parents in relation to parenting practices, they should inform families in a sensitive way that:

- certain child rearing practices that are accepted in other cultures may infringe Western Australian laws or accepted practice.
- WA legislation and responses applies equally regardless of cultural background and history.

Working with interpreter services

The Telephone Interpreter Service (TIS) (T 131 450) provides 24-hour telephone service and has a code of ethics that addresses confidentiality, accuracy and impartiality. Be aware of any specific local protocols your Health Service Provider might have in place to access the TIS. For example, account numbers to access the professional interpreter services.

An interpreter should be engaged as soon as it is determined that a child or family member may have difficulty in speaking or understanding English or has a background that may impact on the ability to communicate with them. WA health system staff are required to seek assistance from an accredited interpreter as per the WA Health system Languages Services Policy Guidelines. Where possible use a Level lll Health or Mental Health accredited interpreter, depending on the situation, CALD adults may find it easier to discuss and disclose confidential and challenging information to an interpreter over the phone rather than face-to-face.

Almost all families from refugee-like backgrounds in WA have limited English proficiency; 40% of parents are illiterate in their primary language. Most adults require 5-8 years to obtain sufficient English proficiency for informed consent; provision of professional interpreters is recommended[24].

If a child is in immediate danger and the interpreter service is not available, consider using a family or community member, although this practice is discouraged in other circumstances due to a potential conflict of interest. Children (under 18 years of age) should not be used as interpreters.

[24] Brophy-Williams S., Boylen S., Gill F., Wilson S.,& Cherian S. (2020). Use of professional interpreters for children and families with limited English proficiency: the intersection with quality and safety. *J Paediatr Child Health*. doi: 10.1111/jpc.14880.

Female genital mutilation/cutting (FGM/C)

The World Health Organisation, through UNICEF, estimate over 200 million girls and women alive today have been subjected to Female Genital Mutilation/Cutting (FGM/C). This practice is most prevalent in countries from Africa, the Middle East and Asia.[25] Under section 306 of the *Western Australian Criminal Code*[26] it is an offence to perform FGM/C on another person or to take a child or arrange for the taking of a child from Western Australia for FGM/C and is liable to imprisonment.

FGM/C involves the partial or total removal of external female genitalia or other injuries to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women, is considered a form of gender violence towards women and girls and is a violation of their human rights. It is mainly performed on young girls between infancy and 15 years of age.[27]

Factors that may assist identify a girl at high risk of female genital mutilation/cutting:

- Any female child or adolescent from a country where FGM/C is prevalent.
- Any newborn female whose mother or sisters have been subjected to FGM/C as well as any other female children within the extended family.
    - Record the age that FGM/C was performed for other females in the family.
    - FGM/C may be an indicator of future risk for other females within the family.
- Families from communities that practice FGM/C, who are less integrated into the community or with limited contact outside the immediate family and have limited access to information on FGM/C.
- Signs that FGM/C is imminent include:
    - a female elder visiting from the country of origin
    - the child referring to a 'special procedure' she is to undergo
    - the child requesting help if she suspects she is at imminent risk
    - parents or the child indicating the child is going out of the country for a prolonged period (including unintended school absences)
    - the child or family are considered to be a flight risk.

Responding to a girl who is at risk of female genital mutilation/cutting

If a child is at imminent risk of having, or being removed from Australia for, FGM/C contact should be made with the Australian Federal Police on 131237. Consultation with the WA Police (T 131 444) and Communities, Child Protection and Family Support - Central Intake Team (T 1800 273 889 / 1800 CP DUTY) should also occur.

[25] Female Genital Mutilation Country Profiles [Internet] https://data.unicef.org/resources/fgm-country-profiles/

[26] Criminal Code Act Compilation Act 1913

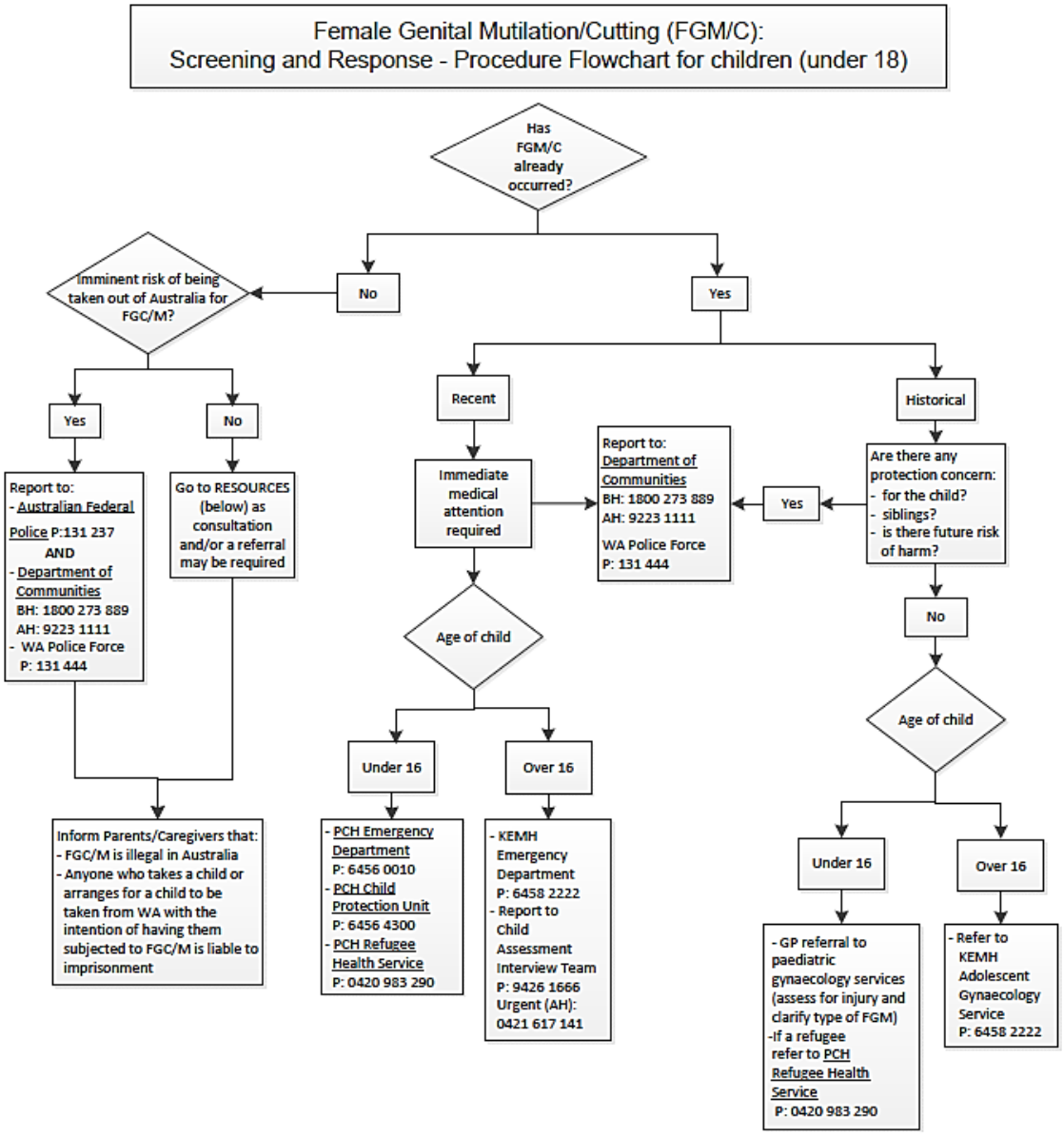
[27] Female Genital Mutilation [Internet] https://www.unicef.org/protection/female-genital-mutilation

Parents should sensitively be advised that female genital mutilation/cutting (FGM/C) is illegal. Staff should not use the terminology “mutilation” with patients or families as it is deemed offensive. Rather the terms “circumcision and/or cutting” should be used when broaching the subject. Information to parents on the health issues associated with FGM/C should be provided. Consultation with Perth Children’s Hospital Child Protection Unit may assist with preliminary assessment/information gathering and notification to Communities. When female genital cutting/ mutilation has occurred (see Figure 8).

For acute injuries or signs of recent FGM/C, the child should be seen at Perth Children’s Hospital Emergency Department for children of up to 16 years of age or King Edward Memorial Hospital (KEMH) Emergency Department for children over 16 years of age.

If the child resides in a regional or rural area, they should be seen at the local regional hospital, preferably by a Paediatrician. Consultation with Perth Children’s Hospital Child Protection Unit is still recommended unless the practitioner is experienced in working with FGM/C. If the child or adolescent is of a refugee-like background, then consultation with the Perth Children’s Hospital Refugee Health Service (Figure 8) should be undertaken.

Figure 8. Female Genital Cutting / Mutilation



RESOURCES / REFERRALS
The following services are available for consultation and referral:

Department of Communities
- Metro: Central Intake Team P: 1800 273 889 and submit a Child Protection Concern referral report
- Country: Local regional office during business hours and submit a Child Protection Concern referral report
- After hours: to report immediate concerns, contact Crisis Care Unit, P: 9223 1111

- PCH Refugee Health Service P: 0420 983 290 (Monday to Friday, business hours) for refugee/asylum seeker
- KEMH eLearning FGC/M E-learning package
- FGC/M Booklet
- Child Assessment and Interview Team, P: 9428 1666 Email: ChildAssessmentandInterviewTeamSMAIL@police.wa.gov.au
- National Education Toolkit for Female Genital Mutilation/Cutting Awareness (NEFTA)

Forced and underage child marriage

Forced marriage is a marriage that is performed under duress and without the full and informed consent or free will of both parties. Underage marriage is also a significant risk, particularly in some cultural groups where it is considered normal practice. There may be no signs of “duress”, but underage marriage is within the realms of child protection concerns. Furthermore, Australian legislation pertains to legal, cultural and religious marriages and applies to children and adolescents under 18 years of age. For those between 16-17 years of age, marriage is only permitted through Court order regardless of parental consent.

Being under duress includes feeling both physical and emotional pressure. Some victims of forced marriage are tricked into going to another country by their families.

Victims fall prey to forced marriage through deception, abduction, coercion, fear, and inducements or through more subtle means including psychological oppression, abuse of power or taking advantage of a person’s vulnerability. Forced marriage is different from an arranged marriage where the choice of whether or not to accept the arrangement remains with the prospective spouses. There is a grey area between forced marriage and arranged marriage as many arranged marriages are forced by nature. The issue remains around the normalisation of such practices amongst certain cultural groups.

A forced marriage may be between children, a child and an adult, or between adults. Forced marriage is a crime in Australia under the Australian government’s *Criminal Code Act, 1995*. It is considered a violation of the United Nations Convention on the Rights of the Child and is proscribed under the Convention on the Elimination of All Forms of Discrimination against Women (Article 16).

Responding when a child is at risk of forced marriage

If a child is at imminent risk of a forced marriage or being removed from Australia for the purpose of forced marriage, contact should be made with the Australian Federal Police (T 131 237) and the WA Police (T 13144) or in an emergency, dial 000. A child protection report should be submitted to Communities, preferably within 24 hours.

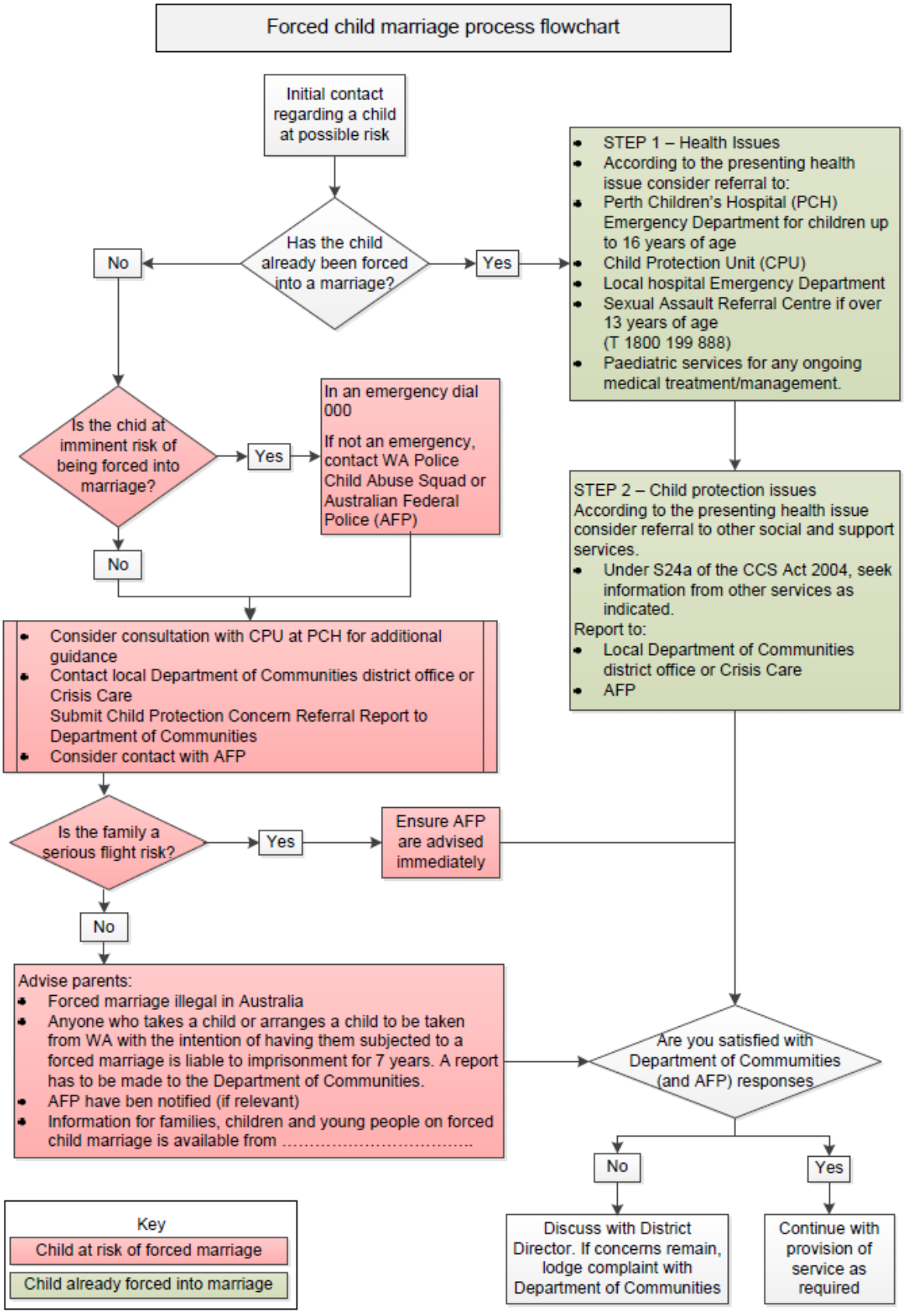
If there are non-urgent concerns that a child is at risk of forced marriage in the future, contact should be made with Communities and a child protection report submitted as soon as practicable. The Perth Children’s Hospital Child Protection Unit (T 6456 4300) can assist with preliminary assessment/information gathering and notification to Communities.

Parents should sensitively be advised (if it is safe to do so) that forced marriage is illegal in Australia and that a person who takes a child or arranges for a child to be taken from Western Australia to have them subjected to forced marriage is liable to imprisonment for up to seven years.[28]

If the child or adolescent is of a refugee-like background, then consultation with the Perth Children's Hospital Refugee Health Service (Figure 9) should be undertaken.

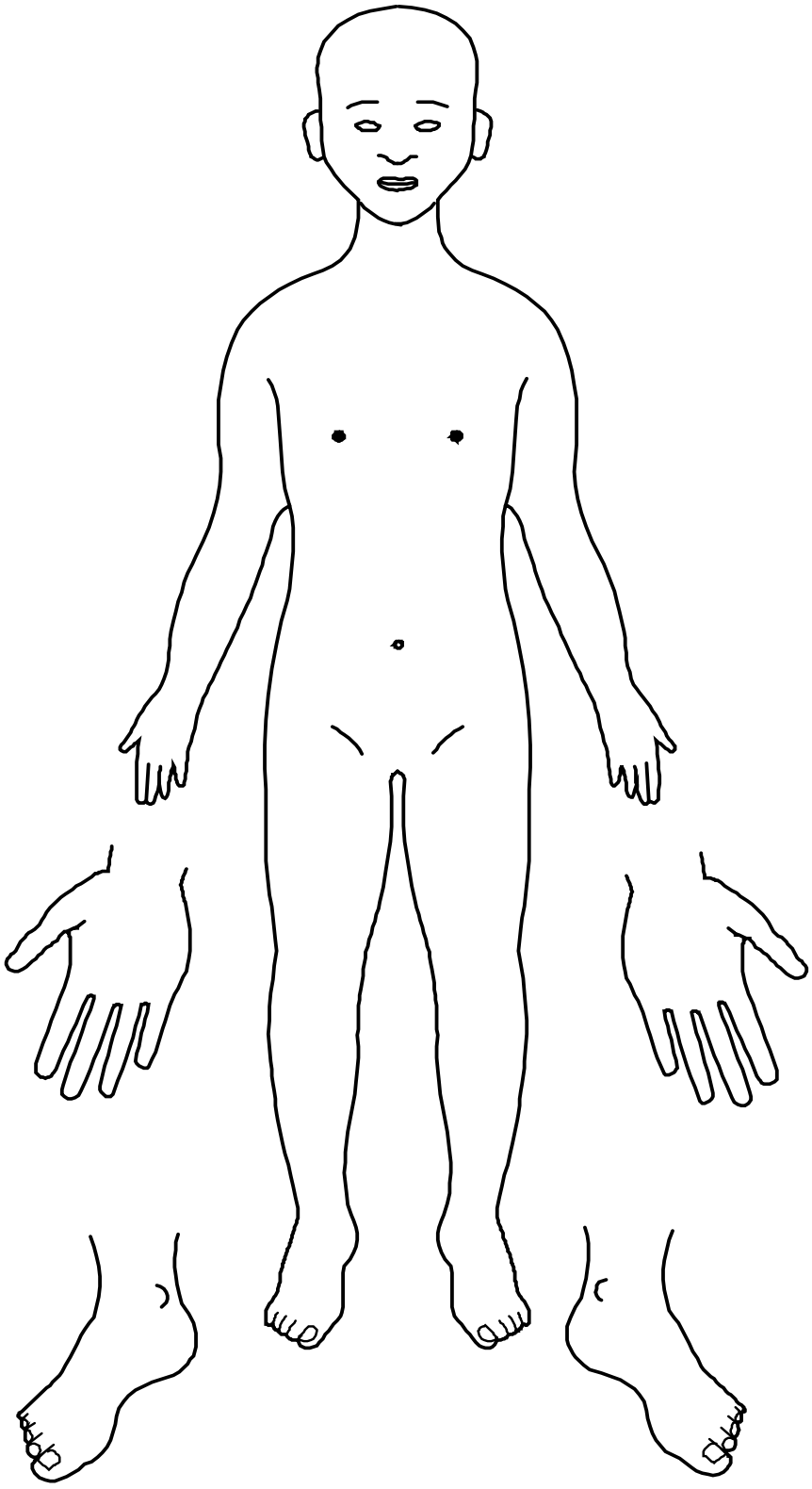
28 Criminal Code Act, 1995

Figure 9. Forced child marriage



Appendix A

When describing wounds (bruise/abrasion/laceration/burn/incision) record site, size, shape, colour, depth, borders, contents, healing.



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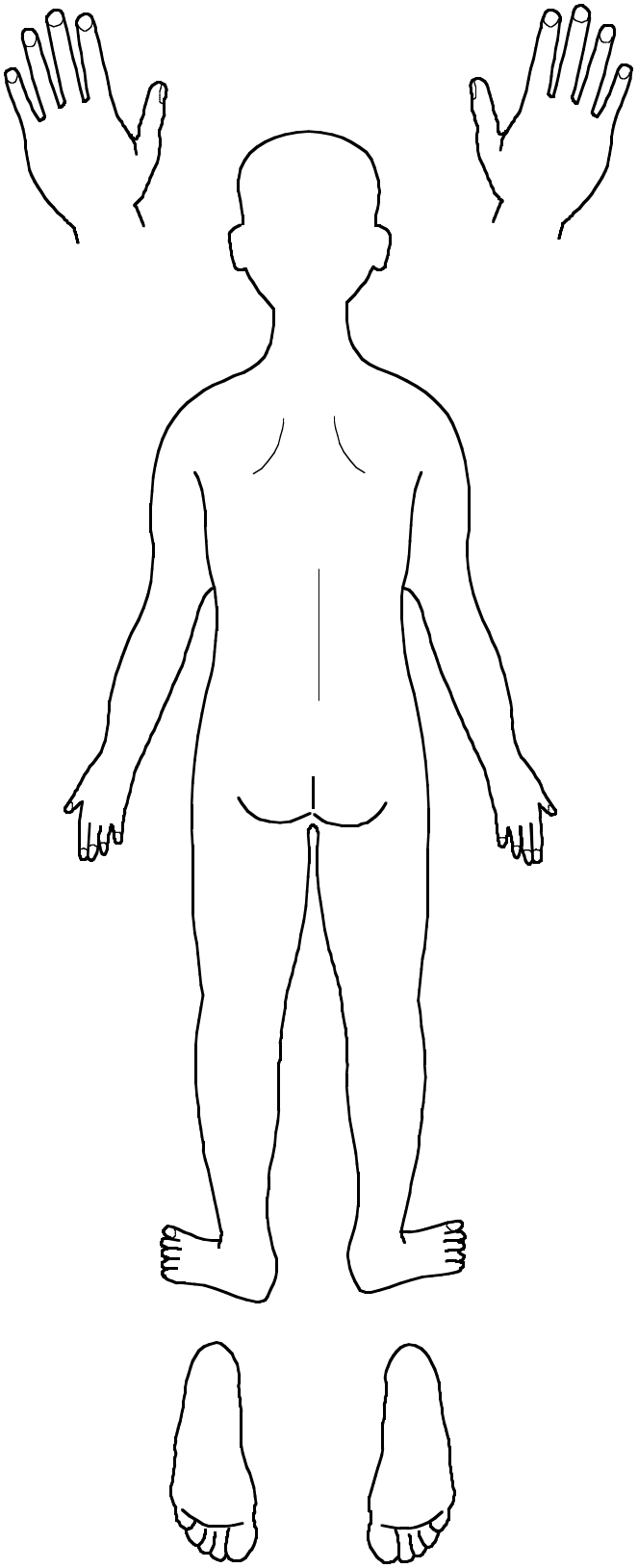

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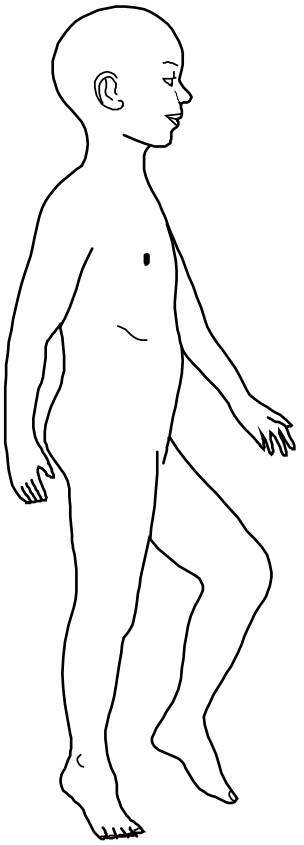

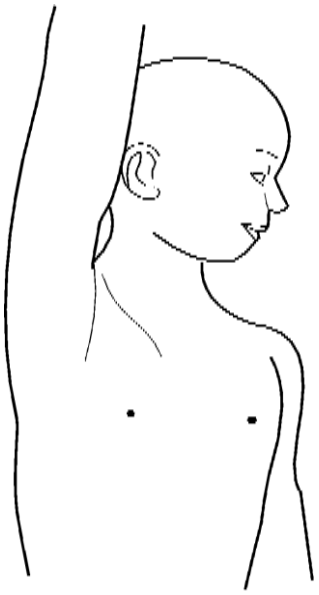

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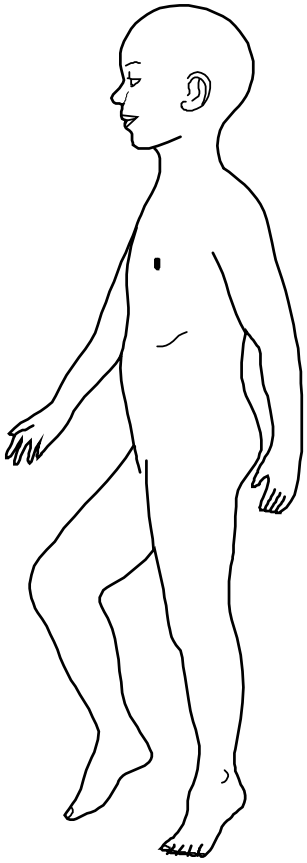

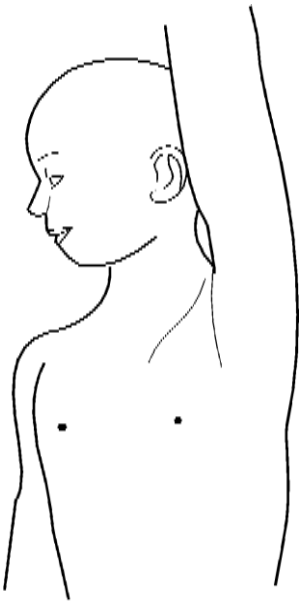

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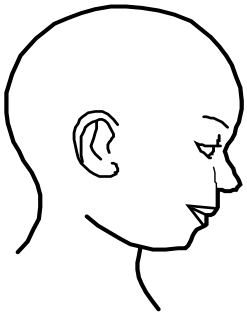
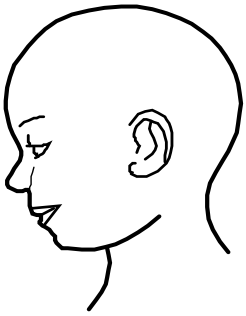
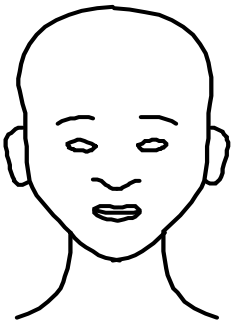
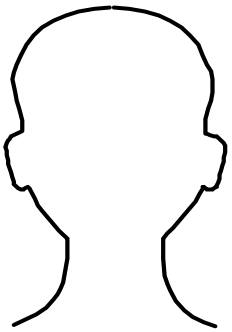
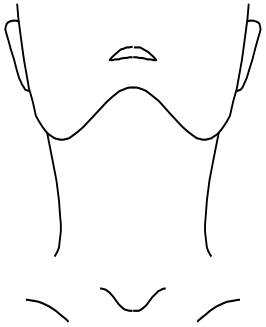




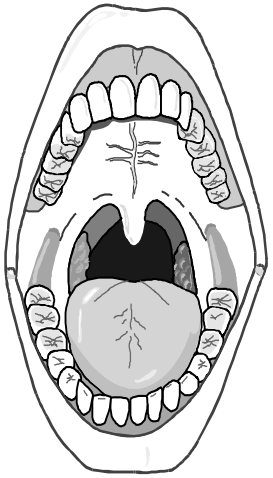




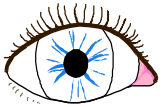
Mouth

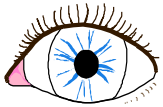


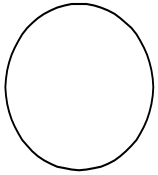
Jaw and Neck

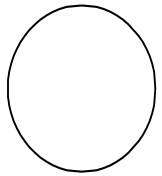


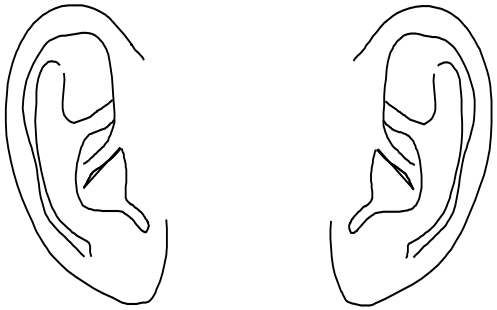
Note: Palate, teeth, gums and frenulum











Glossary

Term	Definitions
Authorised Entity	***Authorised entity*** means — (a) the CEO of a non-government provider; or (b) the governing body of a registered school or school system under the *School Education Act 1999* Part 4: Non-government social services organisations are non-government providers and are providing social services under a contract or other agreement with a prescribed authority or with Communities. Non-government schools and Independent schools are authorised entities. The Principal is the delegated officer.
CaLD	Culturally and Linguistically Diverse. Refers to people or communities for whom English is not the first language and/or who were born into a culture significantly different from the dominant non-Aboriginal Australian culture. CaLD groups include refugees, asylum seekers and migrants.
Child	A child is a person who is under 18 years of age, and in the absence of positive evidence as to age, means a person who is apparently under 18 years of age.
Child abuse	All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power (World Health Organisation)
Child protection concern	Concern about the wellbeing of a child based on the observation of indicators or information that may lead to a concern for: • the care of the child; • the physical, emotional, psychological and educational health and/or sexual development of the child; and the safety of the child (s3 *Children and Community Services Act 2004*).
Child safe organisation	The Australian Children's Commissioners and Guardians define a child safe organisation as one that consciously and systematically: • creates conditions that reduce the likelihood of harm occurring to children and young people; • create conditions that increase the likelihood of any harm being discovered; and • responds appropriately to any disclosures, allegations or suspicions of harm.
Child/ren in care	In relation to a child in care under section 30(a) and (b) of the CSSA, the Chief Executive Officer has a legal authority in place of the parents and holds all decision-making authority for that child. In relation to a child in care under section 30(c) the CEO may have legal responsibility. The child's parents are still legally responsible for their child if that child is in the CEO's care under section 32(1)(a).
Communities	The statutory government agency for child protection in Western Australia (formerly known as the Department for Child Protection and Family Support).

Child Protection Unit (CPU)	The Child Protection Unit, based at Perth Children's Hospital is a specialised, hospital-based service providing medical, forensic, social work and therapeutic services for children and their families when there is a concern that a child has, or may have suffered from child abuse.
Emotional abuse	Emotional abuse occurs when an adult harms a child's development by repeatedly treating and speaking to a child in ways that damage the child's ability to feel and express their feelings. Emotional abuse also includes being exposed to family violence.
Family and Domestic Violence	The Restraining Orders Act 1997 (WA) Section 5A(1) defines Family and Domestic Violence (FDV) as '*violent, threatening or other behaviour by a person towards a family member that coerces or controls the family member or causes the family member to be fearful.'*
FGM/C	Female genital mutilation/cutting
Health Service Provider	The WA health system is broken into the Department of Health as well as seven Health Service Providers including • Child and Adolescent Health Services • North Metropolitan Health Services • South Metropolitan Health Services • WA Country Health Services • East Metropolitan Health Services • PathWest • Health Support Services A Health Service Provider is a public hospital, a public health service facility or public health service assigned to a health service area and who provide for the health services in Western Australia. As statutory authorities, Health Service Providers are accountable to the public for their operations and subject to a range of legislation. Health Service Providers are responsible and accountable for providing safe, high quality, and efficient health services to their local communities.
Mandatory Reporters of Child Sexual Abuse	Within this document mandatory reporters refer to mandatory reporters of child sexual abuse. Doctors, nurses, midwives, teachers, police officers and boarding supervisors who form a belief of child sexual abuse on reasonable grounds during the course of their work, either voluntary or paid, are mandatory reporters of child sexual abuse under the Children and Community Services Act 2004.
Mature Minor	A young person under 18 years whose maturity is assessed as being such that he/she can interact on an adult level for specific purposes such as consenting to medical treatment.
MOU	Memorandum of Understanding. A formal, non-legally binding, agreement between two or more parties covering shared intent, responsibilities and agreed actions.
Neglect	Neglect is the failure of a parent or caregiver to provide, arrange or allow the provision of adequate care for the child or effective medical, therapeutic or remedial treatment for the child. Neglect can be intentional or the unintentional

	failure of the caregiver to provide a child with adequate food or shelter, nurturance or supervision to a severe and/or persistent extent.
Physical abuse	Physical abuse occurs when a child is severely and/or persistently hurt or injured through behaviours including, but not limited to, beating, shaking, excessive discipline or physical punishment, inappropriate administration of alcohol or drugs, attempted suffocation.
Prescribed Government Authorities	*Prescribed authority* means a public authority (other than Communities). Prescribed authorities can share information with each other if it is relevant to the wellbeing of a child or the safety of a victim of Family Violence, without the involvement of Communities. Regulation 20A of the *Children and Community Services Regulations* (2006) prescribes the Western Australian public authorities that are able to use the information sharing powers in section 28B of the *Children and Community Services Act 2004*. They are referred to as ***prescribed authorities***. Some examples of prescribed authorities are the departments of Education; Justice; the Premier and Cabinet; Treasury; The Western Australian Police; State Training Providers; the WA Health system (not a complete list). A complete list of prescribed authorities can be located at www.cpfs.wa.gov.au
Public Authority	Public authority means a department of the Public Service; or a State agency or instrumentality; or a local government, regional local government or regional subsidiary; or a body, whether corporate or uni-corporate or the holder of an office, post or position, established or continued for a public purpose under a written law. ***WA Health is a public authority.***
SARC	Sexual Assault Resource Centre. It provides a 24-hour emergency medical, forensic and counselling service in metropolitan Perth to anyone 13 years and over who has been sexually assaulted within the previous 14 days. It also provides counselling in centres across the Perth metropolitan area to people who have experienced sexual assault and sexual abuse in the past.
Sexual abuse	Sexual abuse occurs when a child has been exposed or subjected to sexual behaviours that are exploitative and/or inappropriate to their age and developmental level and that the child does not comprehend or to which she/he is not able to give informed consent. It includes behaviours where the child is subject to bribery, coercion, threats and violence; the child has less power than the other person involved in the behaviour; there is significant disparity in the developmental function or maturity of the child and another person involved in the behaviour.
STI	Sexually Transmitted Infection.

Resources

A comprehensive health service supporting the health, development and wellbeing of young Western Australians. Includes:

Child and Adolescent Health Services

Child and Adolescent Community Health - offers child health assessments, screening, immunisation, support and advice to every child born in the Perth metropolitan area. Additional services are offered to families who might need them, including children with developmental delay, Aboriginal families, refugee families and families in need of additional support.

Child and Adolescent Mental Health Service - offers support, advice and treatment to young people and their families who are experiencing mental health issues. Children and families are referred to Mental Health by their treating therapist, specialist, GP, School or other community organisation.

Perth Children's Hospital

Child Protection Unit is a specialised, hospital-based service providing medical, forensic, social work and therapeutic services for children and their families when there is a concern that a child has, or may have suffered from child abuse

Koorliny Moort (Walking with Families) Ambulatory Care Coordination Services provides out of hospital care to Aboriginal families who might find it hard to come into hospital for their paediatric appointments or who want to stay closer to home. We aim to improve out of hospital care for Aboriginal children and provide care closer to where families live.

Refugee Health Service is a multidisciplinary service consisting of both hospital and community health care providers from medical, nursing, social work, dietetics, dentistry, mental health and school liaison services. It aims to meet the medical, developmental, educational and psychosocial domains of care for children and adolescents from refugee-like backgrounds in Western Australia within a culturally appropriate and trauma-informed framework.

Kind Edward Memorial Hospital

Adolescent Support Service - begin building a relationship with the young women booked to the KEMH Adolescent antenatal clinic during their pregnancy. The midwives provide ongoing care into the postnatal period for up to four months (longer if required). The Adolescent Support Service liaise with and handover care to the Child Health Nurse upon discharge from our service.

Mental Health Commission The Mental Health Commission strives to establish mental health, alcohol and other drug systems that provide and partner in the delivery of:

- prevention, promotion and early intervention programs (mental health, alcohol and drugs)
- treatment, services and supports
- research, policy and system improvements.

Information resources

Australian Institute of Family Studies: AIFS) are the Australian Government's key research body in the area of family wellbeing.

Child Family Community Australia: (CFCA) is AIFS' information hub for evidence, resources and support for professionals working in the child, family and community welfare sector.

Commissioner for Children and Young People **-** Western Australia
The Commissioner undertakes projects, research, publishes reports, and hosts events to highlight specific aspects of children and young people's wellbeing. Using research and the other evidence available, the Commissioner seeks to positively influence legislation, policy, services and attitudes.

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Women and Newborn Drug and Alcohol Service (WANDAS)– Information booklet

Family and Domestic Violence Toolbox

Gender based violence in the CALD community

Forced Marriage – bluesky.org.au (Australian Government initiative)

Sexual Assault Resource Centre (SARC) SARC is part of the Western Australian Department of Health and provides a range of free services to people 13 years old and above affected by sexual violence. SARC provides:

- Emergency services including medical, forensic and counselling support, up to 2 weeks after a sexual assault
- Counselling services for recent and past sexual assaults, rape and child sexual abuse
- Advice for health staff members about to see a patient following a sexual assault
- Education and training for professionals

Patient Care and Cultural Learning Guidelines (CAHS)
This guideline are designed as a quick reference tool to support healthcare staff in delivering safe, clinically and culturally responsive care to Aboriginal and Torres Strait Islander patients.

Royal Commission into Institutional Responses to Child Sexual Abuse - Final Report 2017

Statewide of Protection of Children Coordination Unit (CAHS)

Information sharing for the Protection of Children booklet Disability and Child Protection Issues

Self care - Employee Assistance Program (EAP)

All WA health system staff is provided with support through the EAP. Please contact your Health Service Provider employee support officer or Human Resources for further information on how to access this program.

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