



Government of **Western Australia**
Department of **Health**



Guidelines for Protecting Children 2015

Rescinded 14 March 2022.
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

About these Guidelines

The Guidelines for Protecting Children 2015 cover the purpose, legislative and operational basis, roles, responsibilities and practice principles for the protection of children with which all WA Health employees must comply.

The Guidelines detail the obligations of all WA Health staff when identifying or responding to health and safety concerns for children as a result of abuse or neglect and should sit alongside the use of due care and skill by WA Health staff involved in the provision of health care to children and their families.

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Foreword from Department of Health WA Child Safety Director

WA Health has a strong commitment to ensuring the health, safety, welfare and wellbeing of all children in this State. This commitment is reinforced by supporting, educating and informing WA Health staff of their roles and responsibilities for protecting children through the **Guidelines for Protecting Children 2015**.

These **Guidelines for Protecting Children 2015** detail the obligations of WA Health staff under the *Children and Community Services Act 2004* and related WA Health policies. Health staff have a responsibility to recognise and respond to health and safety concerns for children. As a part of this role, WA Health staff need to take action whenever a child has been identified as being in need of protection from harm arising from abuse and neglect. All WA Health staff are required to comply with the Guidelines.

The policies and procedures in these Guidelines, including the WA Health Protection of Children Policy, inform practice and guide health staff in the strengthening of their role as important players in child wellbeing and child protection.

The main premise of the Guidelines is to ensure the safety, protection and wellbeing of children as a shared responsibility. WA Health, Department for Child Protection and Family Support (CPFS), other government and non-government departments, communities and families provide an integrated system of collaborative endeavour that can help identify and address the complex needs of vulnerable children and their families.

These Guidelines confirm the ongoing role of WA Health staff in providing health services to children once a notification of child abuse or neglect has been made, provide additional information or information exchange in child protection and include a new section on special risk groups.

It is with great pleasure that I present this edition of the **Guidelines for Protecting Children 2015**. I encourage users of this guide to collaborate across all levels of WA Health and to work with key stakeholders to ensure that the children in our care have their health, safety and wellbeing needs recognised and addressed.

Child Safety Director, Department of Health WA

What to do – a summary: Identification of and Responses to Possible Child Abuse and Neglect

STEP 1 – Identify concerns

Familiarise yourself with risk factors and possible indicators of child abuse and neglect

Prioritise the possible impact on the child over and above any concerns for the parents/carers

You may be concerned about a child because you have:

- observed indicators
- received a disclosure
- knowledge of risk factors.

Document concerns and the basis for them.

Consult with colleagues.

GO to STEP 2

STEP 2 – Assess, consult, examine and document

You need to:

1. Provide or refer for emergency/first aid treatment if the child has acute injuries.
2. Complete a full assessment of the child and the circumstances, including identifying any indicators of child abuse, neglect and/or family and domestic violence.
3. Respond sensitively to the child throughout the assessment e.g. not his/her fault, happened to others, help available. Be sensitive to the child's age, development, gender, ethnicity, culture and psychological state and how this may impact on the child's ability to engage.
4. Respond to the parent/carers e.g. be honest as appropriate, supportive, clear about health worker responsibilities.
5. Consult with an appropriate health worker or your line manager.
6. Consider issues of information sharing, confidentiality and consent to treatment.
7. Consider that the assessment may also include a physical examination at, or in consultation with, [PMH Child Protection Unit](#) and/or [Sexual Assault Resource Centre](#) and/or by a specialist medical officer in country regions. If after hours: refer directly to PMH Child Protection Unit and/or Sexual Assault Resource Centre or identified specialist medical provider in country regions.
8. Consult, as appropriate, with other/external agencies e.g. Mental Health Services, [Department for Child Protection and Family Support](#) (CPFS), WA Police Child Abuse Squad.
9. Document your concerns, observations and actions according to your local health area protocols.

IF you have formed the belief that the child has been harmed or is likely to be harmed:

Have your notes and the child's details ready and

Go to STEP 3

IF you still have concerns, but not for immediate safety issues:

Go to STEP 4

STEP 3 – Taking action/making notifications and referrals

Based on level of harm/risk assessed:

If assessment indicates the child has been abused or neglected or is currently at clear risk then notify CPFS as soon as practicable on a [Child Protection Concern Referral Form](#).

Follow up any verbal report to the local CPFS office with a completed form as soon as possible.

- Document and file all information as per local health area protocols.
- Consultation with PMH Child Protection Unit (9340 8646) or identified specialist medical officer is highly recommended prior to making any notification to CPFS.
- Refer to Section 2:3 for other possible actions/referral options

STEP 3a – Notify child sexual abuse – mandatory reporting

If you are a Mandatory Reporter (doctor, nurse or midwife) for child sexual abuse you must report as soon as practicable (and after any consultation with colleagues, supervisor) to the CPFS Crisis Care Mandatory Reporting Service that you have formed a belief based on reasonable grounds that a child who is still aged under 18 years has been, or is being, sexually abused.

Mandatory Report forms can be accessed at www.mandatoryreporting.dcp.wa.gov.au

- Send the report to CPFS Mandatory Reporting Service (mrs@dcp.wa.gov.au) or fax 1800 610 614.
- CPFS will provide a Receipt Number, indicating they have received the report, within 24 hours.
- CPFS will provide a standardised letter confirming if the report has been forwarded to a CPFS District Office.
- File a copy of the report, Receipt Number and letter from CPFS in accordance with area health child abuse and neglect protocols.

The requirement to report is in addition to, and does not affect, any other function that the reporter has with respect to the child in the course of the reporter's work.

STEP 4 – Ongoing management

May result in notification to CPFS at any stage

The choice of intervention will depend on the needs of each child and their family. These needs will often be complex and therefore it is important that individual health staff members consult with colleagues/line managers whenever possible so that they do not have to make decisions regarding ongoing care in isolation.

Options may include:

- further assessment to clarify current concerns, to obtain other information about exposure to abuse, neglect, family/domestic violence
- a physical examination as a component of assessment
- referral within WA Health (e.g. to a social worker) and/or another agency
- case management meetings
- ongoing monitoring and support
- other intervention as appropriate to your role/agency/profession
- consultation with line management or local specialist medical staff
- consultation with, or referral to, Child Protection Unit, PMH
- consultation with CPFS.

If at any point during ongoing case management you identify:

- ongoing indicators of abuse, neglect, family and domestic violence
- escalation of concerns about abuse, neglect, family and domestic violence
- multiple or further risk factors, then

Return to Step 3

If at any point during ongoing case management you (as a doctor, nurse or midwife)

- Form a belief, on reasonable grounds, that the child has been or is likely to have been sexually abused, then

Return to Step 3a

Useful contacts

WA Health

Child Protection Unit, Princess Margaret Hospital

Mon–Fri (8.30am–5.00pm) 9340 8646

Sat–Sun (8.30am–midnight) 9340 8222

Mon–Fri (5.00pm–midnight)

Outside these hours the call will be directed to PMH Emergency Department.

Sexual Assault Resource Centre – Metro

24-Hour Emergency Line

Phone: 9340 1828

(free call except from mobiles) 1800 199 888

Regional Sexual Assault Services

Call SARC metro service (above) for details and/or refer to list in Section 5

Statewide Protection of Children Coordination (SP2CC) Unit

Phone: 9224 1932

www.health.wa.gov.au/mandatoryreport

Telephone Interpreter Service (TIS)

Phone: 131 450

Department for Child Protection and Family Support (CPFS)

Crisis Care

Phone (24-hr service): 9223 1111

(free call except from mobiles) 1800 199 008

Family Helpline

Phone (24-hr service): 9223 1100

(free call except from mobiles) 1800 643 000

CPFS Mandatory Reporting Service

Phone: 1800 708 704

www.mandatoryreporting.cpfs.wa.gov.au

WA Police

Child Assessment Interview Team (CAIT)

Phone: 9428 1666

Child Abuse Squad

Phone: 9428 1500

(24-hr 'on call' for urgent matters)

0421 617 141

Useful local contacts

Aboriginal Medical Service – local contact

Name: _____

Phone: _____

Child abuse colleague/consultant – local contact

Name: _____

Phone: _____

Department for Child Protection and Family Support – District Office

Name: _____

Phone: _____

Health social worker – local contact

Name: _____

Phone: _____

Police – local station

Name: _____

Phone: _____

Other

Name: _____

Phone: _____

Name: _____

Phone: _____

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Reporting of Child Sexual Abuse
Training Policy**

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Glossary of terms and abbreviations

Term	Definition
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
At risk	Children in families where there are risk factors and limited protective factors indicating the children may be at risk of abuse and/or neglect.
Authorised Entity	Non-government providers and school bodies that, under the CCSA (section 24A,B,C), are protected from liability when they disclose confidential information related to the wellbeing of a child or group of children between themselves and/or Prescribed Government Authorities.
Best Beginnings	A joint CPFS/WA Health nurse home visiting service for families of new infants that aims to improve child health and wellbeing, parent and family functioning and social support networks for 'at risk' families.
Best interests of the child	The requirement that a decision-maker or person taking action in relation to a child must regard the best interests of the child or young person as the paramount consideration.
CAIT	Child Assessment Interview Team
CALD	Culturally and linguistically diverse, comprises people for whom English is not their 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.
CAMHS	Child and Adolescent Mental Health Service. Provides mental health programs in community and hospital-based settings to infants, children, young people under 18 years and their families who are experiencing significant mental health issues.
Case management	Overall coordination, implementation and management of care plans for a child and/or their family.
CCSA	<i>Children and Community Services Act 2004</i> ; the legislation that covers all protection of children matters in WA.
CDCD	Department of Health Communicable Diseases Control Directorate.
CDS	Child Development Service
CEO of CPFS	The Chief Executive Officer of the Department for Child Protection and Family Support.
Child	Anyone under 18 years of age, including unborn children.
Children in care	For a child in care under section 30(a) and (b) of the CSSA, the CEO of CPFS has legal authority in place of the parents and holds all decision-making authority for that child. For 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).
Child maltreatment	An inclusive term that refers to all forms of child abuse and neglect.
Child protection	Statutory services designed to protect children who are at risk of harm.
Child wellbeing	The care, development, health and safety of the child. It includes their physical and emotional development and wellbeing.
Collaboration	An intra- and inter-agency approach to planning, information exchange and service provision, designed to achieve better outcomes for children.

Term	Definition
CPFS	Department for Child Protection and Family Support. The statutory government agency for child protection in WA (formerly known as the Department for Child Protection).
CPFSMRS	Department for Child Protection and Family Support Mandatory Reporting Service. The branch of CPFS that manages the receipt and initial assessment of all mandatory reports of child sexual abuse.
CPU	Child Protection Unit. A specialist hospital-based (Princess Margaret Hospital) service for children and their families where abuse or neglect is a concern. It provides medical and forensic examinations, a social work and therapy service and a consultative service to health staff on child protection matters.
Cumulative harm	The effects of patterns of circumstances and events in a child's life. Cumulative harm may be caused by an accumulation of a single, recurring adverse circumstance or event, or by multiple circumstances or events. The cumulative daily impact of these experiences on the child can be profound and exponential, and diminish a child's sense of safety, stability and wellbeing.
Domestic violence	As it relates to any dependent child living in a home where one adult they are dependent on (usually the father) subjects the other adult (usually the mother) to ongoing threatening, abusive or intimidating behaviour; resulting in detrimental consequences for the child.
Emotional abuse	The sustained, repetitive, inappropriate, ill treatment of a child through parent/caregiver behaviours such as: threatening, isolating, withholding of emotional nurturance and closeness, discrediting, belittling, teasing, humiliating, bullying, confusing, ignoring and inappropriate encouragement.
FGM	Female genital mutilation.
Good enough parenting	Parenting that adequately meets the child's needs, according to prevailing cultural standards which can change from generation to generation. Includes physical care, nutrition, safety and emotional care which includes love, commitment, consistent limit setting and the facilitation of development.
Harm	Any detrimental effect of a significant nature on a child's physical or emotional wellbeing as a result of the actions or inactions of caregivers.
Healthcare planning for children in care	A healthcare plan is required for all children in care. The plan comprises an immediate medical examination on entry into care that identifies current health needs. An annual health care assessment is also undertaken that aims to improve the physical, developmental and emotional and mental health outcomes for children.
Indicators of abuse and neglect	Physical, emotional, behavioural or relational signs that can point to the possibility of child abuse or neglect. Each possible indicator is to be considered in relation to other indicators and to risk factors.
Infant	A child aged from zero to 12 months.
Inflicted injury	Injury caused as a result of the intentional actions of another.

Term

Definition

Information exchange	A two-way process for the giving and receiving of relevant, client-specific information concerning the care, health, safety and development of a child. It covers WA Health requesting information, responding to requests and initiating the provision of information. These processes support ongoing WA Health assessments and service provision alongside any assessment and investigation undertaken by other agencies.
Mandatory reporting of child sexual abuse	The legal requirement for doctors, nurses and midwives (and police and teachers) to make a formal report to CPFS whenever they have formed a belief, based on reasonable grounds, that a child has or is being sexually abused.
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 certain 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	The persistent intentional or unintentional failure of the caregiver to meet a child's basic physical, medical and/or emotional needs, such failure being likely to result in the serious impairment of the child's health and/or development.
Non-accidental injury	See 'Inflicted injury'.
Non-substantiation	The outcome of an investigation and assessment by CPFS that results in a determination that there is nil or insufficient evidence that the child has experienced, or is at risk of experiencing, harm.
Notification	Informing CPFS – via a mandatory report of child sexual abuse or for abuse or neglect via a <i>Child Protection Concern Referral Form</i> – about a child abuse or neglect concern for a child or group of children.
OD	Operational directive
Physical abuse	Severe and/or persistent ill-treatment through behaviours including, but not limited to, beating, shaking, excessive discipline or physical punishment, inappropriate administration of alcohol or drugs, attempted suffocation.
PMH	Princess Margaret Hospital
Prescribed Government Authorities	A number of state government departments that, under the CCSA (section 28A,B,C) are protected from liability when they disclose confidential information related to the wellbeing of a child or group of children between themselves and/or an Authorised Entity.
Reasonable grounds	The basis for suspecting that a child or young person may be at risk of significant harm, based on firsthand observations, what the child young person, parent or another person has disclosed and/or what can reasonably be inferred, based on professional training, judgement and/or experience.
Risk Factors	A range of historical and current background information concerning the parent and/or the child that can indicate a higher-than-average likelihood of child abuse or neglect.

Term	Definition
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	Exposure or subjection to sexual behaviours that are exploitative and/or inappropriate to the child's age and developmental level. Examples include sexual penetration of the vagina, anus or mouth, inappropriate touching, exposure to sexual acts or pornographic materials, and using the internet for grooming and soliciting children for sexual exploitation.
SIPM	Serious injury planning meeting
SOS	Signs of Safety. The child protection practice framework used by CPFS to inform their assessment, planning and decision-making processes.
SOS Meetings	Signs of Safety Meetings. The case management process by CPFS where families and involved others (including WA Health) are brought together to gather and share information to assist planning and decision-making.
STI	Sexually transmitted infection
Substantiation	The outcome of an investigation and assessment by CPFS that results in a determination by CPFS that a child has been or is likely to be abused, neglected or otherwise harmed. Substantiation requires a lower level of proof than that required in a court of law.
UNICEF	United Nations Children's Fund
WACHS	Western Australian Country Health Service
WA Health	Refers collectively to the public health system of Western Australia including the Department of Health, the various metropolitan and country area health services, public hospitals and other public health agencies.

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1. Background information

1.1 WA Health Protection of Children Policy

1.2 Child abuse and neglect facts – Western Australia

1.3 Communicating with families when there are protection of children concerns

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1. Background information

1.1 WA Health Protection of Children Policy

Introduction

The WA Department of Health (WA Health) recognises that every child (0 to under 18 years of age and including unborn children) has a right to be safe and to live without fear, abuse or violence in their families and communities. Children and young people who experience physical, emotional or sexual abuse and/or neglect, including living with family and domestic violence, are likely to suffer harm that is detrimental to their wellbeing and development and their potential to grow into secure, well-adjusted adults.

Most child abuse and neglect is perpetrated by adults who have a care responsibility for the child (parents, carers or guardians), and is rarely an isolated incident. Most children who are maltreated are subjected to multiple and ongoing forms of abuse.

WA Health has a responsibility to take action that promotes children's safety and wellbeing and, when necessary, to make reports to the appropriate authorities. Health services should be alert to the possibility of child protection and wellbeing concerns with the children of parents receiving adult health services. Parental health problems, such as chronic and complex health needs, drug and alcohol abuse, mental illness, domestic violence and the impact of historical trauma and disadvantage, are significant contributors to an increased risk of child abuse and neglect.

All health staff need to be able to recognise and respond to child wellbeing and protection concerns. It is important to know what action to take to protect children and to be supported to address concerns as early as possible, in consultation with internal and external colleagues as appropriate.

It is also important that if a health staff member remains concerned – and regardless of any alternative opinions from colleagues with whom they have consulted – that a child has been abused or neglected or is at clear risk, then they should take appropriate action, including notifying CPFS.

Purpose

This policy is WA Health's approach to safeguarding and promoting the health and wellbeing of children and young people when there are concerns about abuse and neglect, including when statutory action has already been taken. It provides the foundation for the development of child protection-related policies and procedures relevant to each area health service.

This policy is informed by and compatible with the following WA Health frameworks and guidelines:

- [Level 1 Strategic Bilateral MOU between WA Health and Department for Child Protection](#)
- [Joint guidelines on information sharing between WA Health and Department for Child Protection](#)
- [Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby Is Identified as at Risk of Abuse and/or Neglect.](#)
- [Operational Guidelines: Interagency Management of Children Under 14 Who are Diagnosed With a Sexually Transmitted Infection \(STI\)](#)
- [MOU: Information sharing between agencies with responsibilities for preventing and responding to family and domestic violence in Western Australia](#)
- [Guidelines for Responding to Family and Domestic Violence, Women and Newborn Health Service, 2014](#)

All WA Health staff must act in accordance with these documents.

Governance

WA Health's Director for Child Safety is appointed by and reports to the Director General on matters related to child protection and child abuse across the department. The WA Health Protection of Children Advisory Group comprises senior representatives from each health service area, who advise and report to the Director for Child Safety. The group coordinates and oversees the WA Health policies and processes with regard to child abuse and neglect.

Child abuse and neglect

For the purposes of this policy, child abuse and neglect refers to the harm experienced by children as a result of the actions, inactions or inability of the people with parental responsibility for them. The harm experienced by the child may arise from a significant event or from the cumulative effect of a pattern of abuse and neglect.

This policy recognises that child abuse and neglect is rarely an isolated incident and is more likely to be an ongoing and sometimes escalating pattern of behaviour. All forms of child abuse can have short-term and long-term impacts for children, and not all children react to harm in the same way. Some children show no observable effects of child abuse, while others show a wide range of signs. There may be long-term impacts even when short-term effects are not apparent. The younger the child, and therefore the more vulnerable they are, the more serious the consequences are likely to be.

Relevant legislation

The [Children and Community Services Act 2004](#) (CCSA) is the Act concerning child protection. Relevant sections are:

- Division 2 General principles relating to children
- Division 3 Principles relating to Aboriginal and Torres Strait Islander children
- Section 23 Requesting and disclosing information with the Department for Child Protection and Family Support
- Section 24A Requesting and disclosing information – authorities other than the Department for Child Protection and Family Support
- Section 28 Describes when a child is considered to be in need of protection
- Section 33A Chief Executive Officer Department for Child Protection and Family Support may cause enquiries to be made before a child is born
- Section 40 Power to keep child under 6 years of age in hospital
- Section 129 Protection from liability for giving confidential client information
- Section 240 Protection to the confidentiality of a reporter
- Division 9A Mandatory reporting of child sexual abuse requirements.

Role of WA Health and health staff

All WA Health staff have a professional obligation to take action on behalf of a child that they believe is being, or is likely to be, abused or neglected. When there are concerns of possible child abuse and/or neglect, the health staff member should endeavour to engage with the caregiver to help them understand the likely impact of their actions/inactions on the health, safety and wellbeing of the child and to support and strengthen their capacity to provide adequate care and protection for that child. The child's best interests are paramount so the health staff member must ensure the child's wellbeing is their primary focus and, where necessary, notify their concerns to CPFS and/or the WA Police.

All doctors, nurses and midwives are legally obliged to comply with the mandatory reporting of child sexual abuse legislation. WA Health has mandated that all professionally registered doctors (including Visiting Medical Practitioners), nurses and midwives employed by WA Health on a full- or part-time, permanent or contracted basis, or providing consultancy or sessional services and regardless of their current work role, must complete an information session on the mandatory reporting of child sexual abuse.

When concerns about a child exist

Action should be taken, in consultation with others, to ensure that plans are put in place to protect the child from (further) abuse or neglect. The involvement of other services cannot preclude the continuing provision of appropriate health services to that child (and their family).

In situations where WA Health staff have reasonable grounds for concerns regarding the immediate safety and wellbeing of a child, or significant harm caused to a child because of child abuse or neglect, a notification should be made to CPFS as soon as practicable, preferably within 24 hours or if immediate protective action is required, to WA Police.

Whenever concerns identified by a health staff member are not supported by others they have consulted but their concerns remain, they should still take action to ensure the wellbeing and safety of the child.

In situations where:

- no current harm has been detected but where potential risk is identified
- harm to a child is likely due to a perceived incapacity of the child's caregiver to protect the child
- possible abuse or neglect is suspected but there is insufficient information to formally refer to CPFS

the health staff member should ensure that any ongoing service provision remains alert to any change in risk status and the need to take additional action, as indicated.

Mandatory reporting of child sexual abuse

In addition to the ethical and professional obligations to ensure that action is taken to protect children from abuse or neglect, doctors, nurses and midwives are also legally obliged to report to CPFS whenever they have formed a belief, based on reasonable grounds, that child sexual abuse has occurred or is occurring.

A child is anyone aged under 18 years or, in the absence of evidence, appears to be aged under 18 years. Under [s124A of the CCSA](#), 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.

Reporters do not need to have evidence that a child is being sexually abused in order to make a report, but rather only a belief formed on reasonable grounds. For further information regarding obligations related to mandatory reporting refer to Section 2.3 of these guidelines, or contact the WA Health State-wide Protection of Children Coordination (SPOCC) unit or visit the [WA Health Child Abuse and Neglect website](#).

Obtaining consent for information shared and sought, and actions undertaken

The general principles regarding patient confidentiality and the seeking of consent to share information are set out in the [Information Circular: Patient Confidentiality](#). However, under the CCSA, confidential information may be provided without the consent of the parent and/or child (see Section 4 – Legal Information). Any decision not to seek the parent's and/or child's consent regarding a notification to CPFS should only be made after consultation with a senior colleague and should be based on an assessment of:

- flight risk or further risk of harm to the child
- serious security risk to the staff or other patients/clients.

The best outcomes for children are based on open and transparent practices that facilitate a trusting staff/client relationship, including that of supporting the parent to stay engaged with the health service provider and accepting referrals to other services.

Actions taken must be determined by the best interests of the child, including any indicated ongoing provision of health services.

Working together with CPFS to maximise safety and protection for children

Effective intervention to ensure the ongoing safety and protection of children is based on inter-agency collaboration. When agencies share relevant information, more holistic assessments and integrated provision of services can be provided to families and children with complex needs.

WA Health staff are most likely to interact with CPFS in matters of abuse and neglect. While the health staff member is primarily concerned with the child's physical, emotional and psychological health needs and the CPFS worker is concerned with the safety and protection of the child, collaboration will achieve better outcomes for the child.

The health staff member should aim to:

- develop working relationships with local CPFS workers
- seek and provide appropriate information and feedback
- be available to attend CPFS [Signs of Safety meetings](#)
- continue to provide health services after a notification to CPFS
- ensure the health needs of the child are met.

WA Health is a signatory to the State Cabinet endorsed whole-of-government Rapid Response framework in Western Australia. This framework prioritises access to government services for children and young people in the care of the Chief Executive Officer (CEO) of CPFS. WA Health prioritises according to clinical need and health impact and recognises that children in care are amongst the most vulnerable children, especially if they have complex high level health needs.

When a health staff member is concerned about possible abuse or neglect or risk of harm, but where the level of that concern or the available information does not indicate an immediate notification to CPFS, then the health staff member should leave the option of subsequent notification to CPFS open in any ongoing case management plan. Regular monitoring of the level of risk to the child and referral to other services must be considered.

All children who are in the care of the CEO of CPFS must have a healthcare plan. A systemic collaborative approach ensures that the health impacts of abuse and neglect for each child entering care will be identified and responded to by WA Health service providers and the information provided to CPFS.

See:

- [Schedule between CPFS and WA Health: Health Care Planning for Children In Care \(January 2015\)](#)
- [Joint guidelines on information sharing between WA Health and CPFS](#) for further information

1.2 Child abuse and neglect facts – Western Australia

Child abuse and neglect affect a small proportion of children in our society at any given time but the impact on those children may be significant and long-term in nature. Children who are abused and/or neglected are at increased risk of a range of adverse long-term developmental outcomes when compared to non-abused children. As adolescents, abused children have more drug and alcohol problems, behaviour problems, criminal offending and mental health disorders and lower academic achievement than non-abused children. For some, these early experiences of abuse and/or neglect place them, as adults, at higher risk of failing to adequately care for, nurture and protect their children.

Nationally, younger children have higher rates of substantiated abuse and neglect than older children. Abuse and neglect is substantiated amongst children less than 12 months of age at a rate (13 per 1000 children) more than four times higher than for 15–17 year olds. Retrospective research consistently demonstrates that the prevalence of child abuse and neglect is far higher than the statistics for notification and substantiation. This suggests that the majority of children experiencing abuse and neglect never come to the attention of, or are identified by, agencies and services.

In Western Australia, CPFSA received 19 336 notifications of child abuse or neglect involving 17 929 children during 2013/14. This was an 10.6% increase in notifications over the previous 12-month period. Emotional abuse was the most common form of abuse reported and was substantiated in 37% of finalised cases, followed by neglect (34% substantiation rate), physical abuse (28%) and sexual abuse (21%). The total number of finalised assessments of all child abuse and neglect notifications resulted in 29.4% substantiation. Many children experienced more than one type of abuse or neglect; in such cases the substantiation recorded the abuse considered by the child protection worker to be the most significant/harmful for that child.

Doctors, nurses and midwives were the notification source for 29% (623) of the 2169 mandatory reports of child sexual abuse submitted during 2013/14.

Aboriginal children comprise 5% of the total child population, yet on 30 June 2014 they comprised 51% (2144) of the 4237 number of children in care in Western Australia on that day. The reasons for this hugely disproportionate over-representation of Aboriginal children are complex and include the legacy of past government policies and their continuing inter-generational impact.

Alongside very young children and Aboriginal children, children with disabilities comprise another high-risk group. Research (Sullivan and Knutson, 2000) indicates that children with disabilities are three times more likely to experience maltreatment than their non-

disabled peers. In particular, children with communication impairments, behaviour difficulties, intellectual disability and sensory disability experience higher rates of abuse.

The number of children and young people from culturally and linguistically diverse (CALD) and refugee backgrounds coming to the attention of child protection authorities in Western Australia is unknown. A Victorian research study showed that approximately 13% of children in out-of-home care were from CALD or refugee backgrounds (Kaur 2012). International research has identified a lack of consistency in identification and intervention of child protection concerns for CALD and refugee families, based on cultural ignorance and/or the over/under consideration of cultural norms when assessing child-rearing practices and child abuse.

It is increasingly recognised that child maltreatment experiences are rarely isolated incidents; different forms of abuse often co-occur, and trauma often develops over prolonged periods. Cumulative harm, sometimes described as chronic maltreatment, involves repeated exposure to a single adverse event by a single perpetrator or multiple adverse events with multiple perpetrators over a period of time. As Miller and Bromfield (2010) described:

The unremitting daily impact of these experiences on the child can be profound and exponential and diminish a child's sense of safety, stability and wellbeing. (p.5)

Violence in the home, predominantly against women and children, is one of the major underlying factors in child protection cases. The WA Police attended over 45 000 incidents of family and domestic violence in 2013/14 and over 80% of these cases involved dependent children for whom the police filed an incident report with CPFS. All children exposed to ongoing domestic violence are indirect victims of violence and abuse. In addition, over half these children also experience direct violence, abuse and/or neglect. Research (e.g. Jordan and Skitchley 2009) has shown that babies, including those in utero, show signs they are adversely affected by family and domestic violence.

The majority of parents/caregivers of children where abuse or neglect has been substantiated have complex needs and struggle with a range of problems and stressors. These may include low socio-economic status, poverty, homelessness, crowded dwellings, domestic violence, alcohol and substance abuse, mental health issues and intellectual or psychiatric disability. Only 13% of notifications of child abuse or neglect come from families with none of these risk factors. Families with complex issues will usually require multi-agency approaches for the lives of their children to be significantly improved.

1.3 Communicating with families when there are protection of children concerns

Good communication with clients is based on transparency, honesty, respect and openness and includes:

- seeking their opinion regarding their health issue
- explaining the course of action indicated
- hearing and discussing concerns
- considering their wishes
- keeping them informed
- being respectful of their capabilities and capacity to contribute to the achievement of the desired health outcome.

Communicating with families when there are protection of children concerns is no different. Acknowledging the child's psychosocial development and the context of the interaction builds the trusting relationship necessary to support and protect children and their families.

Core communication principles

Transparency and honesty

Good outcomes are maximised if the health staff member is as transparent and honest as possible with the parents (and the child as appropriate) about:

- informing parents/carers and, where appropriate, children and young people about the professional and ethical responsibilities of the health staff member. For doctors, nurses and midwives this will include information on the legal requirement for mandatory reporting of child sexual abuse
- the nature of, and reasons for, any concern
- the need to take action and what action may be indicated.

Respect

Achieving positive health outcomes for children requires a balance between having a respectful relationship with the child and their family and having the health, safety and

wellbeing of the child as the primary concern. This involves recognising that the ability to support parents, whose actions or inactions may possibly have harmed the child, is usually in the best long-term interest of that child.

Openness

Being open with parents is sometimes hard, especially if the health staff member fears that to do so may jeopardise any ongoing or future uptake of services. However, research consistently demonstrates that being open, honest and respectful with clients maximises better outcomes, including supporting families to stay engaged with services.

Therefore, outcomes are improved when discussion with a family occurs regarding:

- the responsibility of the health staff member to take action if needed to protect a child, even in circumstances where the parent/child might not agree with the need and/or suggested action
- any proposed actions
- the provision or seeking of further information to or from other workers/agencies.

See:

- [Information Sheet 6. Safety for workers reporting child protection concerns](#) for health staff who may have concerns for their own safety.

The nature of the concern for a child

The nature of a health staff member's concerns will influence their communication with the child, their family and significant others. Situations that warrant notification to CPFS or the WA Police may result in legal action and require sensitive assessment and treatment.

There may be situations where preventing further abuse or neglect requires immediate action and communication should be focused on meeting the child's immediate clinical and emotional needs.

Where concerns for children relate to ongoing or cumulative factors, situations where the details may be vague or ambiguous, or where harm may not be so clearly apparent, the health staff member will need to build up a picture over time in order to become clear about the abuse or neglect issues and a recommended course of action that aims to maximise the safety, health and protection of the child. The health staff member's role is to gain information that will assist with assessments for the medical and safety needs of the child.

It is important to be aware that inappropriate questions may compromise any legal process. If you are unsure or feel uncomfortable about what questions to ask or how, check with an appropriate staff member with child abuse and neglect expertise.

It is not the role of health staff to interview a child with the purpose of eliciting a disclosure. The WA Police and CPFS have workers with specialist training in the forensic interviewing of children.

The level of abuse or neglect detail sought

With the exception of health staff conducting forensic medical examinations, it is not the role of health staff to obtain evidence or proof that a child has been abused or neglected; this is the responsibility of those whose role it is to formally investigate abuse or neglect allegations.

The role of the health staff member is to obtain sufficient information to assist with providing for the medical and safety needs of the child, in collaboration with other services as appropriate.

If, during the course of engagement with the child/family, it becomes clear through:

- observing sufficient behavioural and/or physical indicators and/or an abusive situation and/or
- receiving a partial or full disclosure from a child and/or
- receiving sufficient information from another source (e.g. a colleague, a family member, case notes)

that a child has been, or is likely to be, abused, then conveying this level of information in a clear and unambiguous verbal and/or written manner, with the assistance of clear and accurate documentation and file notes, will usually be sufficient for investigative specialists to proceed while the health staff member provides for the child's medical/health needs.

Receiving a disclosure from a child

Child abuse and neglect is rarely a single isolated incident; it is much more likely to be an ongoing and cumulative process. A child's disclosure of abuse and neglect is also an ongoing process rather than a single event. Some children may begin a process of disclosure with a health staff member and when this occurs it is important that the staff member responds in a manner which is honest, supportive, non-blaming and helpful for the child. This will maximise the willingness and ability of the child to continue the disclosure process with the appropriate staff member. See the box on the following page for further information.

Receiving a disclosure from a child is not the most common pathway to alerting a health staff member that there is a child protection concern. (See [Information Sheet 15: Barriers to children disclosing sexual abuse](#)). Rather, the health staff member is more likely to reach such a conclusion via a process of observation, information gathering, colleague discussion and asking further questions as needed.

Clients from culturally and linguistically diverse backgrounds

Where possible, consult with a health staff member who has an understanding and expertise in the culture of the child and their family. However, given the cultural diversity of Western Australia this may not always be possible. Irrespective of their cultural background, most children and adults respond well to a quiet respectful manner and clear, jargon-free explanation of the health staff member's concerns, proposed treatment or ongoing management plan.

Cultural explanations to excuse or minimise child abuse or neglect, such as customs of under-age marriage, female genital mutilation, accepted use of physical discipline, must never be accepted as justification not to take action to protect a child. See Section 3 – Special risk groups, for further information.

Working with Interpreter Services

An interpreter should be engaged as soon as the health staff member determines that a child or family member may have difficulty in speaking or understanding English, or has a background that may impact on the health staff member's ability to communicate with them. Health staff are required to seek assistance from an accredited interpreter; where possible a Level III, Health or Mental Health accredited interpreter should be used. Depending on the situation, CALD clients can find it easier to discuss and disclose difficult and confidential information over the phone rather than face-to-face.

The Telephone Interpreter Service (TIS), 131 450, provides a 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 might have in place to access the TIS. Use these protocols e.g. specific account numbers, to access the professional interpreter services.

If a child is in **immediate** danger and the interpreter service is not available, consider using a family or community member. Although this is best avoided on the grounds of a conflict of interest, it can be used as a last resort in an emergency.

How do I communicate with a child who has begun a process of disclosing abuse and/or neglect with me?

DO

- find a quiet place to talk, somewhere likely to feel safe for the child
- be aware of the client's age, ethnicity, culture, religion, psychological state and how these factors may impact on the child's ability to engage with you
- discuss the limits of confidentiality
- listen to the child and let them tell their story, at their own pace and in their own words
- maintain a calm and accepting manner to support the disclosure process
- comfort the child if they are distressed, and let them know how brave they are being
- always believe the child and convey that belief through your words and actions
- let the child know that what the adult/other person did to them is not the fault of the child' even if the child might feel right now that it is
- ask the child what they want to have happen next
- tell the child what you need to do next, and why, if this does not match their preference
- explain this will almost always include involving others as this is what is going to be needed to keep them safe
- write down what the child has told you, the context in which it was told and your observations.

DON'T

- promise confidentiality
- ask leading or specific questions; you only need enough detail to ensure that the disclosure can be followed up
- interview or investigate; this is the role of CPFS and/or the WA Police
- make the child repeat their story/disclose to another person in your agency
- confront the person alleged by the child to be responsible for the abuse.

Rescinded 14 March 2022. Mandatory
Superseded by MP 016612
Reporting of Child Sexual Abuse
Training Policy



2. Identifying and responding to child abuse and neglect concerns

2.1 Step 1: Identify concerns

2.2 Step 2: Assess and examine, consult, document

2.3 Step 3: Taking action/making notifications and referrals

2.4 Step 4: Ongoing case management

Step 1: Identify concerns

2. Identifying and responding to child abuse and neglect concerns

2.1 Step 1: Identify concerns

Child abuse and neglect continues to be vastly under-detected and under-reported (AIHW 2013). Health staff who develop their capacity to recognise and identify concerns and take action can contribute to early intervention and reduction of abuse and neglect, and its potentially severe and long-term consequences for children.

There are many risk factors and indicators of child abuse and neglect. This section is presented as a guide to support professional judgement and assist health staff assess possible child abuse and neglect from what they may see, hear or read from file notes about a child or parent. The indicators in this section do not provide an exhaustive list of all harms, behaviours or presentations that could raise concerns about possible abuse or neglect.

Coexistence of multiple forms of abuse

Where one form of abuse or neglect is suspected, it heightens the need to look for other forms of abuse or neglect. In particular, the presence of domestic violence in a household, itself a form of child abuse even when the child is not a direct recipient of violence or abuse, significantly heightens the possibility for the children in that family to be exposed to other forms of abuse or neglect.

When assessing protection of children issues, the following core principles apply:

1. Every child has a right to be protected from abuse and neglect.
2. The paramount consideration guiding intervention must be the ongoing physical, emotional and psychological safety, protection and wellbeing of the dependent child.
3. Child protection is the responsibility of individuals, families, communities and the society as a whole. This is best achieved through a collaborative approach.

When assessing concerns from this viewpoint, the practitioner is led to consider the **effects** of the (suspected) abuse on the child, rather than focusing on what might have been the intent (or lack of intent) behind the actions of the adult/parent. These core principles should also be kept in mind when working with adult clients who have dependent children, whether or not a health service is being provided to the children.

Step 1: Identify concerns

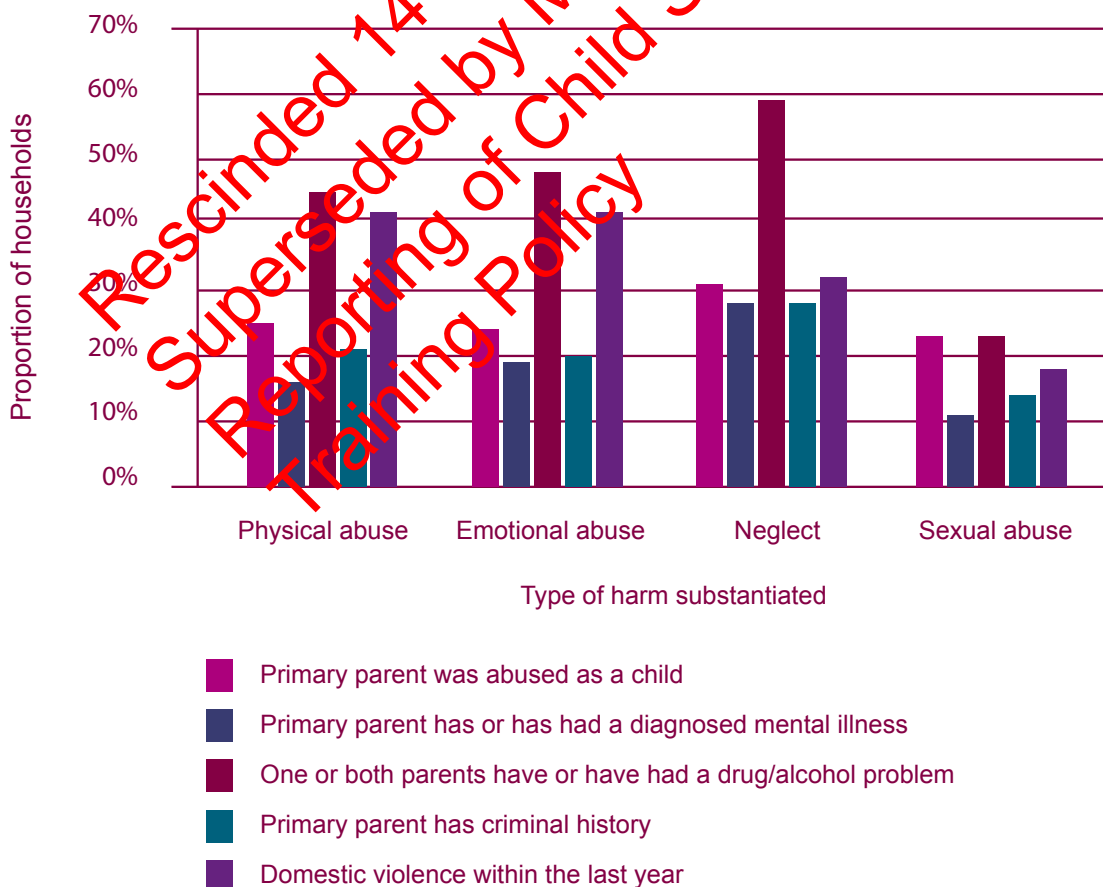
2.1.1 Risk Factors

Having some background information on the child's family and observing the parent-child interaction and relationship can be the most useful type of knowledge in assisting with the awareness and interpretation of behaviours and the identification of concerns. Knowledge of the most common parental risk factors known to be related to increased risk of child abuse or neglect is also important.

The five most common parental risk factors for child abuse and neglect:

1. The primary parent/caregiver suffered some form of abuse or neglect as a child.
2. The primary parent/caregiver has, or has had, a diagnosed mental illness.
3. One or both parents have, or have had, a drug/alcohol problem.
4. One or both parents have a significant criminal history, particularly crimes of drug use and/or violence.
5. Domestic violence has occurred within the last 12 months.

Prevalence of parental risk factors by harm type (Queensland Government 2008)



Source: Department of Child Safety

Step 1: Identify concerns

As illustrated in the graph, through an analysis of the family backgrounds of children in Queensland where abuse or neglect had been substantiated, almost two-thirds of households with a child in need of protection have more than one of these risk factors, although one-third of families where a child has been sexually abused do not display any of these risk factors. Only 13% of families with a child at risk do not display any of the five parental risk factors. This research did not include (family and) domestic violence as a separate category of child abuse although it is noted that domestic violence is the second-highest parental risk factor after having a criminal history.

Additional parental risk factors

There may be additional parental risk factors if one or both parents:

- have a history of abuse towards another child
- have had prior involvement with the child protection system
- have, or have had, post natal depression
- have significant cognitive or intellectual impairment
- come from a disadvantaged background
- are under 21 years of age
- are living in poverty and/or have a transient lifestyle
- have minimal family or community support
- have a poor parent/child attachment parenting style
- engage in punitive parenting and/or have unrealistic expectations of the child.

Child risk factors

Child characteristics that can exacerbate the difficulties of parenting in some families can further predispose some children to increased risk. These key characteristics include:

- being under 12 months old
- having a congenital abnormality
- having an intellectual or physical disability.

See:

- [Information Sheet 1: Family and domestic violence is a child protection issue](#)
- [Information Sheet 13: Parental mental illness can be a child protection issue](#)
- [Information Sheet 14: Parental substance abuse can be a child protection issue](#)

Step 1: Identify concerns

2.1.2 Indicators of abuse and neglect

One indicator in isolation may not necessarily indicate abuse or neglect. Each indicator needs to be considered in relation to other indicators and, importantly, to the risk factors noted in Section 2.1.1 – Risk Factors.

Identifying possible child abuse or neglect will almost always involve a process of building up a picture over time from background knowledge of the child/family, observations and the noting and consideration of possible indicators.

There is a growing body of evidence to show that the various types of child abuse and neglect do not occur independently and that a significant proportion of abused children experience not just repeated episodes of one type of abuse, but are likely to be the victim of other forms of abuse or neglect. Health staff should therefore remain alert to the possibility of other forms of abuse and neglect when assessing indicators within any of the categories of abuse mentioned below.

Physical abuse (inflicted injury)

Physical abuse is when a child has experienced severe and/or persistent ill-treatment through behaviours including, but not limited to, beating, shaking, excessive discipline or physical punishment, inappropriate administration of alcohol or drugs, attempted suffocation. The difference in presentation between accidental and inflicted injury may be slight and require expert investigation to differentiate.

The 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. Children who experience physical abuse from their carers will also experience emotional harm. Children under 12 months are particularly vulnerable to physical abuse and resulting adverse impact on their physical and emotional development.

Significant indicators for physical abuse in children can include:

- explanation by the caregiver and/or child that is evasive and/or not consistent with the injury
- no accompanying history
- any injury/bruising in pre-mobile infants
- retinal haemorrhages in an infant, not previously identified at birth, as these can be indicative of acquired head injury
- bone fractures, especially in children under 2 years of age

Step 1: Identify concerns

- lacerations and welts
- burns, including cigarette burns, and scalds
- ingestion of poisonous substances
- facial, head or neck bruising
- multiple injuries or bruises, including bruising and marks that show the shape of the object that caused it e.g. a belt buckle
- bruising of the pinna (external ear)
- the child appearing fearful when in the company of the caregiver.

To improve the identification of children in the age group most likely to be the victims of inflicted injury, a [Child Injury Surveillance Programme](#) is currently being introduced into WA Health hospitals for any child less than 2 years of age who presents to triage with injury, poisoning or burns. This program is based on the format in use at PMH Emergency Department and offers a [parent information sheet](#), an injury assessment template that forms the medical record and the proposed format of a child injury surveillance program.

See:

- [Information Sheet 5: Physical abuse is a child protection issue](#)

Sexual abuse

Sexual abuse is when a child has been exposed or subjected to sexual behaviours that are exploitative and/or inappropriate to their age and developmental level. Examples include sexual penetration of the vagina, anus or mouth, inappropriate touching, exposure to sexual acts or pornographic materials, and using the internet for grooming and soliciting children for sexual exploitation. Many children who are sexually abused are subjected to an ongoing process of entrapment, grooming and increasing sexually abusive behaviours over a period of time perpetrated by someone they know.

Harm that may result from sexual abuse can include significant emotional trauma, physical injury, infections and impaired emotional, social and sexual development.

It is relatively unusual for health staff to see clear physical indicators directly related to sexual abuse, therefore the following list includes a number of possible indicators.

Step 1: Identify concerns

Significant indicators for sexual abuse can include:

- child's disclosure of sexual abuse
- sexually transmissible infections (STIs)
- child complaining of pain to the ano-genital area
- bruising or injury to the ano-genital area
- child experiencing difficulty sitting/walking due to injury/pain in ano-genital area
- bleeding from ano-genital area (not related to menstruation)
- persistent unexplained throat complaints, particularly in younger children
- other somatic or psychosomatic complaints
- bruising of the pinna (external ear) through being physically forced to perform fellatio
- age-inappropriate, compulsive and persistent sexualised behaviours with self and/or other children
- displaying a degree of sexual knowledge (through talk/actions/drawings) above the level appropriate for the child's age
- displaying a lack of appropriate boundaries when physically interacting with other children and/or adults
- regression in development, including the loss of toileting control previously gained by younger children
- self-harming and/or self-destructive behaviours e.g. cutting, reckless behaviour showing a disregard for self and safety, drug taking
- wearing of over-sized clothes, or several layers of clothing, that conceal body shape
- neglecting bodily hygiene
- physical, emotional, psychological and behavioural patterns of interaction between the adult and child and/or an older child and a younger child that indicate a lack of appropriate boundaries
- family contact with a known child sex offender.

A lack of medical or physical evidence of sexual abuse can be due to several factors, including:

- the type of abuse
- the age of the child
- the child meeting the perpetrator's desire/demand to keep the abuse hidden and secret
- the length of time between an abuse episode and any medical examination.

Step 1: Identify concerns

The absence of medical or physical evidence does NOT necessarily mean that abuse has not occurred and should not override professional judgement regarding the health and safety needs of the child, and notifying CPFS of concerns.

Emotional abuse

Emotional abuse is the sustained, repetitive, inappropriate, ill treatment of a child through parent/caregiver behaviours such as threatening, isolating, withholding of emotional nurturance and closeness, discrediting, belittling, teasing, humiliating, bullying, confusing, ignoring and inappropriate encouragement. There is now a general consensus that emotional harm is an inevitable result of all forms of parent-to-child maltreatment and special attention is required in assessing for emotional abuse without any accompanying physical or sexual abuse, neglect or exposure to domestic violence. Older children can also experience emotional abuse and psychological harm through bullying, ostracising etc. in out-of-home settings.

Children who have been emotionally abused are more likely to be fearful, withdrawn and/or resentful, distressed and despairing. They are likely to feel unloved, worthless and unwanted or only valued in meeting another's needs. Such feelings might be difficult to identify as such children may have a reduced capacity to express emotions and/or a determination to try and prevent external scrutiny of the family.

The harm caused to children through this abusive style of parenting can damage the development of secure attachment between child and primary carer, the child's developing sense of self, including their self-esteem and the ability to form and maintain trusting relationships. Intellectual faculties and processes, including intelligence, memory, recognition, perception, attention, imagination and moral development, can also be adversely affected by emotional abuse.

Significant indicators for emotional abuse can include:

In children and young people

- 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

Step 1: Identify concerns

- bullying, disruptive or aggressive behaviours towards peers
- displaying a lack of connectedness/empathy for the experiences of self and/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.

In parents/carers

- known history of significant postnatal depression
- known history of familial domestic violence
- excessive presentation with unproven medical concerns
- factitious disorder by proxy (the deliberate production or fabrication of physical or psychological symptoms in a child by a parent or carer).

Observed in parent/child interactions

- avoiding eye contact with mother/carers (in young babies)
- constant criticism, belittling, teasing
- ignoring or withholding of praise or affection
- excessive or unreasonable demands, including expectations above what is appropriate for the child's developmental level.
- expressing resentment towards the child's dependency on them
- preoccupation with their own needs and a prioritising of their needs above the need to parent their child adequately.

See:

- [Information Sheet 3: Emotional abuse is a child protection issue](#)

Domestic Violence

Domestic violence – as it relates to any dependent child living in a home where one adult they are dependent on (usually the father) subjects the other adult (usually the mother) to ongoing threatening, abusive or intimidating behaviour – can result in a range of detrimental consequences for the child. (Please refer to [Guideline for Responding to Family and Domestic Violence 2014](#)). The impact for the child can include physical and emotional harm and neglect and is usually categorised by CPFS as emotional abuse.

A broad range of controlling and abusive behaviours can be involved, which cause fear, stress, emotional and sometimes physical harm to any dependent child, as well as the

Step 1: Identify concerns

adult to whom the behaviours are directed. This is independent of any behaviours directed specifically at the child and/or anything the child may or may not have experienced, witnessed or heard directly. Domestic violence often commences and/or increases during pregnancy and after birth, making babies in utero and newborns particularly vulnerable.

The harm caused to children living in households where one parent terrorises the other can be significant and long-lasting and can cross all the abuse and neglect domains. As well as the child having to manage high levels of stress and fear, the protective parent's capacity to provide the secure framework for their child's healthy attachment is likely to be severely compromised through the need to attend to their own physical/psychological safety. A common controlling tactic of perpetrators in households with very young children is that of preventing the mother's ability to respond to the infant's or young child's need for food and comfort.

Significant indicators for domestic violence can include:

In children and young people

- pre-term and low birth weight infant
- low weight for infant and/or faltering growth
- unexplained physical injuries
- hyper-vigilance and jumping/cowering at sudden movements or noises
- somatic or psychosomatic complaints
- repetitive and compulsive behaviours in attempts to self-soothe e.g. rocking, sucking, head banging
- aggressive or violent behaviour
- poor school attendance and/or falling asleep at school
- social isolation
- reticence/shyness/attempts not to draw attention to self.

In adult parent victims

- bruising and other unexplained or inconsistently explained injuries
- unexplained miscarriage or stillbirth
- social withdrawal/isolation
- repeat/after-hours presentations at medical services with unexplained injuries/anxiety/depression
- hyper-vigilance and jumping/cowering at sudden movements or noises
- depression/anxiety

Step 1: Identify concerns

- submissive/withdrawn behaviour
- no financial independence
- looks to partner for permission to respond/express their view.

In adult parent perpetrators

- dismissive and disrespectful attitude towards partner, including belittling and speaking on behalf of/over the partner
- expresses rigid stereotypical views of gender roles
- always accompanies partner/children to health appointments
- history of criminality, drug/alcohol abuse, mental illness.

See:

- [Information Sheet 1: Family and domestic violence is a child protection issue.](#)
- [Guidelines for Responding to Family and Domestic Violence, 2014.](#)

Neglect

Neglect is the consistently intentional or unintentional failure of the caregiver to provide a child with adequate food or shelter, effective medical, therapeutic or remedial treatment, and/or care, nurturance or supervision to a severe and/or persistent extent.

Aboriginal children are grossly over-represented in substantiations of neglect by CPFS, a fact which is likely to be related to experiences of the Stolen Generation, which denied the opportunity to absorb and pass down 'good enough' parenting through subsequent generations.

The harm caused to children through parental neglect can be profound and life-long, diminishing a child's sense of safety, stability, and wellbeing. The younger the child and more prevalent the neglect, the greater the cumulative harm and more pernicious the consequences for the child. Neglected children, relative to children impacted by other types of maltreatment, experience more severe cognitive and academic deficits, social withdrawal, and internalising behaviours. Permanent changes in the brain, including lack of neural connections and pathways, as a result of early neglect may permanently limit the child's ability to develop normally.

Community health staff are to refer to the [neglect protocol](#) (intranet access required).

Step 1: Identify concerns

Significant indicators for neglect can include:

In children and young people

- non-organic growth faltering
- 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
- self-comforting behaviours e.g. rocking, thumb sucking
- flat and superficial way of relating, lacking a sense of genuine interaction
- expressions of deep loneliness, anxiety and/or despair
- scavenging for, or stealing of, food
- sporadic school attendance
- developmentally inappropriate over dependence on self to fulfil parental responsibilities, such as caring for self, siblings and household.

In parents/carers

- delay in seeking treatment for injury or illness without adequate explanation
- known history of significant postnatal depression of mother
- itinerant lifestyle
- depriving or withholding physical contact or stimulation.

See:

- [Information Sheet 2: Neglect is a child protection issue](#)
- [CPFS Policy on Neglect](#)

Remember:

Any single indicator should NOT be interpreted as positive confirmation of abuse or neglect.

The presence of any one of these indicators and/or risk factors are clues or warning signs that require further assessment, consultation and interpretation.

Step 1: Identify concerns

Case example: Identifying concerns

You are a community child health nurse visiting a mother new to the district and her new infant. The mother also has a 2-year-old and a 6-year-old and all children are at home, even though it is a school day. The 2-year-old is dressed only in a nappy and is sitting quietly in a playpen. The 6-year-old is asleep on the couch. The infant has only a nappy on even though it is quite cold in the flat. The nappy is soiled and very wet.

The flat is visibly untidy and dirty and there are several cats in the room. There are no children's toys or books evident. There are overflowing ashtrays and numerous empty soft drink and beer cans around the room. You also notice that the 2-year-old appears to be 'in his own little world', and shows little interest in either his mother or her visitor. You notice the infant appears to avoid making eye contact with the mother.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations to this infant and his family?

- Conduct an observational and physical assessment of the new infant, paying particular attention to any possible signs of physical harm or neglect.
- Seek permission to perform a physical check-up of the two older children.
- Acknowledge the stressors of having a newborn and two other young children.
- Make specific enquiries as to how the mother is managing these and what level of support she is receiving from friends and family.
- Make specific enquiries about her opinion as to how the father of the infant is managing the stress and responsibility of having three young children to care and provide for.
- Ascertain who has been looking after the children while the mother was in hospital having the infant.
- Discuss your observations regarding the infant seeming to avoid eye contact with the mother. Ask if she also has noticed this and what her understanding is of the possible cause.
- Discuss your concerns regarding the potential risks posed to the children by specific elements of their environment.

If you judge that the information you have gathered so far has enabled you to identify possible risk of abuse/harm for any of the children, then:

proceed to Step 2: Assess and examine, consult, document.

Step 2: Assess and examine, consult, document

2.2 Step 2: Assess and examine, consult, document

Health staff are not responsible for conducting investigations to substantiate, prove or disprove current concerns of abuse or neglect, or the likelihood of further child abuse and neglect. This is the responsibility of the Department for Child Protection and Family Support and/or the WA Police.

2.2.1 A general guide to assessment

The aim of assessment is to gather sufficient information to decide on the best course of action to safeguard the health, safety and wellbeing of a child within their family.

A careful history must be taken that includes as much information as possible about the child, their family and presenting concerns. The process of gathering sufficient information to inform the best course of action can sometimes take several meetings/appointments with the child and/or their family as well as consultation, information exchange and collaboration with other professionals from within WA Health (including the [Child Protection Unit](#)) and external agencies.

Protection of children concerns can begin to arise while gathering information or engaging with a child or their family in the provision of a service that is initially unrelated to child abuse or neglect. In such cases, the assessment process for possible abuse or neglect will sit alongside the assessment/service provision for the initial presenting health need.

When undertaking assessments for possible child abuse or neglect, health staff should bear in mind:

- Child abuse and neglect are rarely isolated incidents. Different forms of abuse often co-occur and trauma often develops over prolonged periods. Cumulative harm, sometimes also described as 'chronic maltreatment', may involve repeated exposure to a single adverse event, or multiple adverse events with multiple or single perpetrators over a period of time
- Certain groups of children including very young children, Aboriginal children and children with disabilities are statistically more likely than the general child population to experience abuse and neglect. Children under 2 years are over-represented in cases of physical abuse and neglect.
- Many such children are likely to be living in families with complex issues who may require multi-agency approaches across a range of services.

Step 2: Assess and examine, consult, document

- Both children and parents are usually reluctant to disclose the problems they are experiencing and often successfully hide the reality of what is happening in their families. Providing a safe, respectful and transparent working relationship maximises the likelihood of children/families beginning to share that which they might have previously kept hidden.

2.2.2 Information to be gathered and documented

Noting and documenting those factors that have given cause for concern when assessing possible child abuse and neglect is vital in determining the best course of action. The health staff member may develop a generalised concern for the safety and wellbeing of the child over a single meeting or during a course of service provision to the child and/or family members. The worker needs to be able to clearly articulate and document specific information regarding the nature of the concern and the reasons for it.

Sharing this information with the child and parents (as appropriate) and with colleagues, supervisors and other agencies is vital in ensuring that the optimum course of action is taken to protect the child and to prevent any (further) harm.

The health staff member must document factual information and observations about the child and family, noting the context in which they were gathered. Open-ended questions, such as 'Can you tell me what happened?' rather than leading questions such as 'Did you have a fall?' should be asked. Verbatim recording of answers is good practice.

Demographic information (likely to already be recorded unless a new client)

- child's full name (including any other names/surnames they may be known by) or, if not known, a description of the child or information that can assist in identifying the child
- date of birth/age
- current address and phone number
- names of child's parents or guardians
- school, childcare centre, kindergarten
- ethnicity e.g. CALD, Aboriginal, Caucasian
- names, ages and whereabouts of any siblings
- special needs/medical conditions.

Step 2: Assess and examine, consult, document

Family/carer details

- What are the child's care arrangements e.g. both parents, extended family, single carer, kinship carers?
- Are there any Family Court orders in place governing the child's care arrangements?
- Is the family experiencing any of the five parental risk factors (See Section 2.1.1 – Risk Factors), or any other issues, e.g. intellectual disability, social isolation, that may impact on their ability to care for and protect their child?

Concerns – if the presentation is directly connected to a physical injury

- What is the parent/carers/child's explanation of how the injury or incident occurred?
- Where was the child when the injury/incident occurred?
- Who was with the child at the time?
- Is any injury consistent with the explanation provided?
- If possible and appropriate, speak with the child alone and ask the child what has happened.

Concerns – if they arise through something other than a visible injury

- What are the specific factors that have contributed to the concern now held?
- Has anyone else noted these or other factors that point to a similar concern?
- Have these factors and the associated level of concern increased or decreased over the time of the health service engagement with the family?
- Have any of these factors been previously raised directly with the child and/or family? Why or why not?
- Has any such discussion resulted in a reduction or an increase in the level of concern?
- Have you gathered any information from other services involved with the child/family that might support or go towards allaying the current level of concern?

Assessing for any immediate safety concerns

- current whereabouts of child
- if known, details of person believed to have caused the harm
- if known, details of when the child is next expected to have contact with this person
- Does the person believed responsible have other children in their care or access to other children?
- Is the child self-harming or expressing suicidal ideations?

Step 2: Assess and examine, consult, document

General observations

- interaction between parents/carers
- interaction between parent(s)/child.

2.2.3 Assessing for the different types of abuse and neglect

2.2.3.1 Assessing for physical abuse (inflicted injury)

All health staff should be alert to, and take note of, injuries, bruising and other clinical signs of possible child abuse and neglect, such as drowsiness or fitting in small babies. These findings must always be documented by the health staff member who has noticed these signs and symptoms.

- An injury may be the cause of the presentation or may be something that the health staff member notices in the course of providing a service for a different presenting issue.
- For all children less than 2 years of age who present to any hospital emergency department with physical injuries, the [Child Injury Surveillance Programme](#) must be followed.
- The health staff member may come across indicators where the type of physical injury presented, the explanation given, the overall presentation of the child and/or parent give rise to a concern as to whether the injury may be inflicted.
- In a hospital emergency/acute care setting, nursing staff usually perform a brief physical examination to aid referral to the medical practitioner and to assess the need for emergency first aid treatment. If a severe inflicted injury has occurred or is suspected (e.g. requiring inpatient care), immediate consultation with the PMH Child Protection Unit (CPU) (9340 8646) or local identified medical officer with expertise in child abuse and neglect is recommended.
- In instances when inflicted injury is suspected and a medical practitioner with expertise in child abuse and neglect is not readily available, other medical practitioners or nursing staff may need to perform a physical examination and to document the clinical findings. Consultation with PMH CPU in these circumstances is highly recommended.
- For children with immediate safety issues, such as severe physical injury suspected to have been inflicted by parent(s) with whom the child will leave the health setting, consultation with PMH CPU is highly recommended. Outside normal hours, CPU social worker and medical services are managed through the Emergency Department of PMH (9340 8222).

Step 2: Assess and examine, consult, document

The physical examination conducted when assessing for possible physical abuse/inflicted injury should include:

- assessment of the child's cleanliness and clothing
- measurement of height and weight with reference to percentile charts
- measurement of head circumference. A large or increasing head circumference may be a sign of intracranial injury in a child under 2 years
- general physical examination, including assessment of nutrition and illness
- developmental assessment – brief assessment of the child's gross motor and language development.

Specific examination and documentation for physical signs of possible physical abuse/inflicted injury

- Describe bruises, abrasions, lacerations and burns in terms of number, size, shape (e.g. linear, circular, rectangular), pattern (e.g. handprint, shape of object), orientation (e.g. horizontal, vertical, circumferential) and location
- Bruises cannot be aged so describe the actual colour and appearance rather than attempt to age them.
- Comment 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 2.2.4 – Documentation).
- Document the explanation given by the child and parent/carers for each particular injury seen.

Specific investigations that may need to be performed by the medical practitioner

- X-rays. Description of fractures should conform to standard medical description of orientation (e.g. transverse, oblique, spiral), bone involved (e.g. femur) and site along the particular bone (e.g. supracondylar-humerus, metaphyseal-tibia, posterior-left fifth rib).
- full blood count, coagulation screen (for all cases concerning bruising)
- skeletal survey for all infants under 2 years
- A bone scan should be considered to detect recent fractures not apparent on X-ray in infants, especially for ribs, vertebrae.
- head CT scan and/or MRI scan for acute neurological symptoms
- eye examination by an ophthalmologist as early as possible for infants under 12 months, especially if there are neurological symptoms or multiple fractures and/or skeletal injury, for identification of retinal haemorrhages

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- urinalysis, liver function, renal function, amylase and abdominal imaging for abdominal injury
- colposcopy for female genital injury or examination, under general anaesthetic if the child is distressed and in pain.

The [Child Injury Surveillance Programme](#) covers the process for assessing for physical abuse (inflicted injury) in children less than 2 years of age who present at a hospital emergency department.

2.2.3.2 Assessing for sexual abuse

The majority of children who are sexually abused are usually subjected to an ongoing process of entrapment/grooming and increasing sexually abusive behaviours over a period of time, perpetrated by someone they know. In such instances it is likely that non-physical assessments, rather than medical or forensic assessments will form the basis of an assessment of harm.

Health assessments for child sexual abuse can include:

1. non-medical assessment in order to gather information that may indicate a history of possible current or past sexual abuse for which an immediate medical and/or forensic examination is not indicated, and which requires a response to safeguard the health, safety and wellbeing of the child
2. medical assessment in order to
 - a. identify and attend to any injuries following a recent sexual abuse event
 - b. identify and attend to any complications following past sexual abuse
 - c. provide reassurance to the child and/or their parents that the child's body has not sustained any physical damage
3. forensic assessment in order to identify, collect, record and store evidence that can support any criminal charges.

The initial determination as to which health assessment is indicated depends on:

- the level of knowledge already available
- the timing and nature of the (possible) child sexual abuse
- the presence of any other injuries and if any injuries require emergency treatment
- child protection issues – including assessing if the child would be at risk after leaving the health setting
- any likely risk posed to other children.

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Information that guides the need for an immediate medical and/or forensic assessment

- Specimens that are suitable for forensic evidence are optimally collected within 3 days (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 information gathered points to this, a medical and a forensic examination should take place as soon as possible. Consider admitting the child to hospital to allow more detailed assessment by PMH CPU or medical specialist.
- If the (latest) abuse/assault occurred more than 3 days but less than 7 days before presentation, then a medical/forensic examination should be performed as soon as practically possible, in order to maximise the possibility of capturing any fading physical/forensic evidence.
- If the (latest) event occurred within the preceding 7–14 days, then a forensic examination is not usually indicated as it is likely that any possible forensic evidence will have been lost by this stage. Instead, a priority appointment should be arranged for both medical and child protection assessment. This facilitates a supportive medical examination (to the extent that the child is comfortable with) and accurate recall of the event by the child during interview.
- These medical and forensic services should sit alongside any police or CPFS child protection investigation.

See Section 5 and disk for metro and rural services and referral options.

Remember:

Due to:

- the ongoing process of most child sexual abuse
- the difficulties associated with recognising a child is being sexually abused
- the child's difficulties in disclosing abuse
- the skill of most perpetrators in managing not to leave any obvious physical evidence of their abuse

it is often the case that presentations at a health service will not pick up any emotional or physical signs of sexual abuse.

The absence of any physical, medical or forensic evidence does not necessarily mean that sexual abuse has not occurred, and should not override professional judgement regarding the health and safety needs of the child.

Step 2: Assess and examine, consult, document

Non-physical assessment of sexual abuse

Due to both a lack of clear physical indicators that a child may have been sexually abused, and the [barriers to children disclosing sexual abuse](#), assessing for possible child sexual abuse, except in circumstances when this is the reason for the presentation at a health service, generally involves a process of noting possible physical, behavioural or emotional indicators and then further exploration of any risk indicators, often in the course of providing a service for a different presenting issue.

In younger children, one of the key assessment factors can be when either a parent tells a health staff member, or a health worker notices for themselves that a child is engaging in sexual behaviours with themselves and/or with other children that are outside the bounds of what might be developmentally expected. If such behaviour appears obsessive or compulsive, this is a further possible risk indicator. The [Guidelines for responding to Student Sexualised Behaviour](#) provides guidance on developmentally appropriate and inappropriate sexual behaviours of children.

See:

- [Information Sheet 10: When children's sexual behaviours can be a child protection issue](#)
- [Information Sheet 17: Child sexual abuse: a process not an event](#)

In older children, assessment may be focused more on determining if the sexual activity the child is known to have engaged in was consensual or not, than on the issue of whether or not sexual activity has occurred. The key elements of consent to sexual activity include:

- understanding what is being proposed without confusion (not being tricked or fooled)
- knowing the standard for the behaviour in the family, the peer group and the culture (both parties have similar knowledge)
- having an awareness of possible consequences such as punishment, pain, pregnancy or disease (both parties similarly aware)
- having respect for agreement or disagreement without repercussion
- having the competence to consent (being intellectually able and unaffected by intoxication).

See:

- [Information Sheet 7: The mature minor, consensual sex and child sexual abuse](#)
- [Information Sheet 7a: Assessing a child's ability to consent to sexual activity](#)
- [NCPC: Age of consent laws](#)

Step 2: Assess and examine, consult, document

Medical and forensic assessment of sexual abuse

Perth Metropolitan Area

If you are in the Perth metropolitan area it is recommended that you use the specialised clinical service for (suspected) child sexual abuse at the PMH Child Protection Unit:

9340 8646 8.30am to 5:00pm Monday to Friday
9340 8222 8.30am to midnight Saturday and Sunday
5.00pm to midnight weeknights

Children aged 16 years and over should be referred to the [Sexual Assault Resource Centre \(SARC\)](#): 9340 1828 (24-hour service medical/forensic and counselling service).

Regional Areas

- Health services outside of the Perth metropolitan area should seek advice from either PMH CPU (under 16 years), SARC (16-18 years) and/or a health staff member with recognised child abuse expertise in their region.
- A SARC doctor is also available 24 hours a day to provide telephone advice regarding medical/forensic examinations of 13 to 18 year olds.
- Each country health region should have a nominated medical practitioner/paediatrician with appropriate training and expertise in the medical and forensic assessment of child sexual abuse.
- Gazetted nurse practitioners are nurses with specialised training and accreditation to conduct forensic examinations with older adolescents; they can be located via the local regional hospital.
- In the absence of specially trained staff to conduct a more comprehensive examination, early evidence, 'wee and wipe' kits can be used by all regional medical and nursing staff to ensure that any physical evidence of sexual abuse is collected at the earliest opportunity.

The following regional sexual assault services will provide support for children 13 years and over undergoing medical/forensic examinations at the local health facility. They do not provide their own medical/forensic examinations.

Bunbury	Waratah Support Centre	9791 2884
		after hours 0438 949 628
		free call (except from mobiles) 1800 017 303

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Geraldton	Chrysalis Support Service	9964 2173
	after hours	1800 016 789
Kalgoorlie	Goldfields Sexual Assault Counselling and Support Service	9091 1922
	free call (except from mobiles)	1800 688 922
Mandurah	Allambee Counselling Service	9535 8263
	free call (except from mobiles)	1800 199 888
Port Hedland	Acacia Support Centre	9160 2900
	after hours	1300 364 277

For a comprehensive list of sexual assault services in Western Australia see Section 5.

Any physical assessment of sexual abuse should ideally be performed by health staff with specific expertise.

PMH CPU and SARC can assist you to link with either a trained medical officer or a gazetted nurse practitioner in your region.

Remember:

- Sexual abuse involves the takeover and use of someone's body without their consent.
- In any medical examination following (suspected) sexual abuse, extreme care should be taken to guard against the child feeling that the medical examination replicates the sexual abuse experience in any way.
- Medical practitioners should not continue with the medical examination if the child or parent withdraws consent at any time, or if the child is significantly distressed.
- It is important to inform both the child and the parent/carer about the reason for ano-genital examination, as well as giving details about what the examination will involve. Accurately preparing the child and parent/carer will help alleviate anxiety regarding the ano-genital examination.

Step 2: Assess and examine, consult, document

Forensic Medical Specimens

If possible, the child should not change their clothes, shower, clean their teeth, drink anything or wash until a complete forensic examination has taken place.

Forensic medical specimens are collected in order to obtain the DNA of the alleged perpetrator of the sexual abuse. Specimens should be collected within 72 hours of the sexual assault for the best chance of detecting any viable DNA deposited by the offender.

Early evidence 'wee and wipe' kits can be used by all regional medical and nursing staff to ensure that any physical evidence of sexual abuse is collected 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. **First pass urine** collected in a yellow-lid specimen jar (to look for spermatozoa) is also useful for drug screens.
2. **Buccal wash** – instruct the patient to rinse 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. Also wipe gauze over any fluid stains on the body.
4. Place **clothing** into the brown paper forensic bag. If clothing is wet, allow to air dry prior to placing into paper bag.

Please note: forensic specimens should not be placed into culture media. They should be put into plain containers.

The collected specimens should be handed to the police immediately or immediately placed in a locked cupboard/drawer in order to maintain the chain of evidence.

It is anticipated that a full examination by specially trained medical doctors or gazetted nurses would then take place within the following 24 hours.

Step 2: Assess and examine, consult, document

Notifiable infections discovered during a physical sexual abuse examination

See:

- Operational Directive: [Interagency management of children under 14 who are diagnosed with a sexually transmitted infection \(STI\)](#)

After laboratory confirmation of a notifiable infection, the medical officer should use the appropriate [Department of Health Notification Form](#) to notify (by post or fax) the following infections: Chancroid (soft sore), Chlamydia (genital infection), Donovanosis (Granuloma inguinale), Gonorrhoea, Syphilis, Hepatitis B, Hepatitis C and HIV/AIDS infection.

For cases resident in the metropolitan area, notifications are made to the Communicable Disease Control Directorate, WA Health. For cases resident in country areas, notifications are made to the appropriate regional Population Health Unit.

Where appropriate, the health staff member should discuss the notification with the child. This will provide an opportunity for the child to raise any concerns they may have about telling parents/carers and any issues that affect treatment and safety.

Remember:

All children under 14 years of age in whom an STI has been identified must also be the subject of a report to the local CPFS office. If the diagnosing practitioner (doctor, nurse or midwife) has formed a reasonable belief of sexual abuse in a child of any age for whom an STI has been identified, then a Mandatory Report of child sexual abuse must be made to the CPFS Mandatory Reporting Service. For children under 14 years of age, this replaces the report to the local CPFS office. See: Section 2.3: Step 3 Mandatory Reporting for further information.

2.2.3.3 Assessing for emotional abuse

The generally pervasive and ongoing nature of emotional abuse within the parent–child relationship to a level that can cause harm implies that it is likely to be observable by different service providers in different settings over time. Very young, and therefore very dependent, children are more at risk in experiencing longer duration and more severe consequences than are children whose familial situation may have deteriorated after having ‘good enough’ parenting in earlier childhood. Proposed amendments to the CCSA include children’s exposure to family and domestic violence as a form of emotional abuse.

Step 2: Assess and examine, consult, document

Childrearing practices vary according to culture and any assessment for emotional abuse should bear this in mind. However, all children from all cultures will be negatively impacted by persistent emotional ill-treatment and the lack of emotional nurturance and warmth.

Health assessments for possible emotional abuse can include:

1. 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
2. adult/parent medical assessment – any mental health, alcohol/drug, or intellectual disability assessment of parents 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
3. non-physical assessment – gathering information, often over a period of time, from either parents and/or child that may indicate the child's emotional health and development is being compromised through emotionally abusive parenting. See also Domestic Violence below.

The following WA Health publications provide further guidance and support in assessing for emotional abuse.

- [Information Sheet 3: Emotional abuse is a child protection issue](#)
- [Information Sheet 5: Cumulative harm is a child protection issue](#)
- [Information Sheet 13: Parental mental illness can be a child protection issue](#)
- [Information Sheet 14: Parental substance misuse can be a child protection issue.](#)

2.2.3.4 Assessing for domestic violence

Domestic violence often commences and/or increases during pregnancy and after birth, meaning that babies in utero, newborns and infants can be particularly vulnerable to domestic violence and its impact. The health, safety and wellbeing of children exposed to domestic violence is compromised, sometimes to a severe extent, and such children are victims of abuse in their own right. Physical and non-physical indicators may be noticed during service provision to parents (victims and/or perpetrators) or in direct service provision to children.

Step 2: Assess and examine, consult, document

Health assessments for children exposed to domestic violence will frequently be initiated through observations/information from the parents – both those who perpetrate and those who are the victims of the violence.

The [WA Health Guidelines for Responding to Family and Domestic Violence 2014](#) are for all staff within WA Health. They set out principles of screening for family and domestic violence and abuse, intervention and standard information applicable to varied health settings.

1. Non-physical assessment

with the victim parent

- through gathering information, often over a period of time, that may indicate the presence of domestic violence in a household in which dependent children are living
- by following the protocol set out in the [Guideline for Responding to Family and Domestic Violence 2014](#).

with the perpetrator parent

- through gathering information, often over a period of time, that may indicate the client is the perpetrator of domestic violence in their household that includes dependent children
- by being aware of referral options and offering options in a manner that invites the client to address their behaviours and the impact they have on dependent children
- by using some of the [online resources](#) designed for domestically violent men, which may be appropriate for the health staff member to give to men that the health staff member may identify during provision of another health service.

through observation of interactions between parents

- observing interactions that indicate a significant power differential between parents, such as the father not allowing the mother to speak and/or belittling her comments or opinions
- observing interactions that indicate that one parent is fearful of the other
- observing interactions where one parent ensures that the other parent is always accompanied at any health service presentation.

with the child

- through gathering information, often over a period of time and in the course of provision for another health service that may indicate the child is living in such a situation

Step 2: Assess and examine, consult, document

- by identifying indicators of stress in the child; such as insecure attachment, heightened startle response in younger children, hyper-vigilance, poor school attendance, falling asleep in school, bullying or retiring behaviours.

2. Medical assessment

with the parent victim

- usually carried out with the adult via presentation at hospital Emergency Departments (EDs)

with the parent perpetrator

- the primary aggressor parent may also present at a hospital ED as a result of being injured by the primary victim as they defended themselves and/or their children. Victims and perpetrators of domestic violence access general health services at a rate statistically higher than the general population. Most commonly, either can present with emotional health issues such as depression, anxiety, difficulty sleeping, stress

with the child

- if a child presents with injuries for which the explanation (from child and/or parent) does not seem to fit or feels evasive then refer back to the 'Assessing for physical abuse' section.

See:

- [Guideline for Responding to Family and Domestic Violence 2014](#)
- [Information Sheet 7: Family and domestic violence is a child protection issue.](#)

2.2.3.5 Assessing for neglect

Neglect, even more than for other forms of abuse, consists of a series of parental failings or omissions, rather than a single event. Deciding whether or not a child's presentation and/or the presentation or actions of the parent constitute neglect, rather than a temporary failing that is unlikely to persist or to cause the child any ongoing harm, is often a difficult task. Assessing for neglect can also be further complicated by the feelings of the health staff member towards the parent, who may be their primary client. The health staff member may be aware of, and be sympathetic to, stressors being experienced by the client and may find themselves focusing on the progress the parent client is making rather than prioritising the current impact on the child of parental behaviour.

Step 2: Assess and examine, consult, document

A further complicating factor when assessing for neglect can be when the benchmarks held by the health staff member regarding what constitutes the minimal level of care, nurturance etc. necessary for healthy development may not match parental and/or societal expectations at the local level. As the consequences of neglect can be even more harmful for children than other forms of abuse, it is crucial that the health staff member maintains clarity regarding the minimal requirements for healthy physical, emotional and educational development, regardless of the setting in which they work. The [Child Wellbeing Guide](#) has been designed to assist health staff members to note, record and summarise evidence-based indications of possible neglect. It should not replace any other formal assessment tools.

Health assessments for possible neglect can include:

1. non-physical assessment – through gathering information, often over a period of time, that may indicate possible neglect and requires a response to safeguard the health, safety and wellbeing of the child e.g. observation of the child's home-setting, interactions between parent and child, significantly delayed speech acquisition, consistent failure to keep health appointments, presence of risk factors (see Section 2.1.1 – Risk factors)
2. physical assessment – by identifying and attending to any physical manifestations of possible neglect; e.g. growth faltering, where there is a slower than expected rate of growth along a child's previously defined growth curve; poor hygiene; severe skin/nappy rashes; tooth decay
3. forensic assessment – by identifying, collecting, recording and storing evidence that can support any future criminal charges, usually related to physical harm.

The following WA Health publications provide further guidance and support for the non-medical assessment of neglect:

- [Information Sheet 2: Neglect is a child protection issue](#) [Information](#)
- [Sheet 2a: Points to consider when assessing for neglect](#)
- [Information Sheet 8: Child obesity and child protection](#)
- [Child Wellbeing Guide](#).

Step 2: Assess and examine, consult, document

2.2.4 Consultation

When health staff have concerns that a child may be experiencing any form of abuse or neglect, they should consult with their line manager and, whenever possible, with an appropriate health colleague identified as having child abuse and neglect expertise (e.g. paediatrician, medical officer, senior nurse, social worker, psychologist or psychiatrist).

Consultation will usually result in a shared understanding of the level of risk and the appropriate action to take but there may be instances when this is not the case. When a health staff member continues to have concerns for a child's wellbeing in spite of this opinion not being shared by others involved in any consultation process, they should take action based on that concern to ensure the safety of the child. The concern – consultation outcome – including any differing opinions – and any actions taken must be documented.

Consultation is about sharing the responsibility of managing and assessing any concerns for the child, as well as encouraging discussion and good decision-making about the next steps.

Every health staff member should know who to contact and how to access an appropriate staff member with child abuse and neglect expertise. Consultation with the identified staff member should continue to be available for the duration of health contact with the child. The Child Protection Unit at PMH (9340 8646) is available to provide specialist consultation to medical, nursing and allied health professionals. After-hours contact can be made via the Emergency Department at PMH (9340 8222).

In the absence of an available health professional to consult with, or in addition to any intra-Health consultation, the [Department for Child Protection and Family Support](#) can be contacted for advice and guidance. Crisis Care (9223 1111) provides this service outside normal office hours. Initial discussions can take place without revealing the client's name.

You may also need to consult with other colleagues who are involved with the child and family. Further advice may be acquired through consultation with specialist mental health services, e.g. CAMHS or Adult Mental Health, particularly where parental mental health concerns are identified in a non-mental health setting. Similarly, when parents are accessing drug and alcohol services, consultation with these services, which can inform the health practitioner on the likely impact on the child, is also useful.

Step 2: Assess and examine, consult, document

Immediately discuss and decide on:

- the specific risk factors and indicators of abuse that you have detected and your concerns
- your communication with the child and other family members up to this point
- any need to discuss your concerns with the PMH CPU, SARC/nominated specialist medical officer and/or specialist Mental Health Services
- any immediate need to discuss your concerns with CPFS and/or WA Police
- any need to discuss your concerns with external agencies that are known to have provided, or are currently providing, services to the child/family. (See Section 4.2. Confidentiality and disclosure of confidential client information)
- what needs to be discussed with the family and how best to do this
- what needs to happen next.

What else to consider:

- If the child and the family are Aboriginal or have a CALD background, then consider cultural issues and the need to consult with a health staff member who has particular expertise and understanding of working with these communities. See Section 3.1 and 3.2 (Special risk groups) for further information.
- the need for an interpreter or a health staff member/worker with the relevant cultural and linguistic background/training
- any disability issues and the need for an advocate and/or consultation with Disability Services Commission. See Section 3.3 for further information.

If, as a consequence of the assessment and consultation processes, you have reasonable grounds to believe that a child has been abused or has suffered harm through neglect, then appropriate action must be taken as set out in Section 2.3 – Step 3: Taking action/making notifications and referrals.

If you have sufficient information to indicate child protection is required then a [notification](#) to the local CPFS Office must be made.

See:

Section 2.3.2 – Mandatory reports of child sexual abuse to CPFS Mandatory Reporting Service if you are a doctor, nurse or midwife and the belief is about sexual abuse.

Step 2: Assess and examine, consult, document

Remember:

- maintaining a CHILD focus (concentrating on the immediate, short-term and long-term impact of abuse or neglect on that child),
- rather than focusing on the ADULT (concentrating on parental intent, causal factors, possible progress in parenting capacity etc.)
- will enable you to hold the safety and wellbeing of the child at the centre of your thinking and will help give clarity to your consultations and decision-making processes.

2.2.5 Documentation

Documentation includes the case notes and any reports that health staff have made, and kept, when they have contact with a child and/or a family in a care context.

Explain to the parent/carers/child/adolescent that a record of contact with the health staff member is kept and why.

Client records must be current, complete, accurate and objective

- It is important to document as many of the details as possible. This includes documenting any questions you asked together with any responses received.
- Include the date and time of your contact with the child and/or parent and when you wrote your notes (if different from the time of contact).
- The health staff member's factual observations must be recorded by description, using drawings as appropriate. (See Body Map: Section 5.)
- A verbatim record of significant information provided by a parent or child should be recorded as accurately as possible, including recording the context in which it was spoken and heard.
- Health staff should be objective, noting straightforward observations such as the appearance of children and parent-child interaction that is observed.
- The stating of opinions should be limited to areas in which the staff member has specific expertise and must clearly identify between professional opinion and fact.
- When professional opinions are recorded, they should come from, and follow the statements of, any observations. Avoid making any assumptions or judgmental comments.

Step 2: Assess and examine, consult, document

Record:

- details of all family members, including other adults and children living in the family home
- the duration of all meetings
- details and the source of any information obtained prior to the examination or meeting taking place. Such prior information may be, and usually is, relevant to the interpretation of any observations made in future meetings.
- all indicators of possible child abuse and neglect that you have noted, any high risk factors and the findings of your assessment
- the stated or suspected cause of any injuries or abnormalities and when they allegedly occurred
- what you have observed as first-hand information and what was reported to you and by whom as second-hand information
- the client's own words in quotation marks as much as possible
- if known, the name of any identified perpetrator/s and their relationship to the victim
- all communication with the family
- in instances of disclosure from a child:
 - the conversational context in which any disclosure arose (e.g. the question that prompted the disclosure or circumstances when the child disclosed)
 - where the child was and what they were doing as they disclosed
 - who else was present when the child disclosed
 - the physical proximity of persons in the room to each other and the child
- your consultation discussions with the staff member with child abuse and neglect expertise, your consultation with other health staff and any other external agency consultations (e.g. CPFS, WA Police)
- any case discussions and intervention plans.

Documentation of physical examination

Record a detailed description of the physical findings using drawings and the Body Map.

Medical Photography is available routinely at PMH. For medical photography in any other location, local area health procedures should be followed. Alternatively, contact the local Police station where photographs may be taken.

Please Note: Medical photography should not be used without accompanying written description and body drawings.

Step 2: Assess and examine, consult, document

Case example: Assess and examine, consult, document

A referral for a 12-year-old girl is received by Child and Adolescent Mental Health Service (CAMHS) from a school psychologist. The referral concerns include suicidal ideation, mood swings, anxiety, enuresis and sexually inappropriate behaviours. There is a history of sexual abuse allegations and previous court proceedings. The referrer also reports alleged substance misuse and domestic violence. The school has previously made notifications to CPFS regarding concerns for this child and family. As a mental health clinician you provide an initial assessment, assess risk issues and commence provision of a number of sessions that focus on the girl's mental health issues.

When the family is still in the early stages of service engagement, the mother contacts you by phone two hours prior to that afternoon's appointment to tell you that an argument with her daughter that morning while trying to persuade her to get ready for school ended with the mother hitting the daughter. The mother acknowledges that this is not the first time that her frustration with her daughter has reached this pitch and she regrets what she has done. The mother is concerned, given previous notifications to CPFS by the school, that her daughter will be removed from her care.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations to this child and her family?

- Inform the mother that you may need to inform others involved of this conversation.
- Ask for (and receive) her permission to inform the school psychologist (the initial referrer) what the mother has told you.
- Contact the school psychologist and advise of today's phone call from the mother. Suggest that the psychologist may find it advisable to involve the school health nurse.
- Consult with your clinical supervisor regarding whether to take further action at this stage or whether to wait until after the afternoon appointment with the mother and daughter.

If the decision is to assess the situation further with mother and daughter before taking any further action:

- document the action taken so far
- remain open to the necessity of making a notification to CPFS in your meeting with the mother and daughter and seek their written authority to do so if this is the decision arrived at.

If the decision is to make a notification to CPFS:

proceed to Section 2.3 – Step 3: Taking action/making notifications and referrals.

Step 3: Taking action/making notifications and referrals

2.3 Step 3: Taking action/making notifications and referrals

Introduction

Deciding what action to take regarding a child protection concern can be a difficult task for any health staff member. The best decisions are not made in isolation and require collaboration with colleagues, supervisors, line managers and, when indicated, with child protection specialists within and external to WA Health services.

Making a notification to CPFS or a referral to any other service necessitates the sharing of confidential client information with the agency to which the notification or referral is being made. The legislation and policies relating to information sharing are covered within this section. Also included are some common dilemmas that can arise for health staff when there is a need to share confidential client information with other health services and with external government and non-government services.

The CCSA, WA Health Policy Protection of Children Policy (See Section 1.1) and inter-agency guidelines (Joint Guidelines on Information Sharing between WA Health and CPFS) promote and support WA Health staff to share information whenever they have concerns for a child's or group of children's wellbeing. In some instances this may necessitate overruling the client's right to confidentiality if they have refused consent to provide or share information, or consent has not been sought due to significant safety concerns for the child, health staff member or others. (See Section 4.2 – Confidentiality and disclosure of confidential patient information for further information.)

Together with the nature of the concern, personal, professional and organisational factors influence referral practices and other actions taken as a part of the health staff's requirement to ensure the safety, protection and wellbeing of children. These include:

- perceptions and understanding of what constitutes abuse or neglect
- the extent to which evidence-based knowledge overrides instinct or gut reactions
- the availability and knowledge of services in the local community
- the benchmark for 'good enough' parenting held by the health staff member and/or the community in which they work
- the interpretation of role and responsibilities of self and others
- the health staff member's views of colleagues, team members and external agencies
- personal feelings, previous experiences such as fear, guilt, empathy, anxiety about the response of the community.

Step 3: Taking action/making notifications and referrals

The following table (adapted from Horwath 2007) may assist health staff identify these influences on referral practice, particularly as it relates to notifications to CPFS.

Dimensions	Factors to be taken into consideration by health staff
Perceptions of child abuse/neglect and evidence base for concerns	<ul style="list-style-type: none"> • What are my concerns? • What evidence do I have to support my concerns? • To what extent have I considered research and developmental theories e.g. impact of trauma on attachment? • To what extent is my decision as to what to do next influenced by past experiences of similar cases?
Interpretation of role	<ul style="list-style-type: none"> • How clear am I about my own role and responsibility and that of others in terms of identification, assessment and referral? • Am I aware of, and have I used, health area guidance re policies, procedures and relevant assessment tools? • Is it appropriate for me to complete a preliminary assessment? • Who should I consult regarding my role and the next steps to be taken?
Perception of child protection services	<ul style="list-style-type: none"> • How do I think CPFS will respond to a notification for this child? • What am I basing this view on? • How is this perception informing my approach? • Am I able to discuss any of these CPFS practice concerns within my own agency? • Should I be discussing any CPFS practice concerns with CPFS? • If not, how is this influencing the way I feel about and approach this case? • If I have been having discussion with CPFS, how has this influenced my approach to the case?
Personal feelings	<ul style="list-style-type: none"> • How do I feel about this child and family and their situation? • How am I feeling with how child protection concerns 'sit' with my health professional role in providing a particular health service to the child? • What memories of other family/personal situations are triggered by this case? • Am I frightened of the parents/carers in any way? How might this be affecting my judgement and the actions that I plan to take? • Is this case giving rise to any feelings of anger, hostility, helplessness etc? • Am I feeling reluctant to refer or am I determined to get this referral/notification accepted? • Am I afraid of any potential detrimental outcomes for myself as a result of referring this case?
Community role	<ul style="list-style-type: none"> • What is my knowledge base and opinion of community-based referral options in my local area? • Am I concerned about the way the community will respond to this family? • How have I managed issues associated with confidentiality and information sharing?
Perception of the team and team manager	<ul style="list-style-type: none"> • How do my manager and my team perceive child abuse and neglect and CPFS? • How has this influenced my judgement in this case? • What are the team's and manager's approaches to identification and referral in these cases? • How are these influencing my practice?

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Step 3: Taking action/making notifications and referrals

Which service to refer to?

The choice of referral agency will be influenced by the **level of risk** identified by the health staff member. In all instances where a health staff member has identified actual harm, a notification should be made to CPFS and consideration given to referring the child for medical and forensic assessment and treatment services if necessary. Where a clear risk of harm is identified, a notification should be made to the local CPFS office or, if the risk is imminent, to WA Police. Doctors, nurses or midwives who have formed a belief, based on reasonable grounds, about child sexual abuse should make a mandatory report of child sexual abuse to the Mandatory Reporting Service of CPFS (see Section 2.3.2).

In instances where the health staff member has assessed that no actual harm has occurred and there is no current risk of harm but potential future risk has been identified, referrals to support agencies for the parent/carer should be considered.

The provision of any indicated health service should continue, regardless of the agency referred to and the outcome of that notification or referral.

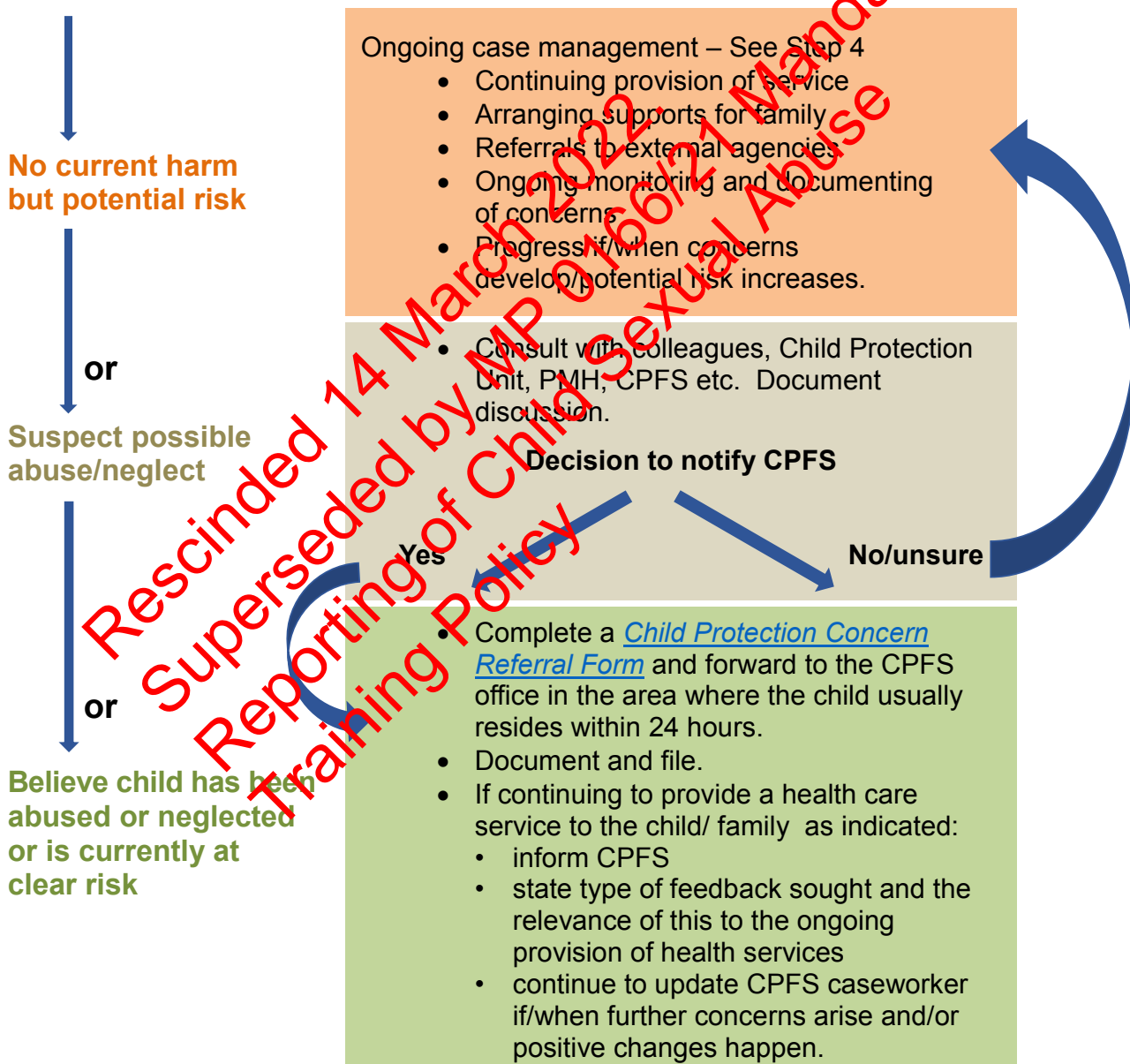
The following flow chart will assist health staff to determine whether they need to notify CPFS or if referral to another agency may be indicated, based on what they have assessed to be the current level of risk.

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Flow chart: Steps to determine level of action required

- Step 1** The health worker has identified possible child abuse or neglect
(if the concern is child sexual abuse and the worker is a mandatory reporter, go to Mandatory Reporting Section 2.3.2).
- Step 2** The health worker assesses the level of concern, consults with others and documents discussions.
- Step 3** The health worker takes actions/makes referrals based on information gathered, professional judgement and consultation with others.



Continue to provide a health care service as indicated

Step 3: Taking action/making notifications and referrals

2.3.1 Notifications to Department for Child Protection and Family Support

The flow chart *Steps to Determine Level of Action Required* (above) assists health staff to determine whether or not a notification for possible child abuse or neglect to CPFS is required or if another course of action/referral option is indicated.

If, after undertaking an assessment and, whenever possible, after consultation with others, you have clear concerns of current physical, emotional, sexual abuse and/or neglect you MUST notify the child to the CPFS as soon as practicable, preferably within 24 hours.

See also Section 2.3.2 – Mandatory Reporting if the notification is for child sexual abuse and the notifier is a doctor, nurse or midwife.

- Consultation with colleagues, line managers and/or PMH CPU (9340 8646) is recommended prior to making a notification.
- If time and/or safety factors prevent or counter-indicate the seeking of parental consent for the notification, this fact should be clearly noted on the file and on the report to CPFS. This lack of consultation with the child/family should be the exception rather than the rule.
- Notifications are made to the duty officer of the appropriate [CPFS district office](#) during usual working hours. The duty officer will inform the health staff member of the intake and allocation process and possible time lines.
- Any verbal notification must be followed with a written notification, preferably using the [CPFS Child Protection Concern Referral Form](#).
- Confidential information can be emailed to CPFS and WA Police when there are child protection concerns (see [WA Health Risk Assessment Process and Form](#)).
- After-hours verbal notifications must be made to the Crisis Care Unit, CPFS 1800 199 008 followed by a completed [CPFS Child Protection Concern Referral Form](#) as soon as practicable.
- Store a copy of the form according to your local Health Area protocols.
- If the health provider is continuing to provide a health service to the child/family then this must be stated in the form. If feedback from CPFS will assist in ongoing health service provision then this needs to be identified in the form.

Collaboration between WA Health and CPFS within the notification process

WA Health and CPFS have a number of shared services, policies, protocols and meeting schedules, all of which aim to ensure that any health service to vulnerable children and any child protection decisions are based on the most complete and up-to-date information available across both agencies. Key ones are listed below:

Step 3: Taking action/making notifications and referrals

- CAIT (Child Assessment Investigation Team)/ChildFIRST Unit

This joint WA Police/CPFS unit assesses all mandatory reports of child sexual abuse received by CPFS. Prior to providing a specialised forensic interview service for children who are the subjects of such reports, they gather relevant information from their data bases as well as information from other sources via Multi-Agency Strategy Meetings. Any health staff member who has submitted a report of child sexual abuse should ensure that they make themselves available to contribute to such meetings, either face-to-face or via telephone. The decisions made by the Multi-Agency Strategy Meeting must be documented and recorded in the child's case file.

- Serious Injury Planning Meeting (SIPM)

SIPMs are called by the PMH CPU within 48 hours of a medical determination that a child patient has injuries that are highly suspicious or diagnostic of inflicted injury. CPFS and WA Police attend, and parents are not invited. Psychosocial assessment, risk assessment, medical prognosis, medical opinion on the injuries, discharge plan and medical follow-up are all discussed at the SIPM, leading to the formulation of an inter-agency plan as to how to proceed with any health service provision, child protection action and/or criminal investigation. PMH CPU provide consultation to other WA Health areas that may call a local SIPM.

- [Child Injury Surveillance Programme](#)

This program follows procedures at the emergency department of PMH (see above) and is currently being rolled out to a number of hospitals in metropolitan and country locations. Doctors treating any child aged less than 2 years who presents at triage with an injury, poisoning or burns follows an 'injury assessment template' in order to identify, or rule out, any inflicted injuries. Any inflicted injuries identified will result in a formal child protection review, which will include consultation/collaboration with the local CPFS office, and with WA Police where indicated. In addition, regular reviews of all child injuries of under-2s presenting to the hospital emergency department are conducted to ensure no inflicted injuries have been inadvertently missed.

- [Best Beginnings Program](#)

The Best Beginnings Program is delivered in partnership between WA Health and CPFS for those families with infants who require extra support in their early parenting. It is a voluntary, structured home visiting service working with families from the antenatal period up to 2 years of age, but can also include older siblings in that family. Fortnightly collaborative team meetings allow for information sharing, discussion and prioritisation of referrals, opportunities for debriefing and discussing team issues. Families currently receiving the service are also reviewed at the team conference.

Step 3: Taking action/making notifications and referrals

- [Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is Identified as At Risk of Abuse and/or Neglect](#)

This schedule specifies that inter-agency meetings, chaired by CPFS, should follow the format of:

1. Initial meeting to be held as close as possible to 20 weeks gestation.
2. Second meeting to be held as close as possible to 26 weeks gestation.
 - CPFS decision stage prior to final meeting.
3. Final meeting to be held as close as possible to 32 weeks gestation.

The decisions arising from meetings concerning risk and safety for the unborn baby should be inclusive and transparent and copies of minutes should be given to all invitees.

- [Strategic Bilateral Memorandum Of Understanding Between The Department For Child Protection and Family Support and the Drug & Alcohol Office](#)

This MOU specifies the role of collaborative case management practice at the local level, as set out in:

- Strong Families Partnership Agreement 2010
- [Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015.](#)

- [Bilateral Schedule between CPFS and CAMHS](#)

This schedule outlines collaborative processes between CPFS and CAMHS to ensure inter-agency collaborative practices for shared clients, whether referred by CAMHS to CPFS or by CPFS to CAMHS. Inter-agency 'consultation-liaison' meetings facilitate this process through monthly meetings (at a minimum) chaired on a rotational basis by CPFS and CAMHS. Such meetings cover discussions regarding individual clients as well as broader policy and practice issues.

Step 3: Taking action/making notifications and referrals

Remember:

- Referring a child to CPFS must not influence and/or terminate the provision of any indicated health service.
- Strong client/worker relationships can be a key factor in safeguarding the ongoing health, safety and protection of vulnerable children.
- Consultation is required whenever professional judgement supports a decision NOT to seek consent/inform the parents/carers or child concerning the making of a notification to CPFS. Factors influencing this decision, such as possible (increased) risk or danger to the child, parents/carers or health staff member, must be documented.
- Health staff are entitled to receive feedback from CPFS to maximise the appropriate health service provision to the child/family and should contact the CPFS caseworker.
- If the health staff member does not receive this feedback or is not satisfied with the feedback, this needs to be addressed in the first instance at the local level. (See Section 2.4.1 – Case management for further information.)

Legalities of sharing confidential client information with CPFS

In instances where the consent of the mature minor or parent has not been sought for the sharing of information with CPFS – or where it has been sought and refused – no civil or criminal liability, breach of confidence or breach of professional ethics, standards, principles of conduct applicable to persons' employment or relevant regulatory statute will arise if the Health Department, public health authority or individual worker discloses information under authority of section 23 of CSA, provided such disclosure is made in good faith.

See:

- Section 4 – Legal information
- [CPFS Guide on information sharing](#)
- [Joint Guidelines between CPFS and WA Health for exchange of information](#)
- [Information Sheet 6: Safety for workers reporting child protection concerns](#)

See **Section 3.5 – Children in the care of the CEO of CPFS** for an explanation in table form for legalities regarding the exchange of confidential information when the child is under the care of the CEO of CPFS.

Step 3: Taking action/making notifications and referrals

Case example: Notifications to CPFS

A 4-year-old child has been brought into the hospital emergency department by his father. The child was brought in because he has had a high temperature and a severe cough. On physical assessment, he appears significantly underweight, has impetigo (school sores), and his clothes and body are dirty and unkempt. His oral health care appears severely neglected and he has dental decay. The identified concerns have been assessed and documented and, based on these findings, actions to protect the child need to be considered.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations to this boy and his family?

- Ascertain who has been looking after the child.
- Make specific enquires about the length of time the child has had these symptoms, and his food intake.
- Ascertain the presence of any pre-disposing risk factors (see Section 2.1.1 – Risk factors).
- Enquire about any other dependent children in the family, their ages and general health status.
- Enquire if the family is receiving any community support.
- Try to facilitate a conversation with the child, preferably not in the presence of the father, to gather additional information.
- Consult with either the hospital social worker, PMH CPU, designated local health service child protection consultant or CPFS.
- Carefully document the findings.

If the father's explanations for the child's neglected state appear plausible and conversations with the father (and the child) are not indicative of ongoing risk:

- Document your findings (including any findings from tools such as the [Child Wellbeing Guide](#)) and the consultation you have undertaken.
- Explore any necessary immediate support options for the family.
- Proceed to Step 4 – Ongoing Management.

If you consider that the father's explanations are not plausible and/or you are concerned that the child or other children in the family may be at risk of ongoing neglect:

- Discuss with hospital line managers.
- Discuss with your line manager and/or PMH CPU regarding the immediate safety of the child and the reporting of this case to CPFS.
- Discuss with the father your obligations to report your child neglect concerns to CPFS.

If, as a result of these discussions, your concerns about ongoing risk of neglect for this child are supported:

- Notify CPFS via a [CPFS generic referral form](#).

Step 3: Taking action/making notifications and referrals

2.3.2 Mandatory Reports of Child Sexual Abuse to CPFS

All health staff are professionally and ethically obliged to take action when they have any concern about possible child abuse or neglect. In addition, doctors, nurses¹ and midwives (as well as teachers and police) are **legally** required, under the CCSA, Division 9A, to make a report to CPFS when they have **formed a belief based on reasonable grounds** through the course of their work that **child sexual abuse** has occurred.

A flowchart outlining the process for the mandatory reporting of child sexual abuse of a child aged 0–17 years is included in this section.

Report forms can be accessed via the [WA Health Child Abuse and Neglect website](#) or directly from the CPFS www.mandatoryreporting.cpf.s.wa.gov.au. Hard copies can be faxed to the CPFS Mandatory Reporting Service on 1800 610 614.

Mandatory Reporting of Child Sexual Abuse Legislation

The CCSA, Division 9A is the legislation that governs the mandatory reporting of child sexual abuse.

Under 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.

Cases of informed 'consensual' sexual behaviour between two adolescents of similar age would generally not fall within this definition of sexual abuse as long as the behaviour is age- and developmentally appropriate. However, the individual circumstances of each case must be considered and, if the reporter forms a reasonable belief that sexual abuse has occurred, or is occurring, a report must be made.

See

- [Information Sheet 7: The mature minor, consensual sex and child sexual abuse](#) for further information.

¹ Any nurse registered under the Health Practitioner Regulations national law e.g. Medibank Health Solutions telehealth nurses, are considered as mandatory reporters under this legislation when dealing with a patient within Western Australia.

Step 3: Taking action/making notifications and referrals

When to make a report

Doctors, nurses and midwives must make a report whenever they have formed a belief on reasonable grounds and in the course of their paid or unpaid work, that a child:

- has been the subject of sexual abuse that occurred on or after 1 January 2009; or
- is the subject of ongoing sexual abuse.

Reports must be made to CPFS, which is required under the CCSA to provide the WA Police with a copy of the report. Where there is evidence a doctor, nurse or midwife formed a belief and did not make a report, they commit an offence and can be liable to be fined up to \$6000 [s124B(1)].

Forming reasonable grounds for a belief

A mandatory reporter does not need to prove that a child is being sexually abused but does need to form a belief based on reasonable grounds. Reporters should not conduct an investigation to establish if there is evidence, as this may jeopardise subsequent investigations by CPFS or WA Police. Information collected in relation to forming a belief should be obtained within the parameters of the reporter's professional role.

A belief may be formed when a mandatory reporter:

- is more inclined to accept than reject that sexual abuse is or has occurred
- observes behavioural and/or physical indicators and/or an abusive situation
- receives a disclosure from a child
- receives information from a notifier. (A notifier is anyone other than the child or reporter who passes on information in relation to alleged abuse to the reporter.)

Forming a belief is the fundamental basis for making the report and no person other than the reporter can determine if they have formed a belief. The Australian Health Practitioner Regulation Agency gives the following guidance regarding judicial consideration of 'reasonable belief':

1. A belief is a state of mind.
2. A reasonable belief is a belief based on reasonable grounds.
3. A belief is based on reasonable grounds when
 - (i) all known considerations relevant to the formation of a belief are taken into account, including matters of opinion and
 - (ii) those known considerations are objectively assessed.

Step 3: Taking action/making notifications and referrals

4. A just and fair judgement that reasonable grounds exist in support of a belief can be made when all known considerations are taken into account and objectively assessed.

If a doctor, nurse or midwife is unsure as to how to assess the information they have gathered, they should clarify their concerns by discussing with:

- a colleague or supervisor
- the CPFS Mandatory Reporting Service (1800 708 704 – 24-hour service)
- PMH CPU (9340 8646) and/or
- staff at the WA Health Statewide Protection of Children Coordination (SPOCC) unit (9224 1932).

Such discussions can take place, if necessary, without identifying the child about whom the worker is concerned.

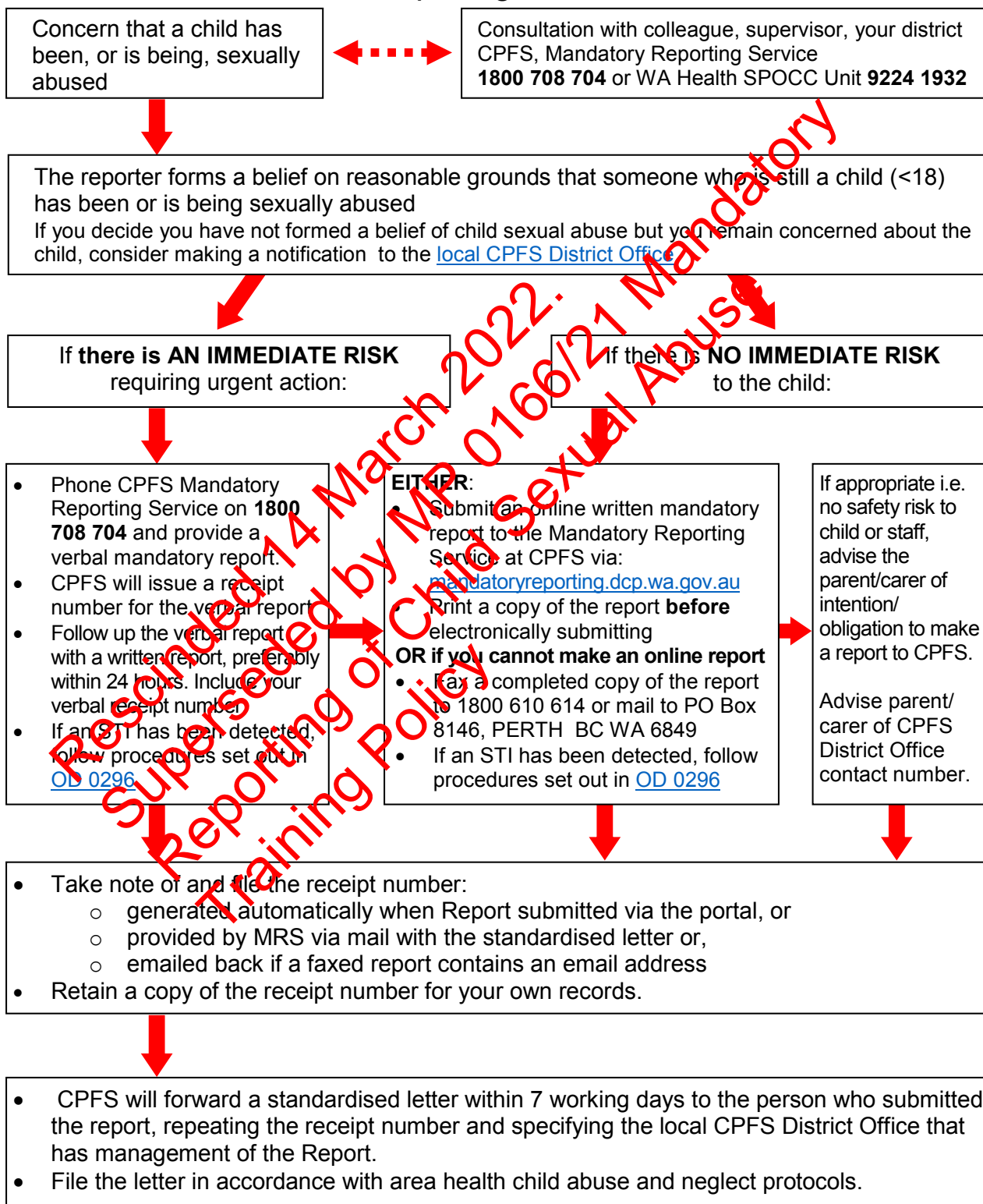
As is the case for all health professionals, if a mandatory reporter does not form a belief that a child has been sexually abused but, based on the information they have gathered, believes that the child may be at risk of any form of abuse or neglect, they are professionally obliged to take action. Such action may include making a (non-mandatory) [CPFS report](#) to the [local CPFS office](#).

Lodging a report: Refer to the Process for Reporting Child Sexual Abuse Flowchart on the next page.

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Step 3: Taking action/making notifications and referrals

WA Health Mandatory Reporters of Child Sexual Abuse: Doctors, Nurses and Midwives Process for reporting child sexual abuse



Step 3: Taking action/making notifications and referrals

Information to be provided

The mandatory report form guides reporters as to what information is required and the section below outlines this information. Once submitted, CPFS may require further information as part of the initial assessment and it is important that after-hours telephone contact details are included in the information provided.

In making a report to CPFS, reporters should be mindful to disclose only the information required by the CCSA as set out below. The CCSA also allows for information to be shared with agencies operating under other State laws, provided that the information is relevant, provided in good faith and to promote the wellbeing of children or in compliance with a request made by CPFS.

CPFS requests for more information

There are further grounds on which additional information can be disclosed to CPFS:

- Section 23 of the CCSA permits authorised officers of CPFS to request an interested person who holds relevant information to disclose that information to the officer. This might be provided in writing or verbally either face-to-face or by telephone. See Section 2.3.1 – Notification to CPFS for further information.
- Public interest disclosure applies where there is a need to share confidential information because of an overriding public interest favouring disclosure of information to a third party. The circumstances in which public interest disclosure applies are limited and legal advice should be sought prior to disclosure. For further information, please refer to [IC0164: Patient Confidentiality](#).

Retention of the report

CPFS assigns each report a unique acknowledgement receipt number, which is provided to the reporter as soon as possible. Once the written report has been received and CPFS Mandatory Reporting Service has completed an initial assessment, a standardised letter is issued to the reporter which will indicate:

- whether no further action will be taken or
- a copy of the report has been forwarded to the Child Assessment Interview Team/ ChildFIRST (a joint CPFS and WA Police unit) for assessment and planning, and/or
- further CPFS action has been recommended and to which local CPFS district office the report has been sent.

For WA Health reporters, the report, receipt and letter must be retained in accordance with area health procedures for the retention of records relating to child abuse and neglect identified in [Operational Directive 0584/15 Patient Information Retention and Disposal Schedule](#).

Step 3: Taking action/making notifications and referrals

Confidentiality and liability

Reporter's identity

Although the CCSA provides protection against disclosure of the identity of the reporter, CPFS must send a copy of the written report to the WA Police that will include the reporter's identity. The reporter's name may also be disclosed in child protection processes or Court and legal proceedings at the direction of the Court.

Patient confidentiality

Where a reporter has formed a belief, on reasonable grounds, that a child is or has been the subject of sexual abuse, making the report in accordance with the requirements set out in the CCSA does not constitute a breach of patient confidentiality, as the report is required by law.

Liability

The legislation affords legal protection to reporters who make reports in accordance with the requirements of the CCSA. If you:

- act in good faith in making a report
- believe, on reasonable grounds, that a child is or has been sexually abused
- formed this belief in the course of your work and
- provide information to CPFS as required by the CCSA,

you will not incur civil or criminal liability. You will not be taken to have breached any duty of confidentiality or secrecy imposed by law, any professional ethics or standards or be taken to have engaged in unprofessional conduct [s 129].

More information can be found at CPFS website www.mandatoryreporting.dcp.wa.gov.au or WA Health Child Abuse and Neglect website.

Alternatively, contact SPOCC on 9224 1932 or spoccunit@health.wa.gov.au

Step 3: Taking action/making notifications and referrals

Information to be provided in a report

Child details:

- child's full name (including any other names/surnames they may be known by) or, if not known, a description of the child or information that can assist to identify the child
- date of birth
- information about where the child lives
- any known details of siblings and/or other children living with the child
- names of the child's parents or other responsible person (which includes an adult relative of the child or an adult with whom the child usually lives).

Reporter details:

- reporter's first name and surname
- contact details
- your profession/job title and area in which you are employed.

The grounds for your belief that the child is or has been sexually abused

Reporters need to provide as much specific information as possible on the grounds by which they formed the belief that a child has been, or is being abused. Important information includes:

- What has the child said or done to suggest they are being sexually abused?
- If the child has disclosed abuse, what did they say happened?
- What was the child's emotional state?
- Describe any behaviours/interactions with the child that are of concern, including frequency and severity of behaviours.

Person who may be responsible for sexual abuse

If known to the reporter, the report must contain the following information in respect of a person who may be responsible for the sexual abuse:

- the person's name
- the person's contact details
- the person's relationship to the child.

If this information is not known to the reporter, the reporter should not attempt to conduct their own investigations as to who may be responsible for the sexual abuse.

Step 3: Taking action/making notifications and referrals

Additional information

Section 23 of the CCSA enables information to be disclosed to CPFS where there are child protection concerns. Section 28A,B,C allows for the exchange of information between prescribed public authorities and with and between authorised entities, provided the information is related to the wellbeing of a child or group of children. Staff who disclose information in good faith under these provisions are protected from liability. Specific circumstances of the case may require seeking legal advice.

What happens after a report has been made?

- Reports submitted via the CPFS Portal automatically generate an on-screen receipt number. This is the unique identifying number that should be used in any correspondence between the mandatory reporter and CPFS.
- Unless the report is categorised as a non-mandatory report (e.g. is about another form of abuse or is from someone other than a mandatory reporter), the reporter will also receive a standardised letter within 7 working days of lodgement, acknowledging receipt of the report. This letter will contain the details of the District Office of CPFS to which the report has been referred.
- A copy of the report, the receipt number and any letters following the assessment or investigation must be filed in accordance with area health child abuse and neglect protocols.
- After initial processing by the CPFS Mandatory Reporting Service (CPFSMRS), all reports are passed to the WA Police Child Assessment and Interview Team (CAIT), co-located with the CPFS ChildFIRST unit. These two services provide a first response from a criminal and a child protection framework.
- A copy of the Mandatory Report is also forwarded to the CPFS District Office closest to where the child lives.
- As part of the assessment or investigation process, reporters may be contacted by CPFS workers from ChildFIRST or the local district office for further, or updated, information.
- Multi-agency Strategy Meetings are held by the CAIT/ChildFIRST Unit to determine a recommended course of criminal and/or protective action. Health staff can be invited to attend (in person or by phone link-up) to contribute their knowledge of the child and family circumstances and any relevant health issues. If a mandatory reporter believes they have a significant contribution to make regarding any child protection decisions and/or health issues, they should specify their availability to contribute to the strategy meeting within their mandatory report.

At any stage the mandatory reporter can contact CPFSMRS and/or the local CPFS District Office quoting the mandatory report receipt number, to request the outcome of the report/status of the investigation. Information will be shared within the legislative limits of information sharing and according to what the reporter conveys regarding the ways in which information requested will support any ongoing health service delivery.

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Legalities of sharing confidential client information with CPFS Mandatory Reporting Service

- Mandatory reporters must comply with the legislative requirements to report child sexual abuse, regardless of any internal organisational policies, professional codes of conduct or confidentiality requirements that would normally apply.
- As is the case when making a non-mandatory report about any form of child abuse or neglect, a person who, in good faith, makes a mandatory report about child sexual abuse is protected from breaching any duty of confidentiality or secrecy, professional ethics, standards or principles of conduct that would normally apply (e.g. doctor/patient confidentiality).
- There are legal penalties for disclosing the identity of a mandatory reporter outside the professional consultation/ notification process.
- In circumstances where a documented decision was made NOT to inform the child/ parents that a mandatory report of child sexual abuse was to be submitted due to possible (increased) risk or danger to the child, parents/ carers or health staff member, this confidence will be maintained, except in limited circumstances that CPFS can discuss with the reporter.
- CPFS staff and other professionals who learn the identity of a reporter through the course of their work must not disclose the reporter's identity to another person, unless it is allowed under one of the legislative exceptions.

For further information, contact the CPFS Mandatory Reporting Service on 1800 708 704.

Parallel reporting of sexually transmitted infections and child sexual abuse

The [Department of Health Notification Form](#) lists notifiable infectious diseases under the *Health Act 1997*. The notifiable sexually transmissible infections (STIs) include Chancroid (soft sore), Chlamydia (genital infection), Donovanosis (Granuloma inguinale), Gonorrhoea, Syphilis and HIV/AIDS infection.

Parallel to the required report to the Department of Health, Communicable Diseases Control Directorate (CDCD):

- For all children under 18 years where an STI has been detected and the doctor, nurse or midwife has formed a reasonable belief that sexual abuse has occurred, a report to the CPFS Mandatory Reporting Service must be made.
- For all children under 14 years where an STI has been detected and the doctor, nurse or midwife has NOT formed a reasonable belief that sexual abuse has occurred, the STI notification should also be sent to the child's local CPFS office.

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See:

- [Inter-agency Management of Children Under 14 Who are Diagnosed With a Sexually Transmitted Infection \(STI\)](#) for further information.

**Rescinded 14 March 2022.
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
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Case example: Mandatory reporting of child sexual abuse

You are a community nurse working in a remote Aboriginal community. A woman brings in her 6-year-old grandson to see you. She is concerned about his sexually aggressive behaviours towards his two younger siblings, a boy of 2 and a girl of 4. She tells you that the boy's uncle is a convicted sexual offender who has recently moved back into the community following his release from prison and she is concerned that her grandchild may have been 'got at' by this uncle. She pinpoints the start of her grandson's disturbing behaviours to the day after the uncle came out of prison three weeks previously. On the day of his release from prison, the uncle spent all day drinking at her house and had then gone to sleep in the room that the 6-year-old shared with his two younger siblings.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations to this boy and his family?

- Assess the grandmother's legal status i.e. is she the child's guardian, can she give consent to a physical examination?
- If not, consent from a legal guardian should be sought, unless to do so would place the child at risk.
- Provide appropriate health care, including assessing the need for an STI check.
- Conduct a psychosocial assessment, including information regarding any current contact the uncle has with the children in the family.
- Obtain from the grandmother those details of her grandson's behaviour that have given rise to her concern.
- Make sure not to ask any leading/investigative questions of the child.
- Carefully document the findings.

If you have sufficient information to form a reasonable belief that the child has been the victim of sexual abuse:

- Discuss with the grandmother, and the 6-year-old as appropriate, your obligations to report this to CPFSMRS.
- Address any concerns they may have regarding this.
- Convey to the child that he is not in trouble and that his grandmother and you are working together to help him.

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- Consult with your line manager, local Aboriginal health worker, identified local medical specialist, local CPFS District Office and/or PMH CPU as to how best to protect the child, the grandmother and/or yourself from any repercussion from reporting, and the need for and the timing of any medical and forensic examination.
- Make an initial verbal phone report to the Mandatory Reporting Service of CPFS.
- Discuss with the grandmother her assessment of potential current and ongoing risk for the 6-year-old and his younger siblings, possible reactions of the uncle and other family members and possible protective options, including possible police contact.
- Liaise with grandmother/CPFS/identified others re how to address the immediate safety issues for the child and his siblings.
- Make sure that there is a negotiated plan of action for immediate safety for all the siblings before the grandmother and her grandchild leave your office.
- Arrange a follow-up appointment to monitor and review.
- Document the relevant parts of these consultations in your follow-up written Mandatory Report to CPFSMPS within 24 hours of verbal notification.

Refer to Step 4: Ongoing case management.

Rescinded 14 March 2022
Superseded by MP 0166/21 Mandatory
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2.3.3 Referrals to Other Services

Immediate threat to safety requiring urgent action

WA Police

In the majority of circumstances any health staff member needing to take action and intervention concerning the safety and wellbeing of a child will refer directly to CPFS, which will then make a determination regarding contacting the WA Police Child Abuse Squad.

In circumstances where a health staff member makes a determination that there is an immediate threat to a child, or any other person, they may decide, after consultation with line management, regional child protection expert or the CPU at PMH (9340 8646), to contact either police emergency (000) or the WA Police Child Abuse Squad on 131 444. In these circumstances a report must also be lodged with CPFS as soon as practical.

No identified current harm but concern for potential risk

Other government and non-government services including other WA Health services

- Referral to these services will be indicated whenever the health staff member has some level of concern about the need for early intervention to prevent possible risk of harm to a child but where the current level of concern does not indicate a need for an immediate notification to CPFS.
- Health staff should familiarise themselves with the range of services in their local area that can provide support and appropriate intervention aimed at reducing parental risk factors and/or providing direct services to the child.
- Parental involvement must be sought in assessing the relevance of suggested services and obtaining consent for referral; including consent for any background information provided in order to enhance the effectiveness of the referral.
- Many services can also be accessed by families via self-referral.

Some of the key referral options are listed below.

Step 3: Taking action/making notifications and referrals

Government Services

Best Beginnings

A combined service with CPFS. Early intervention home-visiting service for families and their newborn children. Priority is given to first-time younger mothers with associated risks.

Child and Adolescent Community Mental Health Service (CAMHS)

Mental health programs to infants, children and young people. Services are available for children and young people under the age of 18, and their families, who are experiencing significant mental health issues. Referral by treating therapist, specialist, GP, school or other community organisation.

Child Development Services

Provides a range of support services for children, with or at risk of developmental difficulties, and their families.

Strong Families

A formalised inter-agency approach for families with complex needs and who are receiving services from a number of agencies.

Find a Mental Health Service

Mental Health Commission online service search for Western Australia.

YouthLink and YouthReach South

Provides a range of multi-disciplinary services to improve the mental health of at-risk and marginalised young people. Also provides advice, training and support to other professionals engaged with the young person.

Drug and Alcohol Office

Online links to advice and referral services.

Women's Domestic Violence Helpline

A statewide 24-hour service that provides telephone support, counselling, information and advice for women experiencing family and domestic violence. The service can refer women to safe accommodation if required.

Men's Domestic Violence Helpline

A statewide 24-hour service providing telephone counselling, information and referral to ongoing face-to-face services if required for men who are concerned about becoming violent or abusive.

Step 3: Taking action/making notifications and referrals

Non-government agencies

Health staff should familiarise themselves with the key non-government referral options in their local area. Listed below are a few of the key services in Western Australia.

Men's Line Australia

A telephone and online support, information and referral service, helping men to deal with relationship problems in a practical and effective way.

Indigenous Parenting Services

An outreach service run by Centrecare for Aboriginal families and their children focusing on early intervention and prevention by assisting clients to develop parenting skills.

Wanslea

Offers a range of support services to families and children.

Mission Australia

A range of services for families, focusing on homelessness and domestic violence.

Legalities of sharing confidential client information with other agencies:

Prescribed Government Authorities and Authorised Entities

Section 28A,B,C of the Children and Community Services Act 2004 allows for the exchange of information without liability between prescribed public authorities (see Section 5 for a list of all such authorities) and with authorised entities, such as non-government welfare agencies, provided the information is related to the wellbeing of a child or group of children. Consent for such information exchange should be sought from the child and/or parent unless counter-indicated.

Remember:

If, after undertaking an assessment and whenever possible after consultation with others, you have concerns of any form of abuse or neglect you **MUST** take action to ensure that protective measures are put in place.

Step 3: Taking action/making notifications and referrals

2.3.4 Common information-sharing dilemmas

Concerns the child or family will cease treatment if told that CPFS is to be contacted about a child protection concern:

- Although it is often difficult to raise with families the need to report concerns to CPFS, if this is done in a skillful and respectful way, it may increase the likelihood that the family will stay engaged with the service during and after any CPFS intervention.
- Not informing the family is more likely to lead to a sense of betrayal and a subsequent lack of trust between the client and the service. This increases the likelihood of subsequent withdrawal from health services.
- The [WA Health Protection of Children Policy](#) states that it is best practice to notify the family prior to any report to CPFS being submitted. Any decision NOT to do so should only be taken after consultation and should be based on serious security risk to the staff, other clients, or to the child or other children.

Determining if consent from the parents (and/or child) is needed before discussing a child protection concern with colleagues/other WA Health workers:

- As a general rule, signed consent for the exchanging of confidential client information should be sought and obtained from the parent.
- If the child is assessed as being a mature minor then consent from the child alone may be sufficient. See [Working with Youth: A legal resource](#) for further information.
- In most circumstances it is possible to discuss concerns with appropriate co-workers/supervisors without mentioning any identifying information, thus ensuring that the client's confidentiality is maintained alongside professional standards and good decision-making practices.
- Even in circumstances where case discussions among and between clinical teams identifies the child/family under discussion, specific consent is not usually necessary – consent is implied.
- Adherence to ethical practices and legal obligations regarding information sharing, including not sharing confidential client information with others outside the clinical teams(s), is required.

See the [Operational Directive on Patient Confidentiality](#) for further information.

Step 3: Taking action/making notifications and referrals

Balancing the rights of mature minors to confidentiality with child protection concerns

- Professional judgement should be used in deciding whether or not a child meets the criteria of mature minor for the provision of a health service and/or the sharing of confidential client information.
- Assessment of a child as a mature minor must be done in the context of the current healthcare decision to be made. It should not be a one-off label which, once obtained, is subsequently applied in all scenarios relating to that child, as their capacity to make mature and responsible decisions will vary depending on the issues and circumstances.
- Under the CCSA, mature minors under 18 years are considered as children. Therefore, at times, statutory provisions will require the sharing of their confidential information with others, even when this is against their wishes. This includes the reporting of notifiable diseases to WA Health under the *Health Act 1911* and the mandatory reporting of child sexual abuse to CPFS by doctors, nurses and midwives (CCSA 2004; Section 124).
- There may also be other situations when professional judgement identifies that there is a requirement to share confidential information so that protective measures are put in place for that mature minor. Being open with the mature minor at the first contact regarding limits to confidentiality, and seeking consent to share information if needed, is best practice and has been shown to not impede good worker/client relationships.
- At times, mature minors have good reason to insist that parents not be informed. Exploring their beliefs for this can result in a rethinking and a willingness to share.
- Always discuss and document any decisions and actions around information-sharing. See: [Working with Youth: A legal resource](#) for further information.

Balancing clients' rights to privacy with the obligation of WA Health employees to take action on concerns of child abuse or neglect

- Health services, health staff and the staff who support them in their work are under a duty to maintain [patient confidentiality](#) in relation to all information that comes to them in the course of providing medical treatment and care to patients, unless that information is in the public domain or 'trivial'. The obligation arises in law, ethics and professional standards and codes, and it is usually a fundamental cornerstone to the therapeutic relationship between practitioner and client.
- The responsibility to report child abuse and neglect concerns overrides the rights of the parents or child to confidentiality or privacy.
- For further information on protection from liability for giving information see S129 (page 105) of the [CCSA](#).

Step 3: Taking action/making notifications and referrals

Managing the ongoing provision of health services following the reporting of concerns to CPFS

- To support the ongoing provision of a health service to the child and/or family, health staff can request information from CPFS regarding the course of the child's investigation.
- It is advisable that any formal request for information is made in writing stating how the information requested may be relevant to ongoing service provision. A copy of the request should be kept on the client's files. If initial responses from CPFS are unsatisfactory, consultation with line managers regarding how to proceed, including using the CPFS complaints process, is recommended.
- Investigations to assess child safety and wellbeing concerns can take a long time as they can involve a great deal of information-gathering from a variety of sources.

Treating adult clients where their presenting behaviour raises concerns about the safety and wellbeing of their children

- The CCSA recognises that actions to protect a child take precedence over a client's right to confidentiality. The [WA Department of Health Protection of Children Policy](#) states that WA Health employees are obliged to act on concerns about the safety and wellbeing of children, even when the child is not the direct client.
- It is always best practice to seek the consent of the adult client in order to share relevant information outside of Health. However, health staff are legally protected in the sharing of confidential client information with CPFS, other prescribed authorities or authorised entities, as long as the information is provided in good faith, is relevant (in the opinion of the CEO or his delegate) to the wellbeing of a child or a function under the CCSA and the disclosure is made to officers holding the necessary delegation – whether or not consent to disclosure has been given.
- When sharing information about the child, information about the child's parent(s) may also be disclosed where this is relevant to the safety or wellbeing of the child, or the performance of a function under the CCSA.

Protection for doctors, nurses and midwives who make a child sexual abuse mandatory report to CPFS when consent has not been sought from the child's family prior to submitting the mandatory report

1. **The identity of the mandatory reporter is protected** – information about a reporter's identity will not be released by CPFS to the family. The only exceptions to this are if CPFS seeks and gains the consent of the reporter to provide this information to the family and if the child's case goes to Court. In this instance the reporter will be given prior warning and steps will be taken to safeguard their safety and wellbeing.

Step 3: Taking action/making notifications and referrals

- 2. There is legal protection** – the mandatory reporter is not subject to civil or criminal liability in respect of sharing information without consent where that sharing of information complies with the CCSA. This means the reporter cannot be sued or charged with an offence as the CCSA authorises their actions and provides that legal action may not be taken in respect of this information sharing.
- 3. There is professional protection** – where information is shared in accordance with the CCSA (i.e. disclosures are made in good faith), the reporter cannot be taken to have breached any professional ethics, standards, principles of conduct applicable to their employment. Sections 23, 24A and 129 are relevant here.
- 4. The workplace** is obliged to ensure that whenever a reporter has concerns for their safety, that these concerns will be addressed and any necessary safeguards will be put in place. In some circumstances, these safeguards may need to be extended to safeguard family members or co-workers.

See:

- [Information Sheet 6 Safety for workers reporting child protection concerns](#) for further information
- [Decision-making steps for information exchange](#) (being revised)
- [Information Exchange](#) on the [WA Health Child Abuse and Neglect](#) website contains further useful information on legal and other considerations for health staff when making notifications to GPEs or referrals to other agencies concerning possible child abuse or neglect.
- **Section 4 – Legal information** regarding further information on duty of confidentiality and the sharing of confidential client information.

Step 4: Ongoing case management

2.4 Step 4: Ongoing case management

Role of the health staff member

Health services have an important role in offering support and intervention services for children and their families, whether or not notifications or referrals have been made to CPFS, WA Police and/or other government or non-government agencies:

- to reduce the risk of child abuse and neglect
- to prevent ongoing or further child abuse and neglect
- to monitor the developmental, physical health and emotional wellbeing of children in families with identified risk factors for child abuse and neglect
- to monitor and contribute to the developmental, physical health and emotional wellbeing of children who have experienced abuse, neglect and family violence
- to provide therapeutic interventions for children who have experienced abuse, neglect and family and domestic violence and/or to link families in to these services offered by agencies external to WA Health.

Depending on their role, health staff have involvement at any point in the continuum of child protection intervention. This may range from a single occasion of service to providing a range of practical and therapeutic services over a period of time to the child and/or their family. This high-end level of service provision would include contact with other internal and external agencies, including CPFS.

Regardless of the level of involvement, whenever there is a concern about child safety, wellbeing or welfare, health staff should ensure that:

- the concern has been made known to relevant others, to the level necessary to ensure an appropriate service response and to manage the level of risk
- follow-up action is taken to monitor that service response
- the steps taken, the rationale behind any course of action taken, and the outcomes of that course of action, are documented and can be supported
- the Dispute Resolution protocol (see below) is followed by the WA Health case manager or line manager in instances where a lack of cooperation and/or appropriate information sharing between WA Health and CPFS occurs, in the view of either agency, to compromise any necessary ongoing service provision to a child.

Step 4: Ongoing case management

2.4.1 Case management

Case management in protection of children matters within WA Health services is both an inter- and intra-agency process that aims to maximise collaboration and communication and to minimise duplication or omission of services. This model of working aims to strengthen outcomes for vulnerable children and their families through integrated and coordinated service delivery between health services and inter-agency partners. Case management is particularly important for children and families with complex and multiple service needs. In addition, child abuse and neglect matters are often complex and therefore it is important individual health staff members do not work in isolation.

When CPFS is involved

If CPFS is involved then it will be the lead agency in child protection matters. Health staff members who have relevant past or present service provision to the child/family should make themselves available to be included in any inter-agency case coordination meeting or discussion.

- Whenever WA Health services have initiated a case management role and a notification has been made to CPFS, it is advisable for the nominated case manager to ascertain whether or not CPFS is acting on the notification i.e. whether or not the notification has instigated a CPFS Safety and Wellbeing Assessment (SWA).
- Whenever CPFS has initiated an SWA, the WA Health case manager should ensure there is ongoing collaboration between CPFS and WA Health.
- Whenever CPFS has not initiated an assessment or, when an assessment has resulted in a non-substantiation of abuse AND the involved health service identifies that concerns are still current, health staff members may also, in conjunction with continuing their service provision to the child/family:
 - consult with line management, regional child protection experts or the PMH CPU for further support and relevant resources
 - request CPFS review the matter
 - submit a [Child Protection Concern Referral Form](#) whenever further information of concern becomes available
 - contact WA Police if any new concerns of imminent risk to the child, other children or workers arise which are of a criminal nature.

Step 4: Ongoing case management

Dispute Resolution between WA Health and Department for Child Protection and Family Support (CPFS)

- Any inter-agency dispute arising from any process involved in attempting to ensure the safety, protection and wellbeing of a child for whom a health service is or has been provided and/or is indicated will, in the first instance, be negotiated at the lowest and most informal level practicable.
 - Actions taken should be recorded and the line manager informed.
 - If the dispute involves the non-provision of requested information then consider using Form 1 (Section 5.3).
- If the issue remains unresolved, the concern should be raised with the CPFS team leader at the local CPFS District Office. If raised verbally, then a written confirmation of the discussion should be forwarded to the team leader.
 - Actions taken should be recorded and the line manager informed.
 - Line manager to monitor request and response.
- If still unsatisfied with the response and/or a lack of response, it must be escalated to the line manager to make contact with the local CPFS District Director.
- If the issue continues to be unresolved, the WA Health line manager should use the formal [CPFS complaints process](#), complete an online [Complaint Form](#) and must alert senior management of actions.
- Senior management will determine if the issue needs to be further escalated.
- If during this process, there are ongoing and/or new concerns for a child's safety and wellbeing then additional child protection notifications to CPFS can be made.

When CPFS is not currently involved

The health service/health staff member with the most contact with the child and/or family will usually be the case manager. Should CPFS become involved at a later date, this worker would become the health service representative in any inter-agency meetings convened by CPFS.

Workers with case management responsibility should use all areas of consultation and support available, for example the Child Protection Unit at PMH, Child Protection and Liaison workers at CAMHS services, SPOCC unit, hospital or community-based social workers and psychologists. All involved professionals should be aware that the level of risk may vary during the time they are involved with a child and/or the family, and that ongoing monitoring and review of the child's status is required and may result in reports to CPFS and/or changes in service needs or delivery.

Step 4: Ongoing case management

Role of the health service case manager

In addition to providing direct client services to the child and family, the case manager will:

- coordinate and chair case conferences within the WA Health service
- determine the role of each health staff member/health worker in the case management team
- use a case conference model with regular scheduled meetings
- coordinate and implement the intervention plan
- discuss the WA Health service intervention plan with the family
- take on the role of contacting CPFS for either consultation or (re)notification
- inform involved health services/workers of the outcome of consultation with or notification to CPFS
- ensure that consent is sought from the child/family for the exchange of information between the health service and other involved services. This will include filing copies of signed consent, or documenting reasons why consent was not sought, or sought but not given
- ensure that there is WA Health service representation at inter-agency meetings concerning the child and/or family. These can include the following meetings coordinated by CPFS:
 - antenatal Signs of Safety Meetings
 - general Signs of Safety Meetings
 - Multi-Agency Strategic Meetings (convened by CPFS and WA Police following receipt of either a mandatory report of child sexual abuse or of significant physical harm to a child)
- support the Dispute Resolution process whenever a dispute, including a lack of necessary inter-agency collaboration or feedback, threatens to prevent or compromise the provision of any (necessary) health service and/or the safety of the child(ren) or any WA Health employee.

Remember:

If, at any stage of your ongoing management of the child/family, your prior concerns about abuse or neglect become stronger and/or gain more substance as you learn more about the child and their familial context, you **MUST** initiate Steps 2 and 3, assessing, consulting, examining, documenting and then notifying the Department for Child Protection and Family Support.

In situations when consultation does not result in consensus and when a health staff member continues to hold a level of concern they believe to be justified although not shared by others, they should still take action based on the level of concern they hold after any consultation.

Step 4: Ongoing case management

Case example: Ongoing case management

You are a nurse based in a local drug and alcohol treatment service. A 30-year-old client, Tracey, has been attending the service on a fairly regular basis for the last 6 months and has made some significant progress in reducing her methamphetamine usage. She has told you that she really does believe that this time she will not slip back into her former drug-using lifestyle. She also tells you that the reduction in her overall use means she is less intoxicated throughout the day and so therefore more aware of her lifestyle and the effect that her drug use has had, and continues to have, on herself and others, especially her children, a 7- and a 9-year-old. As an experienced nurse you are aware the feelings of guilt and shame that Tracey has begun to express could point to possible future relapse.

She tells you that she is petrified that 'the welfare' might take her children from her if they ever found out what a bad parent she had been. In the last couple of weeks you have started to notice signs of relapse; she has postponed one appointment, cancelled a second and did not turn up to last week's appointment. She does arrive today and admits to a drug binge over the weekend. She tells you this was sparked by her ex-partner coming around and threatening her with a crowbar before smashing up her car with it.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations to this parent client and her two young children?

Since the client has entered the service, as well as the usual interventions, you have done the following with the welfare of the children in mind:

- suggested that the children come in to see the children's counsellor. They now see the counsellor regularly and several joint meetings between mum and children with the two involved counsellors have taken place.
- on discovering that her ex-partner was stalking her and making both her and the children afraid, helped her develop a Safety Plan and linked her into services, including counselling services for support.

Step 4: Ongoing case management

Now:

- Discuss with the client your current concerns for her and her children and the need to ensure that they all remain safe.
- Discuss with her the benefits of reporting child protection concerns to CPFS; they can help her link into a Safe at Home DV program; they can link her into other services and you can inform them of the successful steps she has taken already in reducing her drug use and becoming a better mother to her children.
- With her agreement, and with the client in the room, have a phone conversation with the local CPFS office before obtaining Tracey's agreement to submit a notification via the [Child Protection Concern Referral Form](#).
- With Tracey's permission, inform the children's counselor of the weekend's events.
- Make another appointment for one week's time.

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2.4.2 Self-care for health staff members

Dealing with child abuse and neglect can be a stressful and, at times, difficult experience for any health staff member. This can be especially true for workers for whom child abuse and neglect matters do not form a regular part of their work role. Given the prevalence of child abuse and neglect in the general community, it can also be stressful for those health staff who may have a personal history of child abuse and neglect.

Health staff have a duty of care to clients. One aspect of this duty of care is to practice self-care in order to maximise good protection of children outcomes. Management has a duty of care towards their staff and WA Health has a number of clinical supervision and performance management policies that assist in providing support to health staff.

The purpose of clinical supervision is to:

- provide ongoing learning and clinical skill development
- provide support in coping with the demands of clinical work
- promote reflective practice and maintenance of professional and ethical standards
- promote evidence-based practice.

Reflective practice, sometimes called self-assessment, is another tool that can contribute to self-care. Through reflective practice, health staff are able to develop their personal knowledge and use this to inform their future actions. The process of reflection may create emotional experiences that need sensitive guidance and support so that the staff member can use the insights gained to better care for themselves as they care for others. The following practice resources have been developed by New South Wales Family and Community Services www.community.nsw.gov.au:

[Self Care Plan](#)

[Self Care Maintenance Plan](#)

[What is Vicarious Trauma?](#)

[Preventing stress and burnout](#)

There are several WA Health policies and guidelines designed to help health staff look after themselves and know their rights as a worker and what the workplace is required to do in order to provide a safe and supportive working environment. This knowledge can be particularly useful for those whose work location and/or identification with particular communities or cultures might make them vulnerable when reporting concerns about child abuse or neglect

Step 4: Ongoing case management

[Looking after yourself – for WACHS health workers](#) (intranet access required)

[Employee Support Officers – self care](#) (intranet access required)

[Preventing and responding to workplace bullying policy](#)

[Information Sheet 6: Safety for workers reporting child protection concerns](#)

Employee Assistance Program

A free, confidential counselling service is available for all WA Health employees. This can be a useful resource for processing any personal or professional worries or concerns you have concerning the safety and protection of children under your health care service. To ensure you contact the correct external provider for your employment area, refer to your local intranet site <http://intranet.health.wa.gov.au/eas/home/> or contact your Human Resources Unit for contact numbers and general information.

Rescinded 14 March 2022
Superseded by MP 0166/21
Reporting of Child Sexual Abuse
Training Policy



3. Special risk groups

3.1 Aboriginal children and their families

3.2 Culturally and linguistically diverse children and their families

3.3 Children with disabilities and their families

3.4 Pre-borns, infants and their families

3.5 Children in the care of the Chief Executive Officer of the Department for Child Protection and Family Support

Rescinded 1st March 2022.
Superseded by MM 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

3. Special risk groups

No section of our society is free from child abuse or neglect. However, there are certain sections of our society for whom the combination of parental, child and community risk factors (see Section 2.1: Step 1) place the children within these groups at increased risk of abuse or neglect. Health staff need to be especially attuned to the following groups of children and their families, including their statistically increased likelihood of experiencing abuse or neglect, how to act on issues of concern and to be aware of specific resources that can assist the health staff member and the child and their family.

3.1 Aboriginal children and their families

In 2011/12 in Australia, 42 per 1000 of Aboriginal children were the subjects of substantiated child protection matters, compared to a rate of 5.4 per 1000 for non-Aboriginal children. Half of the children currently in care in Western Australia are Aboriginal, although this group comprises only 5.5 per cent of the state's child population.

Many Aboriginal children, families and communities experience significant social and economic disadvantage, and fare worse on almost all measures of health and wellbeing.

- Relative mortality/risk among Aboriginal children remains at between 2 and 4.5 times higher than that for non-Aboriginal children.
- More Aboriginal children than their non-Aboriginal counterparts are brought up in families and communities that are affected by inter-generational poverty, unemployment and trauma, alcohol and drug abuse, family and domestic violence and adult mental health problems.
- The legacy of the Stolen Generation forced removals of children from their families and cultures, thereby depriving such children of the experiences necessary to become successful parents themselves, is a continuing factor in the cyclical nature of why Aboriginal children come to the attention of statutory child protection authorities at such alarming levels (AIHW 2011). This factor is also a reason behind the reluctance of many Aboriginal families and workers to report instances of abuse and neglect to the child protection agency.

Identifying and acting on Aboriginal child abuse and neglect concerns

The following approaches that may contribute to better outcomes for Aboriginal children and their families should be promoted by WA Health services and adopted by WA Health staff where possible:

- openness and transparency about child wellbeing and child protection concerns, where this is appropriate and safe
- workers should be empathetic and appreciate that there are many perspectives on situations that are influenced by culture, while maintaining the position of never accepting culture as a reason to minimise, deny or excuse the harm caused to a child through the actions or inactions of an adult
- raising and addressing common concerns held by some Aboriginal families around health services intervention e.g. making space for conversations regarding possible distrust of mainstream health services, fear of having children removed
- holding to the same expectations regarding the minimum safety, welfare and protection needs of Aboriginal children as for non-Aboriginal children
- using the knowledge and expertise of Aboriginal health workers who can liaise with a range of other agencies, both government and non-government, to provide client/family support and community development
- developing and implementing approaches that are flexible and adaptable to the needs of the community and individual clients
- inter-agency collaboration and integration of service provision between relevant government and Aboriginal Medical Service (AMS) and other involved non-government services. This can include integrated referral and assessment processes, streamlined information sharing processes (with client consent) and local inter-agency networks comprising key services
- sourcing culturally appropriate and sensitive material that supports advice or case plans involving the client or family
- supporting Aboriginal and non-Aboriginal workers and providing regular opportunities to meet, share experiences and exchange information.

Resources:

[SNAICC](#)

[Australian Indigenous Health InfoNet](#)

[Families as First Teachers-Indigenous Parenting Support Services Program](#)

[Learning with Family – Northern Territory Government resource](#)

Relevant Services:

[Perth Aboriginal Resources Directory](#)

[Dooraminda Reunification Service](#)

[Meerilinga Aboriginal Parent Support Service](#)

Case example: Special risk group – Aboriginal children

Marla is a 10-year-old Aboriginal girl living with her mum, Sarah, and two younger brothers – a 6-year old and a baby of 6 months. They live in a three-bedroom Department of Housing house in a regional town. In the last 12 months, Marla has suffered the loss of her maternal grandmother (aged 54 years) through chronic illness, her father (aged 30 years) from an acute myocardial infarction and a male cousin (aged 16 years) from suicide. Three years ago, her sister died from sudden infant death syndrome at the age of 13 months. There is an extensive family kinship system with several aunts and paternal grandparents, and there are often additional relatives staying in the home. The mum, Sarah, has also been struggling with these losses, especially the loss of her mother who she always relied on to fulfil the role of getting the children up, fed, dressed and off to school on the occasional mornings when Sarah was the worse for wear after a heavy night of drinking with relatives.

Marla has lost all interest in attending school and has been spending most of her time at home helping her mother with the baby. Previously, she had been described as a regularly attending, pleasant student achieving average grades, with good physical health and normal developmental milestones.

Sarah is concerned about Marla's school refusal, and admits her school attendance has been patchy over recent years. She is concerned about the school reporting the family to child welfare services and has shared this concern with you, the community health nurse who is providing an enhanced home visiting service to Sarah and her youngest child, focusing on the baby's lack of adequate weight gain over the previous two months. This is yet another concern for Sarah.

Marla says very little in your presence, but admits she enjoys staying home to look after her brother. She has told you previously that she has trouble sleeping and usually ends up in her mother's bed at night. Sarah confirms this, and says that she doesn't mind except when Marla wets the bed, which she does quite frequently.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations for these children and their family?

- Your primary role is focused on mum and baby.
 - Do you have concerns about the capacity of the baby to attain expected developmental milestones?
 - If YES; discuss strategies and/or notification/referral options with mum.
- Consider completing a [Child Wellbeing Guide](#), initially for the 6-month-old only.
- The health and welfare of the two older children do not formally come under your area of responsibility:
 - Discuss any concerns with your line manager. These may include the impact of cumulative loss on all family members, school attendance, possible periodic absence of appropriate parental care if/when mum continues to binge drink.
 - Discuss strategies for support for these family members, including contacting the school health nurse, possible referral to rule out urinary tract infection as a reason for enuresis.
- You and your line manager agree that it would be appropriate to link the mum into some additional services to support her parenting of all three children.

At your next visit Sarah is appreciative of the offer of help in finding support; she says that very often her family members feel to be an added burden rather than an active support.

- Mum asks you to contact the services you have suggested to her right away, which include the Aboriginal Alcohol and Drug Service, and an Aboriginal Family Support Service. Appointments are organised by phone during your visit.
- Mum agrees for these services to provide regular feedback to you on what services are provided, and how things are progressing for the family members.
- Summary documents of all discussions and decisions, along with copies of signed consent to referral are entered into the appropriate health record.

Proceed to Step 4: Ongoing case management.

3.2 Culturally and linguistically diverse children and their families

The number of children and young people from culturally and linguistically diverse (CALD) and refugee backgrounds coming to the attention of child protection authorities in Western Australia is unknown. The annual compilation of Australia-wide child protection statistics does not categorise CALD and refugee children. A research study conducted in Victoria showed that approximately 13 per cent of children in out-of-home care were from CALD or refugee backgrounds, on a par with numbers for Aboriginal children in that state (Kaur 2012). International research has identified a lack of consistency in identification and intervention of child protection concerns amongst CALD and refugee families, based on cultural ignorance and/or the over/under consideration of cultural norms when assessing child-rearing practices and child abuse.

While the risk factors for child abuse and neglect mentioned in Section 2.1.1 are common to all families, CALD and refugee families face a number of unique additional risk factors and challenges. These can be summarised as:

- **Cultural:** lower status of women and children and primacy and status of the husband/father as 'head of the household' which can result in practices such as gender-based violence, [female genital mutilation](#), removal of girls from schooling, [forced/early marriages](#), child rearing differences including use of physical reprimands, lower levels of parental supervision, academic pressure and, for refugees in particular, ongoing impact of exposure to trauma, including post-traumatic stress disorder
- **Migration-related:** poor English language skills, lack of awareness about child protection laws and agencies, lack of extended family support and generational differences, stressors related to acclimatising to new cultures and expectations, interrupted or low levels of literacy and general education, perceived or experienced racism and discrimination
- **Generalist:** homelessness, poverty, mental health issues, domestic violence and alcohol or drug issues

Identifying and acting on child abuse and neglect concerns

- Although there may be wide variation in parenting practice between cultural groups, child abuse or maltreatment is not condoned in any culture.
- Health staff should be aware that certain child rearing practices that are accepted in other cultures may infringe Western Australian laws or accepted practice e.g. physical punishment, female genital mutilation, strictures imposed on women during menstruation and post-childbirth.
- It is the role of health staff to acknowledge these differences with families when they are identified and support change.

Screening for family and domestic violence is highly recommended when working with CALD and refugee families. See [Guideline for Family and Domestic Violence 2014](#) for further information.

Awareness of the prevalence of female genital mutilation (FGM) and/or forced child marriages in many of the ethnic groups represented amongst CALD and refugee families in Western Australia should also form a part of assessment processes with girls and/or their mothers.

Working with Interpreter Services

- An interpreter should be engaged as soon as the health staff member determines that a child or family member may have difficulty in speaking or understanding English, or has a background that may impact on the health staff member's ability to communicate with them. Health staff are required to seek assistance from an accredited interpreter. Where possible a Level III Health or Mental Health accredited interpreter should be used.
- The Telephone Interpreter Service (TIS) – 131 450 – provides a 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 might have in place to access the TIS. Use these protocols e.g. specific account numbers, to access the professional interpreter services.
- Depending on the situation, CALD clients can find it easier to discuss and disclose difficult and confidential information to an interpreter over the phone rather than face-to-face.
- If a child is in immediate danger and the interpreter service is not available, consider using a family or community member. Although this is best avoided on the grounds of a conflict of interest, it can be used as a last resort in an emergency.

Relevant Services

[Multicultural health services](#)

[Association for Services to Torture and Trauma Survivors](#)

[Ishar: Multicultural Women's Health Centre](#)

Migrant Resource Centres:

- [Multi-cultural Women's Advocacy Service](#)
- [North Perth](#)
- [Mirrabooka](#)
- [Fremantle](#)

Resources

[Cultural Diversity and Child Protection: A review of the research](#)

[Female Genital Mutilation](#)

[Forced/early marriages](#)

Case example: Special risk group – CALD children

Amadou, his wife Grace, their two girls Subin (8 years) and Fazilah (5) and son Patrick (6) have been living in Perth's northern suburbs since being granted asylum last year after several years spent in a refugee camp in Malaysia after fleeing Sudan. The children all go to the school where you work as the school nurse. Grace is very involved in the school community, which has a significant number of Sudanese students. The children all have good English and are popular students with good attendance.

Subin is sent to see you one morning after her teacher noticed significant red welts on the back of her legs. Subin answers your question as to how she got the welts by saying "Sometimes I don't do what Dad says fast enough". She then refuses to say anything else. You notice what you think is an outline of a handprint on Subin's thigh as she sits down but when you enquire about this she pulls her skirt down and refuses to speak further. You put some salve on the back of her legs and tell her you will ask the teacher to send her back before the end of the day to see how she is going.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations in relation to this girl and her family?

- Document your findings – including diagrams of the sites of possible physical abuse.
- Speak to Subin's class teacher, discuss your thoughts and check if they have had any concerns about possible physical abuse by either parent.
- Do likewise with the teachers of the two younger children.

Depending on the result of these conversations:

- Discuss with the school social worker and/or psychologist possible support services for the family.
- Consider referral to the local Migrant Resource Centres, which can educate regarding the unacceptability and possible criminality of the use of severe physical punishment by parents towards children.

If any of the teachers consulted share other concerns regarding possible use of excessive physical punishment:

- Consult with CPFS regarding a suggested course of action.
- If deemed appropriate:
 - Ask the teachers to send the other children in to see you; possibly in a joint meeting with the school social worker/psychologist
 - Share your concerns with Subin when she comes back at the end of the day and tell her that you think she might need some help to feel safe at home and that you and the school may be able to help her, her siblings and her mum and dad with that.
 - Continue to monitor, and ask other teachers to monitor the situation with all three children.
 - Remain open and prepared to have the school invite the parents in for a meeting to discuss how they punish their children and, depending on the outcome, consider a possible notification to the local CPFS District Office.

Proceed to Step 4: Ongoing case management

Rescinded 14 March 2022:
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

3.2.1 Particular Issues in some Aboriginal and CALD communities

3.2.1.1 Forced child marriage

According to UNICEF (2014), 250 million females alive in the world today were married before the age of 15 years. Early marriage, or arranged marriages (which comprise 55 per cent of all marriages worldwide) are different from forced marriages. However, countries that practise early or arranged marriages are also those countries in which forced marriages are more likely to occur. In Australia, forced marriages are concentrated within some traditional Aboriginal communities and some refugee and migrant communities.

Forced marriage is a crime in Australia, and is punishable by up to 7 years in prison. Under Commonwealth law, a forced marriage is one where a person gets married without fully and freely consenting because they have been coerced, threatened or deceived. A person can be coerced through obvious means such as force, detention or duress, or through more subtle means like psychological oppression, abuse of power or taking advantage of the person's vulnerability. The Commonwealth law applies and forced marriage is in section 270.7A of the WA [Criminal Code Act 1995](#).

Forced child marriage is considered a violation of children's rights under the United Nations Convention on the Rights of the Child (CRC) and is proscribed under the Convention on the Elimination of All Forms of Discrimination against Women (Article 16).

Marriage is broadly and inclusively defined and includes marriages recognised under laws of foreign countries and de facto relationships registered under a prescribed law of a state or territory. Forced marriage is not limited to any particular cultural group, religion or ethnicity. While the majority of reported victims are young women and girls, men and boys can also be victims. The marriageable age in Australia is 18 years for both men and women. Marriage of somebody who is 16 years but less than 18 years is possible only if the person they are marrying is 18 years or older. In this situation, parental consent and a judge or magistrate's order are required for the minor. Two people under 18 years of age cannot marry each other.

Forced marriage is different from an arranged marriage where choice of whether or not to accept the arrangement still remains with the prospective spouses. Consent is essential within all marriages and if a child does not consent or lacks the capacity to consent to a marriage, that marriage must be viewed as a forced marriage, whatever the reason for the marriage taking place. While it is important to understand the motives that drive parents to force their children to marry, these motives should not be accepted as justification for denying the child the right to choose and enter freely into a marriage. Among communities where forced marriage can be more prevalent, disclosure by the child and/or parent can be

difficult as the need to fulfil obligations to one's extended family and the wider community are overriding. Children have been killed in the name of honour when they have refused to enter into a forced marriage.

Children who are forced to marry can experience poor health due to pregnancy, family and domestic violence, sexual assault, economic dependence and isolation. A child at risk of forced marriage is also at risk of some of the following threats or abuses:

- indecent assault and rape
- physical assault
- emotional and psychological abuse
- kidnapping and/or abduction
- removal from education
- slavery.

When a child is at risk of forced marriage:

- There may be only one opportunity for a service or agency to speak to a potential victim so it is important that staff are aware of their responsibilities and obligations and act immediately.
- If a child is at imminent risk of being forced into marriage or being removed from Australia for the purpose of forced marriage, contact should be made with the WA Police Child Abuse Squad (9428 1500) or the Australian Federal Police (131 237). In an emergency, dial 000. A child protection report should be submitted to the local office of CPFS as soon as practicable.
- If there are not urgent concerns that a child is at risk of being subjected to a forced marriage in the future, contact should be made with the local CPFS district office or Crisis Care (9223 1111 – 24-hour service) and a child protection report submitted as soon as possible. Contact can also be made with the Australian Federal Police (131 237).
- Consultation with RMH CPU (9340 8646) should be considered to assist with a notification to CPFS and provide preliminary assessment/information gathering.
- Parents should be advised that forced marriage is illegal and that a person who takes a child or arranges for a child to be taken from Western Australia with the intention of having them subjected to a forced marriage is liable to imprisonment for up to 7 years. Information for families, children and young people is available from: [Forced marriage | Attorney-General's Department](#).
- The family should be advised that a report has been made to CPFS and/or the police and the process discussed with them, unless it is assessed that this information will result in the family being a serious flight risk.

- When a notification is accepted by CPFS, it will initiate a strategy meeting with other agencies and coordinate the response and subsequent investigation, including possible referrals for support and counselling.
- If a health staff member has concerns about the CPFS response, contact and discussion should be had with the Zone Director. If concerns still remain, then a formal complaint should be lodged with CPFS: [CPFS complaints process](#).

When a child has been forced into a marriage:

- If a child is found to have already been forced into marriage, referral to paediatric services for any ongoing medical treatment/management should be arranged.
- Consideration should be given to a referral to PMH Emergency Department for children of up to 16 years of age, or the local Emergency Department with a request for referral to King Edward Memorial Hospital Sexual Assault Referral Centre (1800 199 888) if over 13 years of age.
- Contact should be made and a notification submitted to the local CPFS District Office or to Crisis Care (9223 1111 – 24-hour service). At the same time a report should be submitted to the Federal Police (131 237).
- Referral to other social and medical support services should be considered.
- Consideration should be given to using Section 28A,B,C of the CCSA to obtain information from other prescribed authorities and authorised entities.
- Where concerns of ongoing parental protectiveness of a child and/or their siblings are present, CPFS will undertake an assessment in collaboration with WA Police. This assessment gives priority to responding to the potential risk of forced marriage for other children in the family.

Potential warning signs or indicators

Someone in, or at risk of, a forced marriage, may have difficulty talking about their situation, so the following may be indicators of forced marriage:

- The child has a family history of elder siblings leaving education and/or marrying early.
- The child is subject to unreasonable or excessive restrictions from their family, such as not being allowed out or always having to be accompanied.
- The child displays new or unexplained signs of depression, self-harming, social isolation and substance abuse, has a decline in behaviour, engagement or performance.
- The child expresses concern regarding an upcoming overseas family holiday.
- The child has absence or persistent absence or requests an extended absence from school, college, or the workplace, or begins to display truancy, low motivation or fear of forthcoming holidays.

- The child has limited career choices or their parents control their income.
- There is evidence of family disputes or conflict, domestic violence, abuse or running away from home.

Best Practice Guide

- See the child in a secure and private place and on their own, even if they attend with others.
- If possible, give to the child the choice of the ethnicity and gender of the person who deals with the case.
- Establish if there is a family history of forced marriage or if other indicators are present.
- Explain the options and inform the child of their right to seek legal advice and representation.
- Provide personal safety advice and develop a safety plan.
- Recognise and respect their wishes and reassure them of confidentiality where appropriate.
- Establish and agree on an effective method of contacting them in the future and obtain full contact details that can be sent to either CPS or the police.
- Where appropriate, consider the need for immediate protection and placement away from family.
- Advise the child not to go overseas and/or discuss the difficulties they may face.
- Provide advice on other services or support.
- Maintain a full record of the decisions made and the reasons.

Taken from: Multi-agency practice guidelines: Handling cases of forced marriage

Refer to the adjacent flow chart for how to proceed when a child is at risk of forced marriage or has already been forced into marriage.

CHILD FORCED MARRIAGE PROCESS FLOWCHART

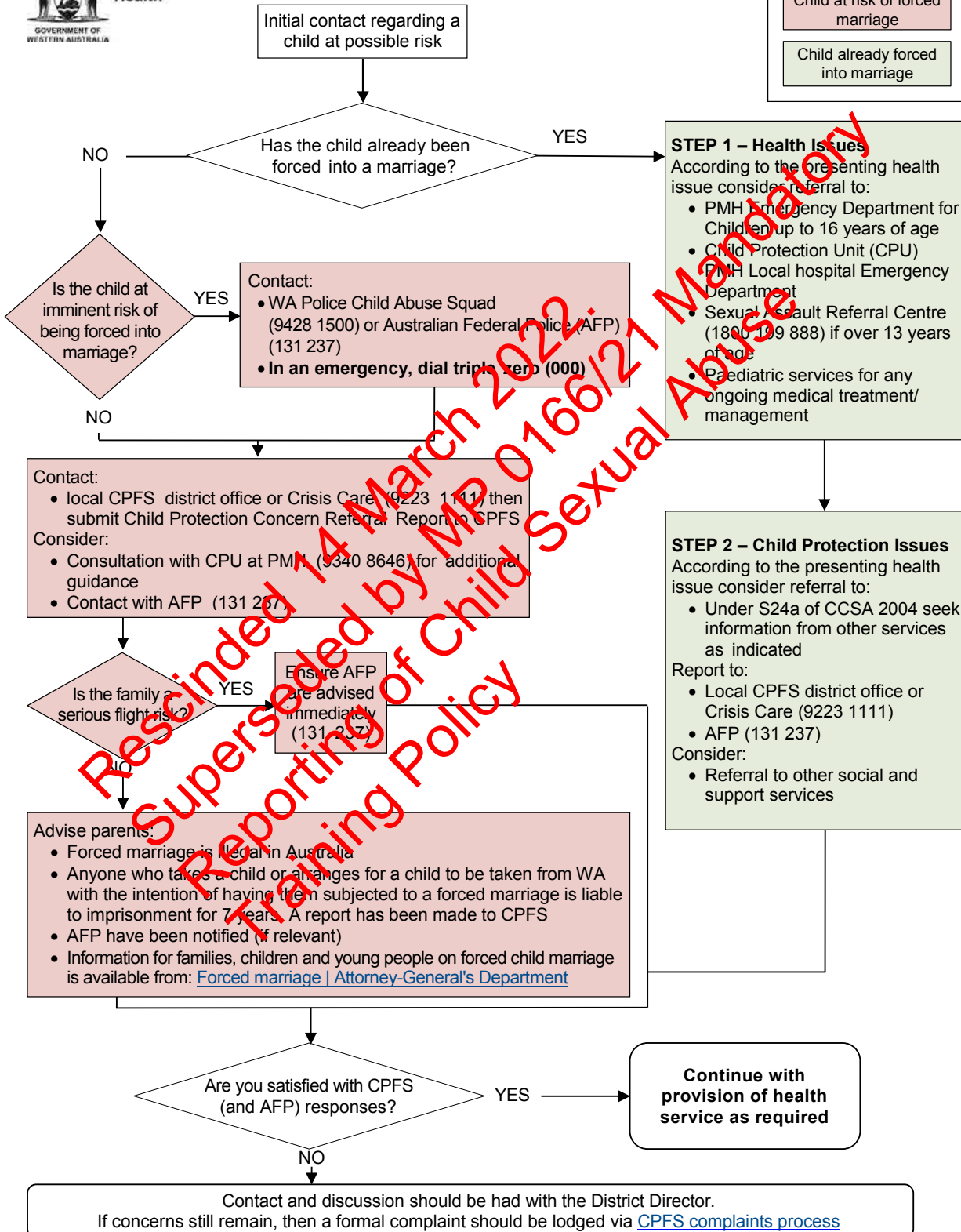


Department of Health

Key

Child at risk of forced marriage

Child already forced into marriage



Rescinded 14 March 2022. Reporting of Child Sexual Abuse Policy

3.2.1.2 Female genital mutilation

There are approximately 30 countries where female genital mutilation (FGM) is practiced, with most of these being in Africa. Rates of FGM in Somalia, Guinea, Egypt, Mali, Sudan, Sierra Leone and Djibouti are all around 90 per cent or higher. UNICEF estimates that 125 million girls and women around the world have suffered FGM and many refugees from several of the countries that practice FGM now live in Western Australia.

FGM is a criminal offence in Western Australia when it is practised for cultural or non-medical reasons. Section 306 of the Western Australian Criminal Code (the Code) provides that a person who performs female genital mutilation on another is guilty of a crime and is liable to imprisonment for 20 years. The fact that the person or their parent or guardian consented to the female genital mutilation is no defence.

Section 306 of the Code also provides that a person who takes a child from Western Australia or arranges for a child to be taken from Western Australia with the intention of having the child subjected to female genital mutilation is also guilty of a crime and is liable to imprisonment for 10 years.

The CCSA is silent on FGM. The CPFS has defined FGM as physical (not sexual) abuse and, whenever identified, a child protection notification should be made to the local CPFS District Office. The CPFS process can be accessed via the CPFS casework practice manual:

[4.4 Female Genital Mutilation](#)

A customised response is provided by CPFS due to the risk and complex nature of FGM, which may include consultation with WA Police, and the reporting health service. Consultation may also include PMH CRU.

Identifying a girl at risk of female genital mutilation

- Any newborn female whose mother or sisters have been subjected to FGM must be considered at risk of FGM, as must other female children within the extended family.
- Although FGM can be carried out at any age, the majority of FGM appears to take place between the ages of 5 and 8 years and girls within that age range would be at higher risk.
- When FGM has been carried out in a family, the specific age at the time of the procedure for each female member should be recorded as a guide to identifying the risk period for unaffected females within the family.
- Those families less integrated into the community, or where girls and their mothers have limited contact outside the immediate family and have limited access to information on FGM, are more likely to carry out FGM.

- Signs that FGM 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; the child or family are considered to be a flight risk.

Action when a girl is at risk of female genital mutilation

- If child is at imminent risk of having FGM or of being removed from Australia for the purpose of FGM, contact should be made to the WA Police Child Abuse Squad (9428 1500, or for urgent matters 0421 617 141).
- If there are concerns a child may be at medium or longer-term risk of being subjected to FGM, the local CPFS District Office or Crisis Care (9233 1111, country free call 1800 199 008) should be contacted and a child protection report submitted as soon as possible.
- Consultation with PMH CPU should be considered to assist with a notification to CPFS and to provide preliminary assessment/information gathering.
- Parents should be advised that FGM is illegal and that a person who takes a child or arranges for a child to be taken from Western Australia with the intention of having them subjected to FGM is liable to imprisonment for 10 years. Information to parents on the health issues associated with FGM should be provided.
- The family should be advised that a report has been made to CPFS and the CPFS process discussed with them, unless it is assessed that this information will result in the family being a serious flight risk.
- When a notification is made to CPFS, it will initiate a strategy meeting with other agencies and coordinate the response and subsequent investigation, including possible referrals for support and counselling.
- CPFS gives priority to FGM concerns due to the possible immediate risk of a child undergoing FGM, the child being removed from the state for that purpose, and the physical and emotional consequences of FGM, including possible life-threatening medical complications.

When a girl has undergone female genital mutilation

- If a girl is found to have already had FGM, referral to paediatric gynaecological services or uro-gynaecology for any ongoing medical treatment/management should be arranged.
- If there are acute injuries or signs of recent FGM, the child should be seen at PMH Emergency Department for children of up to 16 years of age, or the local Emergency Department with a request for referral to KEMH Sexual Assault Referral Centre (1800 199 888) if over 13 years of age.

- Contact should be made and a notification submitted to the local CPFS District Office or to Crisis Care (9223 1111 – 24-hour service). If the child’s safety and wellbeing is at imminent risk, a referral to the WA Police Child Abuse Squad (9428 1500) should also be considered.
- Where concerns of ongoing parental protectiveness of a child and/or their siblings are present, CPFS will undertake an assessment in collaboration with WA Police. This assessment gives priority to responding to the potential risk of FGM for female siblings.
- When undertaking an assessment, the Police/CPFS investigation will consider the role of the person who has performed the FGM and that of the parents/extended family who may have facilitated the practice.

A health staff member who suspects that a person has been subjected to or will be subjected to FGM should contact [Legal and Legislative Services](#) (Intranet access required) for advice.

Relevant Resources and Services

Australian Federal Police

Urgent Assistance 000

Urgent assistance at a major airport Phone: 131 237 (131 AFP)

www.afp.gov.au/

Anti-Slavery Australia

Phone: (02) 9514 9662
antislavery@uts.edu.au

Department of Foreign Affairs and Trade

Consular emergency hotline:

Within Australia Phone: 1300 555 135

Outside Australia Phone: +61 2 6261 3305

Switchboard/Main contact no. Phone: (02) 6261 1111

International Social Services

Phone: 1300 657 843

www.iss.org.au/

National Children’s and Youth Law Centre

Phone: (02) 9385 9588

admin@ncylc.org.au

[Lawstuff WA](#)

Kids Helpline

Phone: 1800 55 1800

www.kidshelp.com.au/

Lifeline

Lifeline’s 24-hour crisis phone line: 13 11 14

Access online one-on-one Crisis Support Chat

Local Lifeline Centre Offices

www.lifeline.org.au/About-Lifeline/Lifeline-Locations/Lifeline-Locations

3.3 Children with disabilities and their families

The existing small body of relevant research indicates that children and young people with disability experience abuse and neglect at rates considerably higher than their peers without disability. Some research (Sullivan and Knutson, 2000) indicates that children with disabilities are three times more likely to experience maltreatment than their non-disabled peers. In particular, children with communication impairments, behaviour difficulties, intellectual disability and sensory disability experience higher rates of abuse. Abuse of disabled children ranges from chronic low level harassment and lack of appropriate care to extreme situations of criminal assault.

Unlike their peers who are usually dependent primarily on parents for physical care, nurturance and protection, some children with disabilities may be dependent on a large number of adults to meet their care needs, thus increasing the number and range of potential abusers. Further points for consideration include:

- The particular disability can contribute both to the difficulty in identifying that a child is being abused and in ensuring that the child is protected from further abuse.
- Indicators of risk of significant harm may be overshadowed by the child's medical condition or disability.
- Particular behaviours may be interpreted as related to the child's impairment and not as indicators of forms of abuse or neglect.
- Some children may have difficulty in physically getting away from abuse experiences and may be unable to communicate with others when abuse is occurring.
- Children with intellectual disabilities can be particularly vulnerable to emotional, physical and/or sexual abuse from non-disabled peers.

Identifying and acting on child abuse and neglect concerns

The following approaches that may contribute to better outcomes for children with disabilities and their families should be promoted by WA Health services and adopted by health staff, according to their role, where possible:

- Improve assessment accuracy by collaborating with a disability professional. Some signs of abuse and neglect can be confused with symptoms of a child's disability.
- Determine issues that may affect the assessment such as communication limitations or behavioural challenges. Adapt the structure or location of the interview and equip yourself with appropriate tools and strategies to address the issues.
- Assess interactions between the parent and child as well as the parent's attitude toward the child for possible signs of maltreatment.

- Offer multiple and varied opportunities for a child with disabilities to self-report abuse or neglect.
- Increase parent knowledge of child development and issues specific to the child's disability. Connect the family to appropriate treatment services and a disability professional who can support the family in providing proper care and adapting parenting skills to the child's unique needs.
- Offer a home visiting program in order to assess their strengths and needs, improve positive parenting strategies, and connect them to needed support.
- If parental care is of concern, work with the family to address attitudes toward physical care and punishment and identify alternative behavioural management strategies.
- Organise parent support groups where parents can share their experiences in a supportive group setting. Parents can trade information on resources, solve issues related to their child's disability, and create informal support networks.

See:

www.kalparrin.org.au for the service offered within Princess Margaret Hospital.

Resources:

[Children with Disability Australia](#)

[Disability Health Network](#)

[Enabling and Protection](#)

[Protecting children and young people with disability](#)

[The Risk and Prevention of Maltreatment of Children With Disabilities](#)

Relevant Services:

[PIP \(People First Program\)](#)

[Secca: Disability, relationships, sexuality](#)

[Identity WA](#)

[Disability Services Commission](#)

[Therapy Focus](#)

Case example: Special risk group – Children with disabilities

Martin is 7 years old and he attends his local state primary school. He has a range of developmental delays including significant communication difficulties. He does not meet the criteria for access to Disability Services Commission funding but he has access to some aide time through his school. Martin and his family also access services from a speech pathologist at their local child development centre.

As the speech pathologist working with Martin and his mother Deborah, you have become concerned about some of the things that are happening to him at school and which he has lately been trying to talk to you and his mother about. It seems that Martin is subjected to almost daily bullying from a group of Year 6 children in mainstream schooling. The bullying has apparently been mainly verbal but last week his mother rang you in distress saying that Martin had come home with his clothes muddied and torn and with a large gash on his left knee. She tells you that Martin has been unable to tell her the details of what happened but had told her “they are going to get me again”. For the two mornings since it has been a real struggle to get him ready for the school bus pick-up. This event also appears to have negatively impacted on the recent gains he had been making in his speech development. At his next appointment Martin repeats this message to you.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations for Martin and his family?

- Check with Deborah what response, if any, she has received from any concerns she has raised with the school.
- Inform Deborah that the school is mandated to have an anti-bullying policy and procedure that is implemented.
- Seek Deborah's permission to speak with the school nurse re any concerns they may also have for Martin's safety in the school setting.
- Document all conversations, including referencing any suspected regression in his communication skills stemming from this incident.
- Consult with the Child Development Service (CDS) social worker about further intervention or support that you or the social worker can offer to Martin and his family.

- Within this discussion, consider the possibility of suggesting and/or convening a case discussion with all involved services, including the CDS social worker and/or psychologist, to develop a collaborative course of action.
- Continue to provide services to Martin, paying particular attention to the impact of the bullying/trauma on his communication development and on helping him use his available communication skills to build up his 'survival strategies' that can assist him to advocate on his own behalf within the school setting, with assistance from the school aide as indicated.

See Step 4: Ongoing case management.

Rescinded 14 March 2022.
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

3.4 Pre-borns, infants and their families

Australian children under 12 months are almost twice as likely as children in general to be the subject of a substantiation of child abuse or neglect (AIHW 2013). Within Western Australia, children from 0–4 years comprise just over 50 per cent of all children taken into care, with two-fifths of this number being under the age of 1 year. Some of these infants will have been taken into care immediately after birth.

While infancy represents only a small part of the child's pre-adult development, it is disproportionately significant in ensuring optimal health and development, including brain development, across the entire lifespan. Because of the critical nature of this developmental phase, experiences of sub-standard care or abuse can have significant long-term impacts upon the child's physical and emotional growth and development. Associated with the parental and child risk factors mentioned in Section 2.1 – Step 1 Identify concerns, the following specific risks are significant:

- The commencement or escalation of domestic violence is statistically most likely to occur around pregnancy and/or the birth of a first child.
- Use of hazardous drugs or alcohol during pregnancy can have severe, and sometimes lifelong, impact on the developing fetus.
- Mental health problems, including postnatal depression can compromise a woman's ability to care for her child.
- Parental histories and/or memories of a parent's own abuse or neglect as a child can resurface and interfere with current capacity to parent adequately.

Any of the above factors can contribute to poor attachment between the infant and the primary attachment figure, the building block for healthy child and adult psychological development. If the infant has specific health needs, these can also compound the above risk factors.

Identifying and acting on child abuse and neglect concerns

The [Bilateral Schedule: Interagency Collaborative Processes When an Unborn or Newborn Baby is identified as at Risk of Abuse and/or Neglect](#) covers the purpose, legislative basis, roles and responsibilities and practice principles that must be adhered to by WA Health and CPFS staff when child protection concerns are identified.

Pre-birth

- Early supportive intervention, particularly during the antenatal period, provides an opportunity to identify special needs and to assist pregnant women to plan for the care of their baby.

- In some cases, this may include making a notification to CPFS aimed at reducing the likelihood of the baby suffering the effects of harm and/or of being placed in out-of-home care.
- Maintain a good knowledge base of relevant resources and local referral options for pregnant women whose children may be at risk. WA Health provides a range of specialist services for teenage mothers, mothers with alcohol and/or drug issues or with mental health issues.
- [Screening for Family and Domestic Violence](#) is recommended for all pregnant women.

See:

[Pre-Birth Schedule](#) for further information.

Post-Birth

- Some predisposing risk factors measured soon after birth continue to be significant predictors of child maltreatment reports through the early years of a child's life. In general, at-risk families with low levels of social support have a higher risk of a maltreatment report.
- Administration of the Edinburgh Postnatal Depression Scale and screening for domestic violence at critical times postnatally, and at any other time when there are concerns, can highlight areas of risk and the need to remain engaged or refer the mother to relevant services.
- Early indicators of possible disturbed attachment in infants such as:
 - avoidance of eye contact with significant carers
 - enduring startle response/hyper-alertness
 - general lack of reaction to others
 should be raised and explored with parents. Appropriate continuing engagement with the family and/or referral to relevant services should be discussed.

Resources

[Responding to Family and Domestic Violence \(Guidelines and Reference Manual\)](#)

[Pre-birth Schedule](#)

[Best Beginnings](#)

[Safe Infant Sleeping](#)

[Fear of Childbirth](#)

[Keeping your baby safe](#)

[Neonatal abstinence syndrome](#)

[Safety Plan in the Event of Alcohol or Drug Use](#)

[Women and Newborn Drug and Alcohol Service – Information Book](#)

[Circle of Security - Roadmap](#)

[Signs of Safety – Pre-Birth Meetings](#)

[Signs of Safety pre-Birth Meetings – Tips for parents](#)

Relevant Services:

[Adolescent antenatal clinic – KEMH](#)

[Childbirth and mental illness ante-natal clinic – KEMH](#)

[Mother and Baby Unit – KEMH](#)

[Perinatal Emotional Wellbeing – Services](#)

[Psychological Medicine Consultation and Liaison Service](#)

[Women and Newborn Drug and Alcohol Service \(WARDAS\)](#)

[Best Beginnings – Intensive home visiting service](#)

[Babbingur Mia – Child Health Initiative](#)

[Child Development Services](#)

Rescinded 14 March 2022.
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

Case example: Special risk group – Pre-borns and infants

A young mother, Nicola, 19-years-old, and her very young baby, Noreen, 4-weeks-old, have just had their first home visit with the Best Beginnings nurse. They were referred into the Best Beginnings program by CPFS following concerns that had been raised during Nicola's pregnancy, specifically her history of acknowledged alcohol use and the documented history of domestic violence by the baby's father against Nicola. They split up when Nicola was 7 months pregnant. The family had been the subject of a Pre-Birth Safety and Wellbeing Assessment process which had concluded that the baby could go home with her mother with a Safety Plan in place. Noreen was a full-term baby, with no drug withdrawal or fetal alcohol syndrome disorder (FASD) symptoms and breastfeeding was well established prior to leaving hospital.

On this first visit, the Best Beginnings nurse notes a number of concerning issues:

- Nicola acknowledges that she has had two episodes of binge drinking since her return from hospital. She stresses that she has followed the recommendation regarding expressing breast milk before alcohol consumption in order to keep her baby healthy.
- The partner, Trevor, comes out of the bedroom midway through your visit and tells you that they are back living together.
- You are aware that the safety plan developed by CPFS with Nicola states that Trevor is not to reside in the house with Nicola and Noreen.
- You notice he appears totally disinterested in both Nicola and Noreen and chain smokes throughout your visit.
- You also notice that Nicola appears edgy around him and defers to his shouted instruction to 'put that bloody baby down'.

What steps should you take to ensure you manage any risk issues and meet any statutory and other child protection obligations in relation to this baby and her family?

- You endeavour to talk to Trevor regarding the requirement that he not live in the same house with Nicola and Noreen and the possible consequences for them all if he does not stick to the agreement.
- You also try to let him know that you are obliged to inform CPFS of this deviation from the Safety Plan and of your role to ensure the safety and wellbeing of baby and mother.

Trevor storms out midway through this conversation; yelling that both Nicola and the nurse 'can go to hell'.

You then:

- Ascertain Nicola's current fear level regarding Trevor.
- Speak with her regarding both her willingness and her ability to ensure that Trevor does not come back into the house.
- Refer to the CPFS Safety Plan and any safety plan she has for herself and her baby.

Nicola says she is afraid of Trevor but even more afraid that CPFS will remove her baby because she is too afraid of Trevor to make him stay away.

- Call the CPFS officer in Nicola's presence and suggest a Signs of Safety (SOS) meeting as soon as possible to discuss these issues and a plan that involved agencies and individuals can commit to as a way of ensuring that mother and baby are not threatened by the father.
- Discuss with Nicola her strategies for ceasing binge drinking and our joint duty of care to ensure that the environment for her baby is a physically and emotionally safe one.
- Leave her with phone numbers of the local police station, [Family and Domestic Violence response team](#), the [local women's refuge](#) and the local alcohol and drug service (9442 5000).
- Organise another home visit in 2 days time, the day before the arranged SOS meeting.

Document all points in the file notes. Discuss with your line manager re ongoing case management and the management of risk.

See: Step 4 Ongoing case management

3.5 Children in the care of the Chief Executive Officer of the Department for Child Protection and Family Support (formerly known as 'wards of the state')

There were 4237 children in the care of the Chief Executive Officer (CEO) of CPFS on 30 June 2014. Many of these children were also members of other high-risk groups discussed in this Section: 51% were Aboriginal, an increase of 9% in one year, and nearly 6% were from CALD backgrounds. Just over a quarter (27%) of all children in care on 30 June 2014 were under 5 years of age and 63% of children had been in care for over 2 years, with most of these being in care for more than 5 years. Children were more than twice as likely to be in relative foster care (49% of all care arrangements) than departmental foster care (20%). The trend nationwide is for children to be admitted into care at a younger age and to remain there longer (AIHW 2013).

The reasons why steps are taken to place children with alternate caregivers are almost always due to a determination that such children are unable to live safely with their parents. This will usually be associated with substantiation by CPFS of parental child abuse (physical, emotional or sexual) and/or neglect. Occasionally it may be due to a determination that the parents are deemed to be unwilling or incapable of protecting a child from the risk of (further) abuse or neglect. Most children taken into care tend to have long histories of serious child protection concerns and extensive contact with support services prior to being taken into care and are therefore likely to have histories of multiple and cumulative trauma experiences and a range of resultant complex needs.

For children in the care of the CEO, WA Health staff have a responsibility to provide any indicated health services to the child as well as assisting CPFS with its overall case management by providing it with relevant health information on the child. The particular section of the CCSA under which the child has been taken into the care of the CEO of CPFS determines the level of decision-making regarding treatment and the exchange of confidential information that the CEO of CPFS and/or others, including the child's parents, is responsible for. Refer to the table below for specific information.

Confidential client information may be released to the identified appropriate person/position within CPFS when requested verbally in emergency situations. However, health workers should ensure they confirm the officer is an authorised CPFS officer by contacting the CPFS District Office. As soon as practicable they should sight the identity card of the person making the request to verify that they are an authorised CPFS officer, and should also put in writing, send and store any information they have already provided verbally.

CPFS Decision-making responsibility, according to that part of s30 CCSA the child is subject to

<p>Maximum Departmental responsibility</p>	<p>s.30(b) Child is the subject of a Protection Order ('Time Limited'¹ or 'Until 18'²)³</p>	<p style="text-align: center;">CEO has FULL parental responsibility/ authority</p> <ul style="list-style-type: none"> • The CEO has 'parental responsibility' in respect of the child to the exclusion of any other person (either for the duration of the Order, or until the child reaches 18, as relevant). This includes being able to provide consent in relation to the child. • 'Parental responsibility' in relation to a child, means all the duties, powers, responsibilities and authority which, by law, parents have in relation to children.⁴
	<p>s.30(a) Child is in Provisional Protection and Care</p>	<p style="text-align: center;">CEO's responsibility/ authority may be FULL or PARTIAL, e.g. subject to an Order</p> <ul style="list-style-type: none"> • Subject to any interim order in respect of the child, the CEO has responsibility for the day-to-day care, welfare and development of the child to the exclusion of any other person. • This includes responsibility for making decisions about medical and dental treatment or procedures.⁶ • The CEO can provide written consent where a parent would normally provide it.
	<p>s.30(c) Child is the subject of a negotiated placement agreement</p>	<p style="text-align: center;">CEO's responsibility/ authority is PARTIAL, e.g. subject to terms of a Negotiated Placement Agreement</p> <ul style="list-style-type: none"> • The extent of the CEO's responsibility or authority will depend on the terms of the agreement, but the CEO does not have full parental responsibility for the child. • A 'negotiated placement agreement' is made where the parents are unable to care for the child. The parents, acting with the CEO, enter an agreement under which the CEO is required to make a 'placement arrangement' for the child.⁸ Under a 'placement arrangement', the child is placed with a person approved by the CEO, or a provider of placement services.⁹ • The CEO cannot make a negotiated placement agreement in respect of a child if there are reasonable grounds to believe the child is in need of protection.¹⁰ If the negotiated placement agreement authorises it, the CEO may give written consent in cases where the consent of a parent is customarily sought.¹¹
<p>Minimum Departmental responsibility</p>	<p>s.30(d) Child is provided with placement services under section 32(1)(a)</p>	<p style="text-align: center;">Parental responsibility for the child remains with parents or other approved adult</p> <ul style="list-style-type: none"> • The CEO does not have parental responsibility for the child. • The CEO has no specific powers of consent. • The CEO can provide or arrange for the provision of social services to the child and or its parent or relative.¹²

¹ Section 54

² Section 57

³ Note that the CEO does not have parental responsibility in relation to Protection Orders (Special Guardianship)(s.60); or in relation to Protection Orders (Supervision)(s.47)

⁴ Section 3 definitions

⁵ Section 29(2)

⁶ Section 29(3A)

⁷ Section 127

⁸ Section 75(1)

⁹ Section 79(2)

¹⁰ Section 75(5)

¹¹ Section 127(2)(c)

¹² Section 32(1)(a)

Also note that a child who has been assessed as a mature minor in the context of a proposed treatment or decision can provide consent, on their own behalf, to matters including treatment and release of confidential information. Just as when assessing mature minor competency in children not in the care of the CEO, the child's maturity should be assessed against the complexities and issues relevant to the decision that needs to be made.

See:

[Working with Youth: A legal resource for community based health workers](#)

Identifying and acting on child abuse and neglect concerns amongst children in care

Almost all children entering care will have experienced some form, and often multiple forms, of prior abuse or neglect. Prolonged exposure to significant parental abuse and chronic neglect also increases vulnerability for further abuse experiences. Any health service provision should ideally take into account the current and possible future impact of such exposure on a child's health, safety and wellbeing.

A health service provider will not always know whether or not a child receiving a health service is under the care of the CEO of CPFS. Apart from referrals for a Health Assessment as part of Health Care Planning, there is no formal process between CPFS and WA Health services that captures this information.

The Health Care Planning for Children pathway is a community based model for assessing the health needs of a child in the care of the CEO of CPFS in order to develop and manage the health dimension of a child's care plan. All health assessments will be requested and informed by referral from a child's CPFS Case Worker. The joint processes and procedures between CPFS and WA Health in the provision of health assessments and health care planning where WA Health or their funded services are the service providers is covered in the Schedule between CPFS and WA Health: Health Care Planning for Children in Care.

The following approaches that may contribute to better outcomes for children who are under the care of the CEO of CPFS should be promoted by health services and adopted by health staff, including those providing a Health Care Planning Health Assessment for children entering care, wherever possible:

- Ensure that any intake questions concerning carer/guardian status are asked and responses, including the contact details for the local District Office of the CPFS with responsibility for the child, are recorded.
- If health service provision is ongoing, ensure that these details are checked for current accuracy every 12 months.
- Ensure that any disclosures from the child regarding past or current abuse are handled appropriately i.e. believe the child, ensure their immediate safety, inform the CEO of CPFS – via the nominated caseworker – as soon as practicable, follow up any verbal discussion with CPFS with a written summary, make and maintain accurate case file notes, follow up with CPFS if any necessary feedback is not received (see Section 2.4.1 – Step 4 – Ongoing case management – Dispute Resolution between WA Health and CPFS for further information).
- In cases where the health staff member forms a belief about child sexual abuse, they should follow the normal procedure for submitting a mandatory report of child sexual abuse, as it cannot be assumed that the information will already be known to CPFS.

See:

- [Schedule between CPFS and WA Health: Health Care Planning for Children in Care \(January 2015\)](#)

Resources:

[Health Care planning for children in care – CPFS Fact Sheet](#)

[Permanency Planning – CPFS Information Sheet](#)

[Rapid Response: Prioritising services for children and young people in care](#)

Relevant Services:

[Advocate for children in care](#)

[Create Foundation](#)

[Family Inclusion Network of WA](#)

Case example: Special risk group – Children in the care of the CEO of CPFS

Stephanie (4) and Eric (7) have been living in Aboriginal relative foster care with the family of their mother's cousin since they were removed from their own parents 8 months ago. They are the subjects of Protection Orders under s30(b) of the CCSA, currently time-limited to 2 years. Both children have a range of challenging behaviours and Eric is currently receiving a service from Child and Adolescent Mental Health Service (CAMHS) for his significant mental health problems, which are related to the maltreatment he experienced while living with his parents. The information provided to CAMHS by Catherine the foster mother and CPFS mentions parental neglect and sexual abuse by the father, who is currently serving a prison term for sexual abuse against another young relative. The children have supervised contact with the mother once a fortnight. Catherine rings the CAMHS psychologist on the morning she is due to bring Eric in for his fourth session. She relates that early that morning she had heard her youngest foster child, 3-year-old Marie, cry out and, on going to see what was the matter, she bumped into Stephanie running out of Marie's room. On entering the room, she saw Eric holding Marie down, spreadeagled on the bed and with only her pyjama top on. Before Catherine could say anything, Eric yelled out "It wasn't me, I didn't do it", before rushing out of the room. She tells the CAMHS worker that she feels it is important that he knows this before seeing Eric again today.

What steps should you take to ensure that you manage any risk issues and meet any statutory or other child protection obligations in relation to all of these children?

- Document the conversation in the file notes.
- Check if Catherine has called the caseworker(s) for all three children. Advise her to do so if she has not done so.
- Consult with your local CAMHS Child Protection Liaison person.

Depending on the result of this conversation:

- Discuss with your line manager/clinical supervisor how to proceed with this issue.
- Contact the children's CPFS caseworker(s) regarding child protection matters for Eric and Stephanie, and for Marie also.
- Check with the CPFS worker that they will be liaising with Eric's school and Stephanie's kindergarten and day care re possible risk issues for both siblings, Marie and other children.
- Document all conversations and any decisions; including any decision to make a written report to the CPFS local District Office.

Continue to provide a mental health therapy service to Eric.

Proceed to Step 4: Ongoing case management

Rescinded 14 March 2022.
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy



4. Legal Information

4.1 Legislation, policies and principles

4.2 Confidentiality and disclosure of confidential patient information

4.3 Consent for treatment of a minor

4.4 Additional matters

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Superseded by MHO 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

4. Legal information

Various statutes, as well as common law, can be relevant to legal issues affecting children. Where legal issues involve child protection, care and wellbeing in Western Australia, the [Children and Community Services Act 2004](#) (CCSA) generally applies.

Health staff who encounter child protection matters should be aware of the key provisions of the CCSA that may be relevant to their work, set out below, along with the principles of confidentiality and consent as they apply to children.

Caution/ Disclaimer

The information in this section is intended as a guide only. It is not intended to be comprehensive and **must not** be relied upon in place of legal advice (or other professional advice) addressing the relevant circumstances.

If you have a legal problem you should seek legal advice tailored to your situation from the Legal and Legislative Directorate at the Department of Health (or from the State Solicitor's Office in the case of teaching hospitals only) before acting or relying on any of the content of this section. A [request form](#) (Request for Legal Advice) for accessing assistance from Legal and Legislative Services can be downloaded from the [Legal and Legislative Services](#) intranet site (intranet access required).

4.1 Legislation, policies and principles

Legal information should be read in conjunction with the following Operational Circulars:

- [Patient Confidentiality and Divulging Patient Information to Third Parties](#)
- [Consent to Treatment Policy for the Western Australian Health System](#)
- [Guideline for Responding to Family and Domestic Violence 2014](#)
- [Memorandum of Understanding – Information Sharing between agencies with responsibility for preventing and responding to family and domestic violence in Western Australia](#)

- [Operational guidelines for interagency management of children under 14 who are diagnosed with a sexually transmitted infection \(STI\), and children aged 14-16 diagnosed with an STI where there is suspicion of sexual abuse](#)
- [Bilateral Schedule between CPFS and WA Health: Interagency collaborative processes when an unborn or newborn baby is identified as at risk of abuse and/or neglect](#)
- [Joint Guidelines on the mutual exchange of relevant information between WA Health and CPFS](#)
- [Practice Code for the Use of Personal Health Information Provided by the Department of Health](#)
- Delegation for Section 28C of the CCSA: Exchange of Information with a prescribed authority when that information is related to the wellbeing of a child or group of children – under development

4.1.1 Specific legislation for the protection of children

The *Children and Community Services Act 2004* (CCSA) is the primary Act concerning child protection, care and wellbeing in Western Australia.

Note that references below to the CEO mean (unless otherwise stated or clear from the context) the Chief Executive Officer, i.e. the Director General, of the Department for Child Protection and Family Support (CPFS).

Some of the key CCSA provisions of interest to WA Health practitioners may include the following sections:

- **Section 8** sets out matters to be taken into account when determining a **child's best interests**.
- **Section 22** sets out circumstances in which the CEO of CPFS can request cooperation and assistance from other services in protection of children matters.
- **Section 23** defines 'relevant information', and sets out how relevant information may be disclosed to or requested by the CEO of CPFS. It includes, at s.23(5), **protection from liability** for those who make disclosures of relevant information in good faith in accordance with s.23(2) and s.23(3).
- **Section 25** provides that the CEO may designate in writing, officers to be **authorised officers** either generally, or in relation to a specified provision in the CCSA. Authorised officers must carry and display identity cards when exercising their designated powers under s26 of the CCSA.

- **Section 28** sets out the circumstances in which a child is considered to be **in need of protection**.
- **Section 28B** sets out **circumstances in which information may be requested by or disclosed to prescribed authorities or authorised entities** (see Section 5 for a list of prescribed authorities). Where relevant information is disclosed in good faith under this provision, no criminal or civil liability will arise and it will not be regarded as a breach of confidentiality.
- **Section 30** defines when a child is **'in the CEO's care'**. The CEO's role and responsibility towards children in his/her care varies, depending on the basis of the CEO's authority (see subsections (a), (b), (c) and (d)).
- **Section 33A** sets out how CPFS may respond when made aware of concerns about the wellbeing of a child **before the child is born**.
- **Section 33B** sets out what CPFS must do when it has determined that action is needed prior to a child's birth to safeguard or promote its wellbeing once born.
- **Section 40** enables the 'officer in charge' of a hospital to **hold a child under the age of 6 years** in hospital for no more than 2 working days. If the child has been brought to a hospital for observation, assessment, or treatment or has been admitted, and the officer in charge believes on reasonable grounds that the child is in need of protection, the officer can keep the child in hospital for the purpose of observation, assessment, treatment or otherwise to safeguard or promote the child's wellbeing.
- **Section 104A** prohibits the **piercing of intimate body parts** of people less than 18 years of age and sets out the consent requirements in relation to piercing of other body parts.
- **Part 4, Division 9A sections 124A to 124H** set out the **mandatory reporting obligations** that apply to doctors, nurses, midwives, teachers, police and boarding supervisors if they form a belief, on reasonable grounds in the course of their work, that a child has been or is the subject of sexual abuse.
- **Section 127** sets out when the **CEO may give consent** in relation to a child.
- **Section 129** sets out the **protection provided to persons who, acting in good faith, provide information** (including any aspect of the child's wellbeing, and suspected child sexual abuse) to the CEO or another officer of CPFS. The information provider is not to incur civil or criminal liability in relation to the disclosure and is not taken to have breached any duty of confidentiality or professional standard or code of conduct.
- **Section 240** sets out **restrictions on the disclosure of the identity** of a 'notifier', i.e. a person who has in good faith given information about a child to the CEO or an officer of CPFS. This section does not include 'reporters' under s.124A.

Key principles of the CCSA in the health care context

In the health care context, key principles and provisions from the CCSA include:

- a) the child's best interests are paramount
- b) defining when a child is in need of protection
- c) information about children that is otherwise confidential may (or in some cases, must) be disclosed, e.g. to officers in other departments, in circumstances set out in the CCSA. Such exchanges of information are protected from criminal, civil and professional liability.
- d) the CEO's responsibilities towards children in his/her care vary depending on the basis of his/her authority
- e) the CEO can delegate his/her powers and duties to particular officers
- f) the CEO can make inquiries regarding unborn children in certain circumstances, and can take certain actions to safeguard their wellbeing once born.

These provisions are detailed further below, as well as the 'mature minor' principle.

a) **Best interests of the child are paramount – Section 8**

In performing a function or exercising a power under the CCSA, a person, the Court or the State Administrative Tribunal must regard the child's best interests as the paramount consideration (s.7 CCSA).

In determining (for the purposes of the CCSA) the best interests of the child, the following factors must be taken into account (s.8):

- (a) the need to protect the child from harm
- (b) the capacity of the child's parents to protect the child from harm
- (c) the capacity of the child's parents, or of any other person, to provide for the child's needs
- (d) the nature of the child's relationship with the child's parents, siblings and other relatives and with any other people who are significant in the child's life
- (e) the attitude to the child, and to parental responsibility, demonstrated by the child's parents
- (f) any wishes or views expressed by the child, having regard to the child's age and level of understanding in determining the weight to be given to those wishes or views

- (g) the importance of continuity and stability in the child's living arrangements and the likely effect on the child of disruption of those living arrangements, including separation from
 - (i) the child's parents or
 - (ii) a sibling or other relative of the child or
 - (iii) a carer or any other person (including a child) with whom the child is, or has recently been, living or
 - (iv) any other person who is significant in the child's life
- (h) the need for the child to maintain contact with the child's parents, siblings and other relatives and with any other people who are significant in the child's life
- (i) the child's age, maturity, sex, sexuality, background and language
- (j) the child's cultural, ethnic or religious identity (including any need to maintain a connection with the lifestyle, culture and traditions of Aboriginal people or Torres Strait Islanders)
- (k) the child's physical, emotional, intellectual, spiritual, developmental and educational needs
- (l) any other relevant characteristics of the child
- (m) the likely effect on the child of any change in the child's circumstances.

The above list is not intended to be exhaustive; other matters may be taken into account as relevant

b) Principle of Child participation – section 10

Where decisions made under the CCSA are likely to have significant impact on a child's life, that child is to be given information relevant to that decision as well as opportunities to express their views and wishes, which must be taken into account as the decision is made. Communications must be tailored to the child's age and level of understanding.

c) Child in need of protection – Section 28

A child will be 'in need of protection' when

- (a) the child has been abandoned by his or her parents and, after reasonable inquiries
 - (i) the parents cannot be found, and
 - (ii) no suitable adult relative or other suitable adult can be found who is willing and able to care for the child
- or
- (b) the child's parents are dead or incapacitated and, after reasonable inquiries, no suitable adult relative or other suitable adult can be found who is willing and able to care for the child

or

(c) the child has suffered, or is likely to suffer, harm as a result of any one or more of

- (i) physical abuse
- (ii) sexual abuse
- (iii) emotional abuse
- (iv) psychological abuse
- (v) neglect

and the child's parents have not protected, or are unlikely or unable to protect, the child from harm or further harm of that kind

or

(d) the child has suffered, or is likely to suffer, harm as a result of

- (i) the child's parents being unable to provide, or arrange the provision of, adequate care for the child or
- (ii) the child's parents being unable to provide, or arrange the provision of, effective medical, therapeutic or other remedial treatment for the child.

For section 28, 'harm', in relation to a child, means any detrimental effect of a significant nature on the child's wellbeing. 'Neglect' includes failure by a child's parents to provide, arrange or allow the provision of (a) adequate care for the child, or (b) effective medical, therapeutic or remedial treatment for the child.

d) Relevant information may be disclosed to or requested by the CEO, and protection from liability for disclosures

The CEO of CPFS determines whether information is, or is likely to be, 'relevant information', i.e. relevant to the wellbeing of a child or a class or group of children or the performance of a function under the CCSA (s.23(1)).

Specific CEO functions under the CCSA are set out at section 21(1) and include:

- (a) to consider and initiate, or assist in, the provision of social services to children, other individuals, families and communities
- (b) to take, or cause to be taken, any action, not inconsistent with this Act, in respect of a child or a class or group of children that the CEO considers reasonably necessary for the purpose of safeguarding or promoting the wellbeing of the child or children concerned

- (ca) to control and manage the property of children who are the subject of a protection order (time limited) or protection order (until 18)
- (c) to provide, and where appropriate, manage facilities (including land, buildings and other property) for purposes consistent with the objects of this Act
- (d) to establish procedures for dealing with complaints about social services provided under this Act or otherwise relating to the administration of this Act
- (e) to promote, encourage, conduct and publish research on matters relating to the objects of this Act
- (f) to collect and publish, or assist in the collection and publication of, information and statistics on matters relating to the objects of this Act.

Under section 23 CCSA, the CEO or an authorised officer may **disclose** relevant information to a public authority, or they may **request** a public authority (and others) to disclose relevant information to them.

Under s.24A, CEOs of prescribed authorities can request relevant information from, or disclose relevant information to, other prescribed authorities. What is relevant information is determined by the requesting or disclosing CEO and in this section refers to 'information that is, or is likely to be, relevant to the wellbeing of a child or a class or group of children'.

Disclosures made under s.23 or s.24A will not result in liability for a breach of confidentiality, and the disclosure is not to be regarded as a breach of professional standards or codes.

In addition to specific protections set out in s.23(5) and s.24A(5) for sharing relevant information, section 129 also **protects from liability** a person who, acting in good faith:

- (a) gives information to the CEO or another officer about any aspect of the wellbeing of a child or
- (ba) gives information of the kind described in section 33A to the CEO or another officer, or
- (b) gives information to the CEO or another officer for the purposes of, or in connection with, an investigation referred to in section 32(1)(d) or 33B(c) or
- (c) gives information to the CEO or another officer for the purposes of, or in connection with, a protection application or any other application to the Court under this Part or
- (d) gives information to the CEO under section 40(6) or
- (e) makes a report under section 124B(1) or
- (f) notifies the CEO of an allegation in accordance with a requirement to do so under regulations made under the Child Care Services Act 2007.

It must be remembered that requests for relevant information are just that – they do **not** oblige a person to provide the requested confidential information and there is no direct penalty for declining a request. It may be appropriate in some circumstances to decline a CCSA-compliant request for information.

This is to be contrasted with mandatory disclosures such as those specified at section 124B (reporting sexual abuse) and section 40(4) (keeping a child in hospital). In these cases there is a duty to disclose the specified information as required by the CCSA. Significant penalties apply for failure to comply.

e) The CEO's responsibilities towards children in his care vary depending on the basis of his/her authority

A child is 'in the care of the CEO' of CPFS when he or she: is in provisional care and protection (s.30(a)); is the subject of a protection order (time-limited or until 18(s.30(b))); is the subject of a negotiated placement agreement (s.30(c)); or is provided with placement services under section 32(1)(a) (s.30(d)).

It is important to know the basis on which the child is in the CEO's care, as this dictates what responsibilities and powers the CEO will have towards that child. The CEO may have full parental rights and responsibilities to the exclusion of any other person (such as under s.30(b) and (c)), or he/she may simply be involved in providing social services to the child or their parent or responsible adult (s.30(d) and 32(1)(a)). In the latter case, the parent(s) or responsible adult retain parental responsibility. See Section 3:5 – Children in the care of the CEO of CPFS for further detailed information.

f) The CEO does not personally perform all the functions or exercise all the powers ascribed to the CEO under the CCSA.

The CEO's powers and functions may be formally delegated to officers, service providers or other persons under section 24. Delegations must set out the relevant powers and functions, be in writing, and be signed by the CEO.

The CEO may also designate officers to be 'authorised officers' either generally for the purposes of the CCSA, or in relation to specific provisions of the CCSA (section 25). Designations must be in writing by the CEO. Authorised officers are required to carry identity cards and display them when exercising powers under the CCSA.

References to the CEO may, depending on the context, mean the CEO, or may mean officers exercising functions or powers on behalf of the CEO consistent with their delegated (or designated) powers.

WA Health staff need to be satisfied that CPFS officers are properly authorised or delegated to perform the relevant function or duty, such as requesting and receiving relevant information.

g) **The CEO when there are concerns about the wellbeing of unborn children**

If, before a child is born, the CEO receives information that raises concerns about that child's wellbeing after its birth, the CEO can cause enquiries to be made that he/she considers reasonably necessary for the purpose of determining whether action should be taken to safeguard or promote the child's wellbeing once it is born (section 33A and 33B).

Section 33A **cannot** be used interchangeably with s.23 requests for information. An unborn child does not have the same legal status as a living child.

See:

Section 3.4 – Pre-borns, infants and their families for further information.

4.1.2 The mature minor principle

In legal matters affecting children, it is important to understand the 'mature minor' principle.

The law in Australia is that a child under the age of 18 years may, if considered a 'mature minor', make decisions about their own health care irrespective of parental opinion on the matter.

Decisions by mature minors can relate to matters such as confidentiality and disclosure, and consent to treatment. Children may be considered competent to make their own decisions in healthcare matters (amongst other things) when they have sufficient maturity and intelligence to fully understand a proposed course of action and its consequences.

There is no set age at which the child is considered to be a mature minor. Whether or not the child is a mature minor must be determined on a case-by-case basis in the context of the proposed healthcare decision. It should not be assumed that because a minor has been assessed as mature in relation to one proposed healthcare decision, they are mature in the context of all healthcare decisions.

In determining whether a child is capable of themselves providing valid consent, regard should be given to factors including (but not limited to):

- maturity and level of functioning of the child, and their age if this is relevant (but note previous comment about age)
- nature of the treatment or procedure about which consent is sought
- the child's ability to fully understand the proposed treatment, including why it is proposed and its short- and long-term risks and consequences
- the child's ability to understand alternatives to treatment, including no treatment
- any relevant background as to why the child seeks to make decisions independent of parents or other responsible adults, including any moral or family issues
- any pressures on the child to make decisions
- potential emotional impact of accepting or rejecting the proposed treatment.

A mature minor's decision may be overridden if it does not reflect their best interests. Note also Section 10: The principle of child participation in decisions impacting on their lives.

4.2 Confidentiality and disclosure of confidential patient information

Health services, health staff and the staff who support them in their work are under a duty to maintain [patient confidentiality](#) in relation to all information that comes to them in the course of providing medical treatment and care to patients of all ages, unless that information is in the public domain or trivial.

The obligation arises in law, ethics and professional standards and codes, and it is usually a fundamental cornerstone to the therapeutic relationship between practitioner and client. The duty protects information created, disclosed or acquired (directly or indirectly) by health staff in their professional capacity and by administrative staff who support the delivery of care.

Patient information that must otherwise be treated as confidential can be disclosed to third parties where one of the following exceptions apply:

with consent:

- a) either implied or express consent to disclosure has been given by the patient, or on behalf of the patient where the patient cannot themselves consent or

regardless of consent:

- b) disclosure is permitted by the law or
- c) disclosure is required by the law or
- d) an overriding public interest justifies the disclosure of necessary information to an appropriate authority or
- e) emergencies.

Note that in all cases WA Health policy is that consent should be sought prior to disclosing a child's confidential information UNLESS doing so would pose a risk to the child or another person. However, it is imperative that WA Health staff understand that if consent is sought but not given in situations where the law either permits or requires disclosure, then the disclosure can or must (as relevant) be made.

Disclosures should be consistent with, and not exceed, the exception that permits or requires them. For example, if details about a child's specific episode of care are requested, it would not be appropriate to release details of all their episodes of care (without first obtaining further authority for doing so). If a patient (or their representative) has consented to the release of certain information about the patient, then disclosure must be confined to the information described in the consent, and it must be made to the person(s) described in the consent.

4.2.1 Disclosure of confidential information with consent

Consent may be either express, or implied.

Express consent may be given by competent adults on their own behalf to the release of confidential information. In the case of children, express consent can be obtained either from the adult who is responsible for the child, or from the child themselves if they have been assessed as a mature minor (see above).

It is accepted that health staff within a particular healthcare facility may generally access a patient's confidential information to the extent this is necessary to provide appropriate medical treatment and care. In these circumstances **implied consent** usually underpins disclosure – there is no requirement to specifically seek or document the consent unless an issue arises. Similarly, administrative staff will need to handle patient information to some extent, and patients will generally be taken to have accepted the administrative procedures of the healthcare facility involved.

If a health staff member wishes to talk over the patient's treatment with a colleague who is not involved with the patient's care but the patient has not expressly consented to their information being shared for this purpose, then the staff member should not give the patient's identifying information to the colleague.

Who may consent to the exchange of confidential client information?

A competent adult can consent to the release of their confidential health information to third parties.

(i) Adults (other than CEO) consenting on behalf of children

In the case of children other than mature minors, as a general rule it is reasonable to assume that either parent who is involved to some extent in the child's life can consent (alone) to the release of confidential information relating to his or her child under 18 years of age, **unless** information is available to suggest different arrangements are in place (e.g. a court order varying parental responsibility or a child in provisional protection and care of CPFS). In that event, further enquiries should be made to identify the appropriate person with authority to give consent on behalf of the child. This may include obtaining a copy of any applicable court order.

(ii) The CEO consenting on behalf of a child

In child protection cases, the CEO of CPFS may or may not have authority to provide consent to release information on the child's behalf.

The fact that a child is in the CEO's care does not in all circumstances mean that he/she can provide consent for release of their health information. The CEO does not have parental responsibility for all children in his/her care and his/her specific authority to provide written consent under s.127 does not apply to all children in his/her care.

See:

Section 3.5 – Children in the care of the CEO of the CPFS for further information.

Regardless of consent and whether or not children are formally in the CEO's care, the CEO is able to request relevant information from prescribed public authorities, and those authorities may disclose relevant information to the CEO, as provided in s.23.

(iii) Mature minors

Minors may consent to the release of confidential information on their own behalf provided they adequately understand and appreciate the reason for, and consequences of the information being released. Consent must be in the context of the decision to be made. Please refer to Section 4.1.2 – Mature minors and [Working with Youth: a legal resource for community based health workers](#) for further information.

Mature minors, including children in the care of the CEO of CPFS (see above) may specifically request that the adult responsible for their care not be informed about any health care sought or provided or may otherwise demand confidentiality in respect of the matters discussed. Limits on confidentiality should generally be explained to the mature minor, e.g. that health staff are required by law to disclose information in certain situations, such as if they are summonsed to give evidence in court, or if there is a real and immediate risk to a person's safety.

4.2.2 Disclosure of confidential information regardless of consent

One or more of the exceptions to confidentiality may apply to permit or require disclosure of a child's confidential health information, regardless of whether consent to disclosure has been obtained or not.

Remember: even when the law allows or compels disclosure, it is WA Policy to seek consent to disclosure unless doing so would pose a risk of harm to the child or another person, but if consent is declined the disclosure may (or must) still be made as set out below. Where a decision not to seek consent is made, circumstances should be documented.

a) Disclosure is permitted by law

Some legislation sets out specific circumstances in which confidential information may be disclosed to particular persons (i) in the absence of consent and (ii) with protection from liability or professional reprimand for breach of confidentiality.

For example, where information is disclosed in accordance with the CCSA, the CCSA provides that:

- a. no civil or criminal liability is incurred in respect of the disclosure and
- b. the disclosure is not to be regarded as a breach of any duty of confidentiality or secrecy imposed by law and
- c. the disclosure is not to be regarded as a breach of professional ethics or standards or any principles of conduct applicable to a person's employment or as unprofessional conduct.

(i) Sharing information with CPFS

Under s.23 CCSA, a child's confidential information may be disclosed to or by authorised officers at CPFS when consent has not been sought and/or given. The CEO can request relevant information, i.e. relevant to the wellbeing of the child or to a group or class of children, or relevant to the performance of a function under the CCSA be disclosed to him.

Not all CPFS officers hold the necessary delegation or authority to request or disclose relevant information. Information must only be exchanged between officers holding the requisite authority.

Information may also be provided to the CEO in response to an inquiry about an unborn child, under s.33A (not to be used interchangeably with s23).

Where persons acting in good faith make disclosures of information in accordance with the CCSA, they will not incur civil or criminal liability, will not be taken to have breached any duty of confidentiality, and are not to be taken to have breached any professional code of conduct or standard (section 129, and specific protections at s.23(5) and 24A(5)).

(ii) Sharing information with 'prescribed (government) authorities' and 'authorised entities' (non-government providers and school bodies)

Prior to 1 January 2016, section 24A dealt with information exchange between public authorities. After this date, s24A covers CPFS obtaining certain reports from Corrective Services (not directly relevant to this policy).

Information exchanges between government providers (other than CPFS), and non-government providers and schools is set out in sections 28A, 28B and 28C. Information must be 'relevant information', as determined by the CEO or delegated officer/ employee (see sections 28A,B and C).

A Health is currently developing a delegation schedule under s.28C that will allow certain WA Health officers to exchange relevant information with prescribed authorities/ authorised entities. In the absence of formal delegation, only CEOs of prescribed authorities have the required power to request or release information under s.28B.

Note that s.23 and s.28B permit rather than compel disclosure, i.e. there is discretion whether or not to disclose. Requests for disclosures may be denied without penalty if appropriate in the circumstances. This should be contrasted with mandatory disclosures, see further below.

b) Disclosure is required by law

The law requires disclosure of confidential information in certain circumstances. In these cases, the patient's consent to disclosure is irrelevant, and no liability or penalty results from the disclosure. Failing to comply attracts serious penalties.

Examples include:

- where a valid summons (also known as a subpoena) requires a person to produce documents or give evidence to the court
- where legislation requires disclosure of particular events when specified persons (e.g. practitioners) become aware of them. For example,
 - s.300 of the *Health Act 1911*, which requires medical practitioners, nurse practitioners and pathologists to give notification to the Department of Health's Executive Director, Public Health of any person with a venereal disease in an infectious stage
 - S.23B of the *Firearms Act 1973* allows health professionals to report suspected firearm injuries (and other matters) to the Commissioner of Police.

Providing confidential information to CPFS is mandatory in certain situations, such as the reporting of sexual abuse required under Part 4, Division 9A. Similarly, if a child is held in hospital under section 40 because the officer in charge of the hospital believes the child needs protection, the officer in charge of the hospital must notify the CEO of CPFS. Where there is a duty to disclose, this overrides the requirement to obtain consent.

c) **Public interest exception justifies disclosure to an appropriate authority**

The 'public interest' exception recognises there may, on occasion, be a need to breach confidentiality because of an overriding public interest favouring disclosure of the information to a third party. In such circumstances the disclosure of the information to a responsible authority without consent may be justified.

The public interest exception should be used with caution. It is likely to justify disclosure only in cases involving a real and identifiable risk of danger to the public (which can include a single person) requiring immediate action. In these cases confidential information may be disclosed to a responsible authority i.e. with a proper interest in receiving the information. Disclosure must not be made to the world at large. Further, the risk to the public or an individual must be a real risk and only the facts necessary to reduce or eliminate the risk concerned should be disclosed.

For example, a health staff member in possession of confidential patient information suggesting that a child may be in immediate and real danger and that urgent action is needed to avert the danger may be justified in disclosing that information to CPFS or the police. This can be done without seeking or after seeking and being refused consent from the child (in the case of a mature minor) or the child's parent (or the adult responsible for their care), as relevant.

Any disclosures of information based on public interest should be made by senior health service staff, and reasons should be documented. Assistance may be sought from Legal and Legislative Services (in the case of non-teaching hospitals) or the State Solicitor's Office (in the case of teaching hospitals) if required.

When health workers are concerned that a child is at risk, circumstances will dictate whether it is appropriate to make disclosures under the CCSA or another exception to the duty of confidentiality.

d) Emergencies

Confidential information may be exchanged in emergencies in the absence of consent. The legal basis underpinning the disclosure will depend on the circumstances of the emergency. The circumstances relevant to disclosure without consent should be documented.

4.2.3 Summary of key principles underpinning the exchange of a child's confidential information

A child's health information is confidential.

Where it has been identified that a child has suffered, or is at risk of suffering abuse or neglect, disclosure of a child's confidential information to a third party is supported by law. In summary:

- disclosures may occur with consent
- regardless of consent the law may either permit or require a disclosure or
- the disclosure may be in the public interest.

In cases involving child protection and wellbeing, the CCSA specifically permits or requires disclosures in certain circumstances. It is necessary to look at the specific provisions of the CCSA to determine compliance requirements. Considerations may include: whether it is mandatory or discretionary to disclose the information; whether the information is relevant information as determined by the CEO; whether the requesting and/or receiving officer has the necessary delegation/ authority; whether the information to be given falls within the scope of the request.

Information relating to child protection and wellbeing must be exchanged as provided under the CCSA, or as permitted or required under another exception to confidentiality, as relevant.

Any disclosures of information based on public interest should be made by senior health service staff, and reasons should be documented. Assistance may be sought from Legal and Legislative Services (in the case of non-teaching hospitals) or the State Solicitor's Office (in the case of teaching hospitals) if required.

When health workers are concerned that a child is at risk, circumstances will dictate whether it is appropriate to make disclosures under the CCSA or another exception to the duty of confidentiality.

d) Emergencies

Confidential information may be exchanged in emergencies in the absence of consent. The legal basis underpinning the disclosure will depend on the circumstances of the emergency. The circumstances relevant to disclosure without consent should be documented.

4.2.3 Summary of key principles underpinning the exchange of a child's confidential information

A child's right to safety overrides an adult or child's right to confidentiality.

Where a child's confidential information needs to be shared with a third party, disclosure is supported by the law as set out in the previous section. In summary:

- disclosures may occur with consent
- regardless of consent the law may either permit or require a disclosure or
- the disclosure may be in the public interest.

In cases involving child protection and wellbeing, the CCSA specifically permits or requires disclosures in certain circumstances. It is necessary to look at the specific provisions of the CCSA to determine compliance requirements. Considerations may include: whether it is mandatory or discretionary to disclose the information; whether the information is relevant information as determined by the CEO; whether the requesting and/or receiving officer has the necessary delegation/ authority; whether the information to be given falls within the scope of the request.

Information relating to child protection and wellbeing must be exchanged as provided under the CCSA, or as permitted or required under another exception to confidentiality, as relevant.

Disclosures may be required in response to legislation other than the CCSA. For example, disclosures are required in response to validly issued summonses, warrants or 'orders to produce', and disclosures to the Executive Director of Public Health are required in the case of venereal diseases.

See:

- [Joint Guidelines for the mutual exchange of relevant client information](#) for further information.

4.3 Consent for treatment of a minor

Duty to obtain consent for treatment

Except in an emergency situation, a health staff member has a legal obligation to obtain the patient's voluntary and informed consent before any physical examination, test, procedure or other treatment is provided.

What is informed consent?

Two key legal principles are relevant to the concept of informed consent.

Firstly, consent must be obtained in order to avoid a legal claim for trespass to the person (in assault, battery or false imprisonment). This requires health staff to explain in broad terms the proposed treatment or procedure to the patient, or to the adult who is responsible for making healthcare decisions about the patient.

Secondly, health staff must warn patients (or the responsible adult, as relevant) of material risks in proposed treatments or procedures, so that they can make informed decisions about associated risks and whether they wish to proceed. Providing sufficient information to the patient (or responsible adult) will negate a claim of negligence for failure to warn.

Thus, obtaining informed consent requires health staff to provide a broad explanation of the proposed procedure or treatment, as well as detail of material risks. Discussion with the patient or responsible adult should be in terms that the person can understand, and should include the following (as relevant):

- an explanation of the patient's condition and diagnosis, including any uncertainty in relation to either
- an explanation of available treatment options, including the likely result of no treatment, and the option to obtain further medical opinions if relevant

- the proposed treatment in the circumstances, and the reasons for it
- the general and specific risks involved in the treatment including any risks in the treatment or procedure itself, as well as short-term and significant long-term physical, emotional, mental, social, sexual or other risks
- the likely outcomes, including expected benefits and/or detriments of treatment
- whether the treatment is irreversible
- the time involved in the treatment
- the likely recovery period and course
- any follow-up treatment or care that may be required
- any costs involved.

Consent must:

- (a) be voluntary and freely given and the patient (or their representative) must understand that it can be withdrawn at any time prior to completing treatment and
- (b) be specific to the treatment proposed and
- (c) come from a competent person, which means the patient (or their representative) must be capable of understanding the nature and effect of the proposed treatment and of making a choice in relation to having the treatment.

The patient should be allowed some time for decision-making, where possible and as appropriate.

Matters that have been discussed between practitioner and patient (or the adult acting on their behalf) should be accurately documented in the client's medical file, including who participated in the discussion, any questions asked by the patient, parent/responsible adult and the answers to those questions.

Who may give consent?

In the case of a child who is not a mature minor, informed consent may be provided by a child's parent or the adult who is legally responsible for that child, as relevant.

Mature minors are able to consent to medical treatment on their own behalf, provided they have sufficient maturity and intelligence to fully appreciate the proposed treatment and its consequences. Minors must be assessed as mature in relation to the treatment proposed. For further detail, see above at Section 4.1.2.

If a child is in the CEO's care, the CEO's power to make decisions about that child's treatment varies, depending on the basis of the CEO's authority. The CEO may have full parental rights and responsibilities towards that child (which encompasses decisions about medical procedures), he/she may have some responsibilities or powers in relation to treatment decisions, or he/she may have no responsibilities or powers in relation to treatment decisions. Determining his/her role requires an understanding of the basis on which the child is in the CEO's care, including any orders and agreements relevant to that child. See Section 3.5 – Children in the care of the CEO of CPFS for further information.

Exceptions to adult consent to medical treatment on behalf of children

(i) The child's best interests

The principle that the child's interests are paramount arises under the CCSA, the *Family Law Act 1975* (Cwth) and the *parens patriae* jurisdiction of the Supreme Court.

Where an adult makes a healthcare decision on behalf of a child, e.g. to consent or withhold consent to treatment and that decision appears to be contrary to the best interests of the child, the Supreme Court may be prepared to overturn that decision. In such cases, concerned health staff can seek legal advice relevant to the circumstances from Legal and Legislative Services (in the case of non-teaching hospitals), or the State Solicitor's Office (in the case of teaching hospitals). Decisions of mature minors may also be overridden by the Court.

(ii) Emergencies

Where a medical emergency arises, consent to treatment should be obtained if possible.

If a minor requires urgent treatment in order to avert a serious and imminent threat to their life or to their physical or mental health, and the minor (or the person with parental responsibility for them) is not able to consent to the required treatment at the time, the minor is deemed by law to have consented to treatment.

The circumstances constituting the emergency and the lack of consent should be clearly documented in the minor's medical record.

Further information about consent can be found at [Consent to Treatment Policy for the Western Australian Health System](#).

4.4 Additional matters

Duty of Care

Health services and health staff are required to take all reasonable care for their clients, within the context of the health-care episode. These obligations or duties are imposed by various statutes, by professional boards (in the case of health practitioners), and by common law. A common law duty of care generally arises in the healthcare context when a person presents at a health service for medical attention and the health service expressly or implicitly accepts responsibility for the assessment and/or treatment of that person.

On occasion, a duty of care may be owed not only to the person presenting for care but also to third parties likely to be impacted by that person's actions (or omissions). This potentially includes children in the person's care where they are clearly at risk. Such circumstances may require disclosure of confidential patient information to help avert harm to that third party.

However, a duty of care towards a third party does not always arise simply because a risk of harm to that third party is foreseeable. If practitioners are unsure whether they should disclose information on the basis of a duty of care to a third party (or under another exception to the duty of confidentiality), they may obtain assistance from Legal and Legislative Services (in the case of non-teaching hospitals) or the State Solicitor's Office (in the case of teaching hospitals) if required.

Power to keep child under 6 years of age in hospital (also known as a 'holding order')

Under section 46 of the CCSA, the officer for the time being in charge of a hospital ('the officer in charge') may keep a child in the hospital for the purpose of observation, assessment or treatment, or otherwise to safeguard or promote the wellbeing of the child if:

- the child is under 6 years of age and is brought to the hospital for observation, assessment or treatment, or is admitted to the hospital, and
- the officer in charge believes on reasonable grounds that the child is in need of protection.

The child may be kept in hospital whether or not a parent of the child consents to that action. However, the child must not be kept in hospital for more than 2 working days (i.e. excluding Saturdays, Sundays, public holidays or public service holidays).

Where a child is kept in hospital, the officer in charge must notify the CEO of CPFS (or an authorised delegate) as soon as practicable. Notification may be given orally or in writing. However, any oral notification must be followed up with a written notification as soon as practicable.

A child who is being kept in hospital under s.40 cannot be taken from the hospital without the consent of either the CEO of CPFS, or the officer in charge of the hospital. The officer in charge must consult with the CEO prior to giving a person consent to take the child.

Intimate body piercing

Section 104A of the CCSA prohibits 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 consent of the child or their parent. Any intimate piercing of a child should be reported to the local CPFS District Office for further assessment.

Mandatory reporters of child sexual abuse are required to report intimate body piercing to CPFS Mandatory Reporting Service if the reporter forms a belief that sexual abuse has occurred or is occurring.

Other forms of body piercing are prohibited for people less than 18 years of age, unless written parental consent is provided. The only exclusions are for children aged 16 years or over, who are able to have their ears pierced without parental consent, and body piercing required for medical or therapeutic purposes.

Rescinded 14 March 2022
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy



5. Policies, forms and resources

5.1 Operational directives and information circulars

5.2 Other online resources

5.3 Forms: print versions

5.4 References and bibliography

Rescinded 14 March 2022.
Superseded by MP 0166/21 Mandatory
Reporting of Child Sexual Abuse
Training Policy

5. Policies, forms and resources

5.1 Operational Directives and Information Circulars

- [OD 0523/14 Responding to Family and Domestic Violence Guideline and Reference Manual 2014](#)
- [OD 0296/10 Inter-agency Management of Children under 14 Who are Diagnosed with a Sexually Transmitted Infection \(STI\)](#)
- [OD 0518/14 Bilateral Schedule: Inter-agency Collaborative Processes when an Unborn or Newborn Baby Is Identified as at Risk of Abuse and/or Neglect](#)
- [OD 0657/16 Consent to Treatment Policy for the Western Australian Health System](#)
- [OD 0286/10 Memorandum of Understanding – Information Sharing between agencies with responsibility for prevention and response to family and domestic violence in Western Australia](#)
- [0164/13 Patient Confidentiality](#)
- [0177/14 Practice Code for the Use of Personal Health Information Provided by the Department of Health](#)

MOUs

- [Level 1 Strategic Bilateral MOU between WA Health and Department for Child Protection and Family Support](#)
- [Joint Guidelines between CPFS and WA Health for Exchange of Information](#)
- [Bilateral Schedule between the Department for Child Protection and Child and Adolescent Mental Health Services](#)
- [Strategic Bilateral MOU between the Department for Child Protection and the Drug and Alcohol Office services](#)
- [Schedule between CPFS and WA Health: Health Care Planning For Children In Care \(January 2015\)](#)

Legal documents

- [Children and Community Services Act 2004 \(CCSA\)](#)
- Prescribed authorities

5.2 Other online resources

Information Sheets

- [1 Family and domestic violence is a child protection issue](#)
- [2 Neglect is a child protection issue](#)
- [2a Points to consider when assessing for neglect](#)
- [3 Emotional abuse is a child protection issue](#)
- [4 Cumulative harm is a child protection issue](#)
- [5 Physical abuse is a child protection issue](#)
- [6 Safety for workers reporting child protection concerns](#)
- [7 The mature minor, consensual sex and child sexual abuse](#)
- [7a Assessing a child's ability to consent to sexual activity](#)
- [7b Guidelines for the mandatory reporting of child sexual abuse when the client is a mature minor](#)
- [8 Child obesity and child protection](#)
- [9 Guidelines for workers responding to requests from the Department for Child Protection and Family Support to monitor at risk children in the community](#)
- [10 When children's sexual behaviours can be a child protection issue](#)
- [11 Information exchange between prescribed government agencies](#)

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- [12](#) [Female genital mutilation is a child protection issue](#)
- [13](#) [Parental mental illness can be a child protection issue](#)
- [14](#) [Parental substance abuse can be a child protection issue](#)
- [15](#) [Barriers to children disclosing sexual abuse](#)
- [16](#) [Sexting, adolescents and the law](#)
- [17](#) [Child sexual abuse: A process not an event](#)

Forms – online

- [Best Beginnings Referral Form](#)
- [Child Injury Surveillance Programme: Injury Assessment template](#)
- [Child Wellbeing Guide](#)
- [CPFS Child Protection Concern Referral Form](#)
- [Legal and Legislative Services: Request for Legal Advice](#) (intranet access required)
- [Neglect protocol](#) (intranet access required)
- [WA Health Risk Assessment Process and Form](#) for emailing confidential information when there is a child protection concern

Practice Resources

- [Circle of Security – Roadmap](#)
- [Fear of Childbirth](#)
- [Working together for a better future for at risk children and families: A guide on information sharing for government and non-government agencies](#)
- [Female genital mutilation](#)

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- [Forced/early marriages,](#)
- [Keeping Your Baby Safe](#)
- [Neonatal Abstinence Syndrome](#)
- [Safe Infant Sleeping](#)
- [Safety Plan in the Event of Alcohol or Drug Use](#)
- [Signs of Safety – Pre-Birth Meetings](#)
- [Signs of Safety pre-Birth Meetings – Tips for parents](#)
- [Signs of Safety CPFS Child Protection Practice Framework](#)
- [Women and Newborn Drug and Alcohol Services – Information Booklet](#)

Service Resources

WA Health

- [Adolescent antenatal clinic – KEMH](#)
- [Best Beginnings – Intensive home visiting service](#)
- [Child and Adolescent Community Mental Health Service](#)
- [Child Development Services](#)
- [Child Protection Unit, Princess Margaret Hospital](#)
- [Childbirth and mental illness ante-natal clinic - KEMH](#)
- [Mother and Baby Unit – KEMH](#)
- [Perinatal Emotional Wellbeing – Services](#)

- [Psychological Medicine Consultation and Liaison Service](#)
- [Sexual Assault Resource Centre](#)
- [Women and Newborn Drug and Alcohol Service \(WANDAS\)](#)
- [YouthLink and YouthReach South](#)

Department for Child Protection and Family Support

- [CPFS Metropolitan Offices](#)
- [CPFS Regional Offices](#)
- [Men's Domestic Violence Helpline](#)
- [Strong Families](#)
- [Women's Domestic Violence Helpline](#)

Non-government agencies

- [Anglicare](#)
- [Aboriginal Parent Support Service](#)
- [Association for Services to Torture and Trauma Survivors \(asetts\)](#)
- [Babbingur Mia – Child Health Initiative](#)
- [Centrecare](#)
- [Ishar Women's Multicultural Health Centre](#)
- [Kalparin: Supporting families of children with special needs](#)

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- [Fremantle Multicultural Centre](#)
- [Metropolitan Migrant Resource Centre](#)
- [Mission Australia](#)
- [Multicultural Women's Advocacy Service](#)
- [Ngala: Early parenting and early childhood services](#)
- [Perth Aboriginal Resources Directory](#)
- [PIP \(People First Program\)](#)
- [Secca: Disability, relationships, sexuality](#)
- [UnitingCare West](#)
- [Wanslea](#)

Self-care for health staff – resources

- [Employee Assistance Program for WA Health staff](#) (intranet access required)
- [Employee Support Officers – self care](#) (intranet access required)
- [Looking after yourself – for WACHS health workers](#) (intranet access required)
- [Preventing and Responding to Workplace Bullying Policy](#)
- [Preventing stress and burnout](#)
- [Self-care Plan](#)
- [Self-care Maintenance Plan](#)
- [What is Vicarious trauma?](#)

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Useful Websites

- [SNAICC](#)
- [Australian Indigenous Health InfoNet](#)
- [Disability Health Network – WA Health](#)
- [Learning with Family – Northern Territory Government resource](#)
- [Northern Territory – Indigenous parenting](#)
- [Children with Disability Australia](#)
- [Find a Mental Health Service](#)
- [Drug and Alcohol Office](#)

5.3 Forms: Print version

1. Request to GPF-S to provide relevant information to WA Health Form
2. Body map

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Form 1: REQUEST TO DEPARTMENT FOR CHILD PROTECTION AND FAMILY SUPPORT (CPFS) TO PROVIDE RELEVANT INFORMATION TO WA HEALTH

FROM: Health Worker: Name: _____

Work role: _____

Address: _____

Phone: _____ Pager: _____ Fax: _____

TO: CPFS _____ Local Office

Workers Name: _____

Work Role: _____

Office Address: _____

Phone: _____ Fax: _____

The client is aware of this request for information Y/N

If no, please provide reason(s): _____

This request follows the prior submitting of a Child Protection Concern Referral Form Y/N

If **YES**, date Form was submitted to CPFS: _____

Has prior contact been made with the CPFS worker or agency to discuss this request for feedback?

Yes

Name of person contacted and date(s)

No

Reason(s) no prior contact made.

This request concerns the following child(ren)

Child 1 Name: _____ Date of Birth _____

In Care Yes No D/K

Child 2 Name: _____ Date of Birth _____

In Care Yes No D/K

Child 3 Name: _____ Date of Birth _____

In Care Yes No D/K

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Family Details

Mother: _____ **Father:** _____
Address: _____ Address: _____
Phone: Home _____ Home: _____
Phone: Mobile _____ Mobile: _____

Other Person with parental responsibility

Relationship with child: _____
Address: _____
Phone: Home _____ Mobile: _____

Health care service(s) currently being provided to the child(ren) and/or family
Provide a brief summary of the reason for the service and the type and frequency of service(s) being provided.

Specific information requested
e.g. Outcome of "Report of Concern" or Child Protection Investigation, case planning outcomes etc.

The ways in which the information requested will contribute to the ongoing provision of health services to the child(ren) and/or family.

Provide a brief summary of how health will utilise the information provided in ongoing service provision

Time Frame for feedback

Urgent (within 24 hrs)

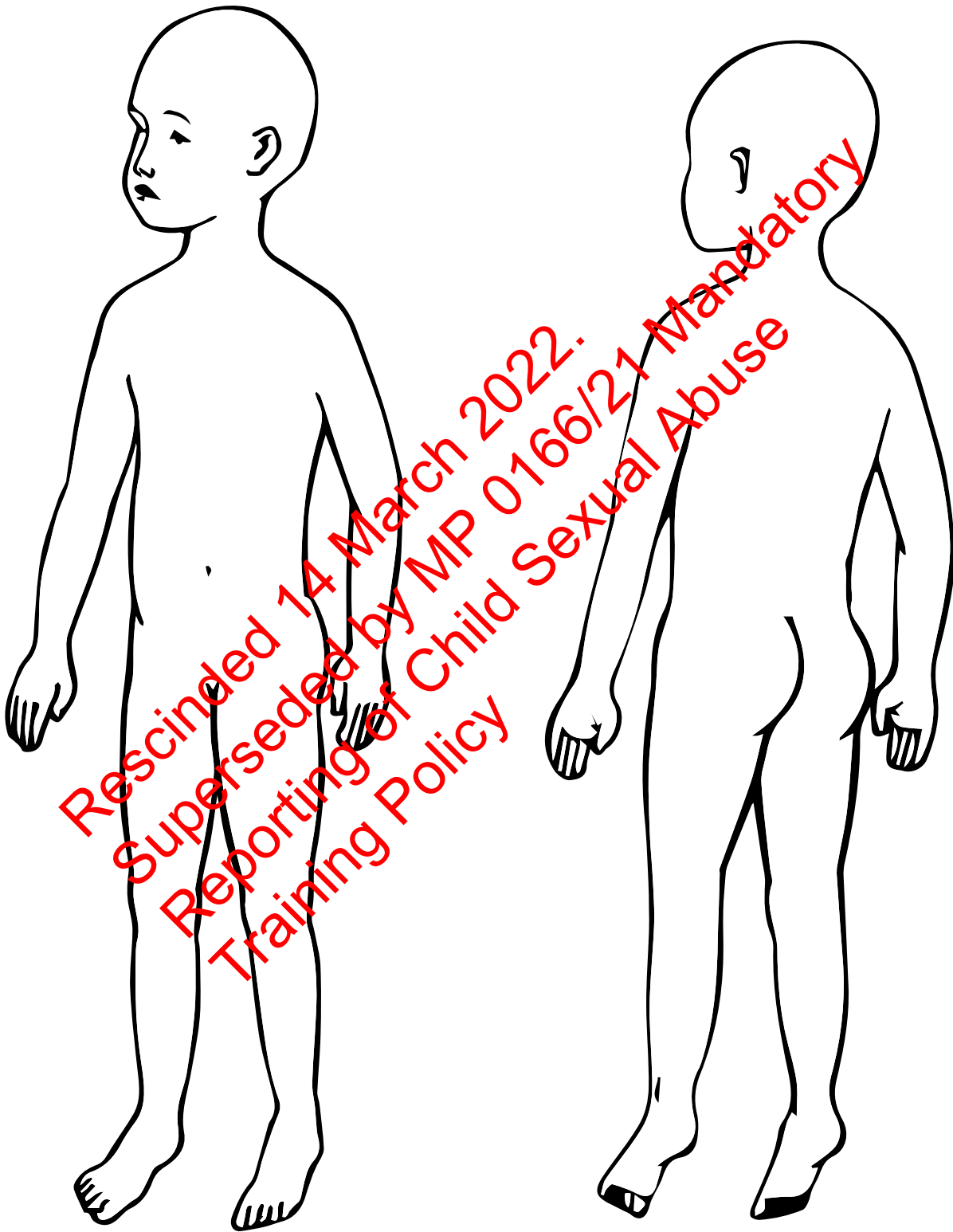
Within 48 hours

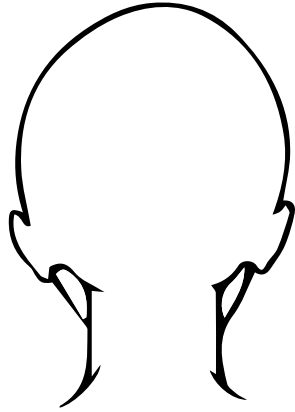
Within 15 working days

Up to 20 working days

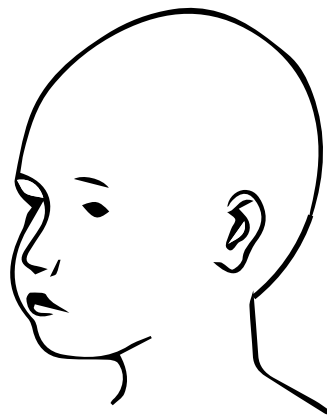
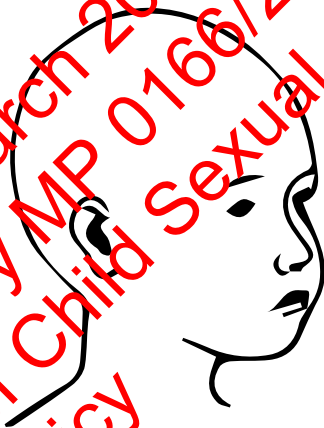
Signature: _____ Date: _____

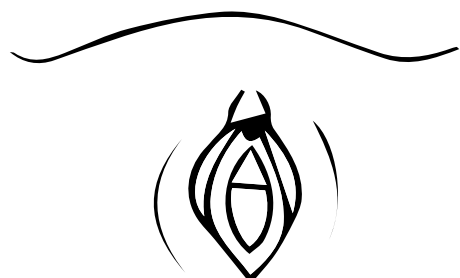
Body Map



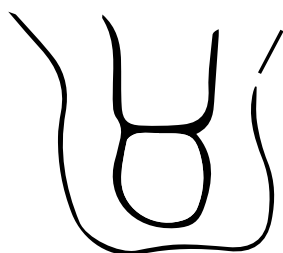


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