Safety of Children in Hospital

Manaakitia a tatou tamariki
CHILDREN'S COMMISSIONER

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EXECUTIVE SUMMARY

This investigation followed two incidents which occurred during 2004 where two infants were hospitalised with suspected non-accidental injury and who were further abused while they remained in hospital.

This investigation relates directly to these two specific incidents. While the Children's Commissioner recognises that cases of this level of seriousness may be small in number, the intention of this report and its recommendations are to provide guidelines for national protocols which will ensure children's safety in hospitals in the future.

The first incident, Case A, occurred in May 2004 in Kaitaia and involved a four week old infant who had been admitted to Whangarei Hospital with a fractured femur. The second incident, Case B, occurred in June 2004 in Nelson and involved a four week old infant who had been admitted to Nelson Hospital with a suspected broken arm.

The investigation was established to determine:

- what protocols were in place at the time of the incidents between key agencies;
- to clarify if, and what, changes needed to be made to keep children safe in hospital when children present with suspected non accidental injury;
- to review the protocols that existed in other District Health Boards nationally and in other hospitals internationally; and
- to clarify who had the responsibility for the safety and well-being of the child at this time.

The purpose of the investigation was to ultimately suggest a model for implementation in all District Health Boards to safeguard children who are admitted to hospital with a suspected non-accidental injury.

The investigation found that:

- In both incidents in Whangarei and Nelson, despite staff in the hospital and the Department of Child, Youth and Family Services having guidelines and procedures to follow, the infants were still further injured while in the hospital.
- Both the hospital and Department of Child, Youth and Family Services have a 'duty of care' towards the child admitted with suspected non-accidental injury. Once a notification has been received by the Department of Child, Youth and Family Services, the duty of care resides with the Department to ensure the child's safety.
- A Place of Safety Warrant should have been sought by the Department of Child, Youth and Family Services, to ensure appropriate and effective protection of both children who were admitted to hospital with a suspected non-accidental injury.
- The investigation identified significant ease of access by parents and other family members to the children's ward, despite in one hospital there being a supervision plan in place.
- The parents' rights to care for and have contact with their child, superceded the child's right to be safe. In both hospitals, the family-centred approach where parents are encouraged to care for their child, did not, for these infants, protect them from further abuse.
- The supervision arrangements for the infants lacked specificity and formality.
- A 'rule of optimism' existed between all the professionals.
- In both cases, nursing staff were unable to provide full time supervision of the child as well as carrying out their usual duties on the ward.
- There is a need for a robust and effective interagency protocol between key agencies to respond to suspected

non-accidental injury of every child presenting at hospital.

- The Police, Department of Child, Youth and Family Services and the District Health Boards in Case A and Case B have subsequently made significant changes in practice and protocols to improve interagency collaboration.
- Following these incidents, the Ministry of Health reviewed policies and procedures around security and safety of children in all District Health Boards. The review found that key safety and security arrangements are either in place or are in the process of being implemented in all District Health Boards.

As a result of this investigation the Office of the Children's Commissioner recommends:

- That in every instance of an admission for suspected non-accidental injury, the hospital notifies the Department of Child, Youth and Family Services and the Police.
- That in all cases where a child is hospitalised as a result of suspected non-accidental injury, and there is no clear indication as to who the perpetrator is, a Place of Safety Warrant is obtained by the Department of Child, Youth and Family Services. This does not preclude the Department from taking any other court action they may see fit, such as seeking a section 78 Interim Custody Order.
- That the child is kept physically safe in the hospital through the adoption of security measures, put in place by the key agencies involved, to protect the child 24 hours a day every day from unscheduled or unsupervised access.
- That there is a liaison social worker appointed in the Department of Child, Youth and Family Services whose role it is to liaise between the Department of Child, Youth and Family Services, Hospital and the Police.
- That a multi-disciplinary team approach is adopted and that a formal meeting between the Department of Child, Youth and Family Services, the District Health Board and the Police (within 24 hours or as soon as is practicable) is held to discuss the situation, share information, and clarify roles and tasks.
- That the multi-disciplinary team communicates collaboratively and effectively. Discussions must include issues such as supervision of the child, access arrangements and arrangements for payment of supervision costs.
- That there be ongoing training of staff in all key agencies to up-skill staff on the recognition and management of child abuse; and to provide opportunities to openly discuss practice issues, examine attitudes particularly around the child's rights to safety and protection, versus the parents' rights to contact in these situations.
- The National Office of the Department of Child, Youth and Family Services, the Police and the Ministry of Health formulate Memoranda of Understanding which clearly establishes responsibilities, processes and procedures in every hospital.
- If an occasion arises in the future where a child is further injured while in hospital, there shall be an investigation conducted by independent reviewers (to the case) to consider practice issues, identify any problem areas and, if necessary, revise or formulate protocols and/or guidelines to address those problem areas.
- Any such investigations shall be reported to the Children's Commissioner, both at the outset of commencing an investigation, and at the conclusion of the investigation process.

INVESTIGATION INTO THE SAFETY OF CHILDREN IN HOSPITAL FOLLOWING ALLEGATIONS OF ABUSE

1 Background

In December 2004, the Office of the Children's Commissioner launched an investigation into the safety of children who have been hospitalised following allegations of abuse.

This investigation was initiated as a direct result of two incidents which occurred during 2004, where infants were hospitalised with suspected non-accidental injury and who were subsequently abused again whilst they remained in hospital. There was wide media interest around these incidents and public debate over who had responsibility to protect these babies. The Department of Child, Youth and Family Services had had prior involvement with both families.

This investigation relates directly to two specific incidents. While the Children's Commissioner recognises that cases of this level of seriousness may be small in number, the intention of this report and its recommendations are to provide guidelines for national protocols which will ensure children's safety in hospitals in the future.

When a hospital notifies the Department of Child, Youth and Family Services that a child has been admitted with suspected non-accidental injury and there is a lack of clarity as to the likely perpetrator of the suspected non-accidental injury, there needs to be a clear understanding as to who has the duty of care for the child. The report reviews two cases to identify where practice could be improved, and where understanding between agencies could be enhanced.

The first incident, Case A, occurred in May 2004 in Kaitaia and involved a four week old infant who had been admitted to Whangarei Hospital with a fractured femur. The second incident, Case B, occurred in Nelson and involved a four week old infant who had been admitted to Nelson Hospital with a suspected broken arm.

1.1 This Report

The following report describes an investigation into two incidents of children who were assaulted in hospital. The facts have been discussed to the extent necessary to understand the procedures, protocols and communications in place between the key agencies.

The investigation comments on the interagency communication that occurred and comments on the practice of the professionals involved. As a result of the publicity surrounding the injuries suffered by these children, the District Health Boards concerned and the local Department of Child, Youth and Family Services offices have made changes in their relationships.

The report comments on these changes and reviews the protocols that exist in all the District Health Boards in New Zealand.

The report does not conclude that there is widespread systemic failure. Most cases of suspected non-accidental injury are managed appropriately by hospital staff and Department of Child Youth and Family Services social workers.

However, on reviewing the national and international policies and procedures that exist to keep children safe in hospital, the report suggests a model that should be implemented in all District Health Boards to prevent further injuries to children following admission to hospital in the circumstances discussed in this report.

1.2 Terms of Reference

This investigation was guided by Terms of Reference (Appendix 1).

1.3 The Investigation

The Office of the Children's Commissioner has statutory authority to undertake an investigation pursuant to sections 12 and 13 of the Children's Commissioner Act 2003.

Section 12 (1) gives authority for the Commissioner to investigate matters relating to children and young people. Section 13 (1) gives the Commissioner authority to investigate matters to do with the Children, Young Persons and Their Families Act, 1989. Details of these are included as Appendix 1.

In undertaking this investigation, the Office of the Children's Commissioner is required to have regard for the provisions of the United Nations Convention on the Rights of the Child (UNCROC) to which New Zealand is a signatory. In preparing this report, the Office has been guided by the United Nations Convention on the Rights of the Child, which has been included as a schedule to the Children's Commissioner Act 2003. The specific Articles guiding this report are:

Article 3	Best interests of the child
Article 4	Implementation of rights
Article 6	Survival and development
Article 9	Separation from parents
Article 19	Protection from abuse and neglect
Article 20	Security
Article 24	Health and treatment
Article 25	Placement

Details of these Articles are attached as Appendix 2.

1.4 Sourcing Information

Following the decision by the Commissioner to complete an investigation, the Children's Commissioner wrote to:

(i) Chief Executive of the Department of Child Youth and Family Services on 13 December 2005 requesting a report into the incident in Nelson. A report on the case from the Department of Child, Youth and Family Services Whangarei had already been received on 2 August 2004.

(ii) Commissioner for Police on 13 December 2004 informing him of the investigation and reports were requested on the incidents in Whangarei and Nelson.

(iii) Chief Executive Officer of District Health Board, New Zealand, on 21 January 2005 informing him of the investigation and invited comment or questions.

(iv) Northland District Health Board on 8 February 2005 informing them of the investigation, and our visit. A meeting with the Board and hospital staff was organised. A report had been received from Northland District Health Board on 17 June 2004.

(v) Nelson Marlborough District Health Board on 9 December 2004 informing them of the investigation and requesting a report into the incident. A meeting with Nelson Marlborough District Health Board was organised. A report from Nelson Marlborough District Health Board was received on 21 January 2005.

(vi) District Commander of Whangarei Police informing him of our visit and the need to meet with relevant staff. A meeting was organised with C.I.B. Nelson Police. A report from Whangarei Police was received on 10 January 2005.

1.5 Interviews Undertaken

Staff from the Office of the Children's Commissioner visited Whangarei on 22 to 24 February 2005 and interviewed:

DEPARTMENT OF CHILD YOUTH AND FAMILY SERVICES:

Whangarei Office on 23 February 2005 – interviewed:

Service Delivery Manager, Whangarei

Practice Manager, Whangarei

Service Team Supervisor and liaison social worker

Kaitaia Office on 23 February 2005 – interviewed:

Supervisor, Kaitaia

Practice Manager, Whangarei office was present

Social Worker, Kaitaia

NORTHLAND DISTRICT HEALTH BOARD

Whangarei Hospital on 24 February 2005 and interviewed:

Chief Executive Northland District Health Board; the Chief Medical Advisor; and relevant staff.

A tour of the Children's Ward also occurred after the meeting.

The Paediatric Clinical Director was spoken to by phone on 14 May 2005 due to his being on leave on day of visit.

WHANGAREI POLICE

C.I.B. on 24 February 2005

STARSHIP HOSPITAL AUCKLAND

Paediatrician and Clinical Director on 25 February 2005

Staff from the Office of the Children's Commissioner visited Nelson on 31 March and 1 April 2005 and interviewed:

NELSON MARLBOROUGH DISTRICT HEALTH BOARD

Paediatrician

Chief Executive of the Board

Chief Medical Advisor, Nelson Hospital

DEPARTMENT OF CHILD YOUTH AND FAMILY SERVICE

Acting Service Delivery Unit Manager for Department of Child Youth and Family Service Nelson office

Supervisor at the time of the incident

Social worker – who was spoken to by telephone on 7 June 2005 as they were on leave at the time the interviews took place in Nelson.

Service Delivery Unit Manager, Department of Child, Youth and Family Services Nelson at the time of the incident, and Practice Manager, Department of Child, Youth and Family Services Nelson at the time of the incident, were interviewed in Wellington on 29 March 2005.

NELSON POLICE

C.I.B. on 31 March 2005

1.6 Information Received to Assist in the Investigation

(i) Inter-agency Protocol for the reporting and investigation of child sexual abuse and physical abuse – a Memorandum of Understanding between Police and the Department of Child, Youth and Family Services.

(ii) Ministry of Health – a survey into hospital security in District Health Boards throughout New Zealand, completed July 2004.

(iii) Paediatric Clinical Guidelines for Abuse and Neglect from Starship Hospital.

(iv) Draft Protocol from Northland District Health Board and the Department of Child, Youth and Family Services.

(v) Draft Protocol from Nelson District Health Board and the Department of Child, Youth and Family Services.

(vi) A draft model for management of children admitted to hospital with suspected non-accidental injury developed by a Paediatrician, Nelson Hospital.

External consultations occurred with legal consultants and Youth Aid Co-ordinator, New Zealand Police.

1.7 Information Received in Response to Draft Report

The following agencies and organisations were provided copies of the draft report for their feedback and comment, pursuant to section 25 of the Children's Commissioner Act 2003. Their responses have been received and considered and where appropriate, changes made to the final version of the report:

(i) Department of Child, Youth and Family Services

(ii) District Health Boards – Whangarei
– Nelson/Marlborough

(iii) Ministry of Police

(iv) Ministry of Health

1.8 Interview Questions

Questions guiding the interviews are attached as Appendix 3

2 Case A and Case B

The purpose of this investigation is to understand the issues that surrounded the incident at Whangarei Hospital (Case A) and Nelson Hospital (Case B) where two infants were further harmed in hospital after being admitted with a suspected non-accidental injury.

CASE A

2.1 Summary:

The baby presented at Kaitaia Hospital on 30 April 2004 and was referred to Whangarei Hospital. The paediatrician in Whangarei who attended was fairly certain that the injuries were non-accidental. On 1 May 2004, the paediatrician notified the Department of Child, Youth and Family Services Call Centre who contacted the Department of Child, Youth and Family Services Kaitaia.

The Department of Child, Youth and Family Services Call Centre categorised the baby's situation as 'urgent' according to the Department's Risk Estimation System (RES). The social worker on duty at Kaitaia received the notification and on 4 May 2004, informed the supervisor and social worker who were attending training in Kaikohe, of the notification.

The supervisor and social worker went to the Whangarei Hospital on 4 May 2004 and sighted the baby. The social worker and supervisor did not believe at this stage that the injury was as a result of abuse by the parents. The Department of Child, Youth and Family Services social workers were of the view that the injury was accidental and appeared to believe the parents' explanation that the baby had been pulled off the bed. The social workers did not apply the Risk Estimation Tool to assist them in their judgement.

A whanau hui was held with the parents and other family members, and no one admitted to injuring the baby. The only explanation provided was that the 18 month old sibling had pulled the baby off the bed and on to the floor and this had caused the fractured femur.

The child was admitted to the Children's Ward and placed near but not observable to the nursing station. There was no specific supervision arrangement made with any family member or other professional apart from the fact that the nurses were aware of the injury and would keep a close eye on the baby.

On 6 May 2004, the paediatrician spoke directly with an experienced paediatrician of Starship Hospital regarding the case. He advised that in his professional opinion that '"an accidental injury is highly unlikely but not impossible". He advised that the Police should be notified immediately in Whangarei.

The social worker from the Department of Child, Youth and Family Services Kaitaia visited the hospital occasionally over the next few days. Despite being advised by professionals at the hospital that the injuries were highly unlikely to be accidental, the social worker continued to believe that the sibling caused the injury and discounted the professional opinion of four paediatricians. At no stage was there a formal interagency meeting of professionals involved in the case during this time.

The Police in Whangarei contacted the Department of Child, Youth and Family Services Kaitaia. They had still not heard back from the Department of Child, Youth and Family Services Kaitaia. Over the next few weeks, the baby remained in hospital with the parents visiting and providing care for the baby. The nursing staff raised concerns directly with the Department of Child, Youth and Family Services Kaitaia around the parenting abilities of these parents.

The Police interviewed the parents and no admissions were forthcoming. They followed this up with a fax to the Department of Child, Youth and Family Services Call Centre. The Police decided to leave the matter to the Department to devise a care and protection plan to ensure the future safety of the child.

At this point the Department of Child, Youth and Family Services Whangarei was not involved as the child came from the Kaitaia area and there had been no request for a case transfer. On 20 May 2004, the Department of Child, Youth and Family Services Kaitaia social worker was informed verbally by the hospital social worker that a further bruise had been noted on the child's face. No formal notification of this further injury was made to the Department of Child, Youth and Family Services.

On 22 May 2004, the Northland District Health Board contacted the Police and advised that the baby had received further injuries of an extremely serious nature. The Police interviewed the father on that day. He admitted inflicting the injuries and he was charged with child abuse offences.

The Police then contacted the Department of Child, Youth and Family Services Whangarei who became immediately involved.

A meeting of the doctors and the social workers was held on Monday 24 May 2004 to discuss the situation. On 25 May 2004, the Department of Child, Youth and Family Services applied for and was granted a section 78 Interim Custody Order. The father was arrested and the parents were banned from the hospital. The baby remained in the hospital until such time as caregivers were arranged and was released to the Department's care.

2.2 Inter-Agency Involvement

Case A

When the notification of a suspected non-accidental injury was made by Northland District Health Board to the Department of Child, Youth and Family Services Call Centre regarding the baby (who had been transferred from Kaitaia Hospital to Whangarei), there were policies in place in both the hospital and the Department of Child, Youth and Family Services, which required the involvement of the Police when the matter was serious. However, in this particular case, they were either not implemented, or implemented inappropriately. This lack of adherence to the policies and procedures placed the child at further risk and failed to protect the child.

At no point prior to the second injury was the CAT/SAT[1] protocol activated or initiated by the Department of Child, Youth and Family Services Kaitaia with the Kaitaia Police. This was a clear breach of the agreed policy.

From the information provided to the investigators, the Department of Child, Youth and Family Services Call Centre was initially notified by the Northland District Health Board on 1 May 2004. The matter was classified by the Department of Child, Youth and Family Services Call Centre as 'urgent' and then referred on to the Department of Child, Youth and Family Services Kaitaia on 2 May 2004.

Once the notification was received by the Department of Child, Youth and Family Services Kaitaia office, there was an opportunity for the classification of the notification to be re-classified as 'critical'. Based on the information from the hospital that the child was 'safe' because the infant was in traction in the hospital, the classification remained unchanged and it was not until 4 May 2004 that social workers were asked to respond and sight the baby.

On 5 May 2004, the social worker requested a copy of the medical notes from the hospital. The medical notes and a report from the paediatrician were faxed to the Department of Child, Youth and Family Services Kaitaia. Again on 6 May 2004, 11 May 2004, and 14 May 2004, the Department of Child, Youth and Family Services requested the same information.

The Northland District Health Board insist that these documents were sent to the Department of Child, Youth and Family Services Kaitaia on the dates requested. The Department of Child, Youth and Family Services staff did not believe these were ever sent. The paediatrician subsequently phoned the Department of Child, Youth and Family Services Kaitaia and stressed the seriousness of the case and their very strong suspicion of non-accidental injury.

On 6 May 2004, the paediatrician at the Northland District Health Board also informed the Police of the case. The Police visited the hospital and interviewed the parents. No admissions as to how the injuries arose were forthcoming at this time. The Police followed this up on 8 May 2004 with a fax to the Department of Child, Youth and Family Services Call Centre notifying them they were aware the child had been hospitalised. The Department of Child, Youth and Family Services Kaitaia office report they did not receive this fax from the Call Centre.

[1] Child Abuse Team/Serious Abuse Team

The Department of Child, Youth and Family Services Kaitaia social worker stated to the investigators that, in their opinion, there was a lack of specific information and evidence around the actual diagnosis of non-accidental injury by the Northland District Health Board.

The Department of Child Youth and Family Services Kaitaia social worker and supervisor did not appear to accept the professional opinion of paediatric staff from the Northland District Health Board, or the opinion of another paediatrician, as to the injury being non-accidental. At that stage, they believed the parents' explanation.

The allocated social worker visited the child in hospital on several occasions. At no point was a professional case conference called or formal meeting held with the professionals involved to discuss the case or its direction. A collaborative and co-operative approach would have enabled all practitioners to focus clearly on the safety and well being of the baby.

There were clearly difficulties in the communication and interactions between the hospital and the Department of Child, Youth and Family Services Kaitaia. This involved professional mistrust of each other's roles and extended to a lack of confidence by hospital staff that the Department of Child, Youth and Family Services would place the baby with family who would keep her safe.

The parents continued to look after the baby while the baby was hospitalised. On 14 May 2004, Northland District Health Board staff expressed concerns to the Department of Child, Youth and Family Services about the parenting skills they were demonstrating, such as feeding cow's milk to a four week old baby and not sterilising bottles. Despite hospital staff notifying the Department of Child, Youth and Family Services of these concerns, the parents continued to care for the baby on a daily basis.

On 18 May 2004, the Northland District Health Board reported that a bruise was noted on the right side of the child's cheek. The father stated that the feeding bottle slipped and fell on the baby's face. The house surgeon examined the baby and no other marks or bruising were noted.

The Department of Child, Youth and Family Services social worker reported that on 20 May 2004 when visiting the hospital, the hospital social worker asked if the social worker had noticed "the bruise on the baby's face?" On receiving this information, the Department of Child, Youth and Family Services social worker went directly to the baby and noted a small bruise. The explanation given was that the father had "accidentally dropped" the bottle on the baby's face.

The Department of Child, Youth and Family Services social worker was concerned that a formal notification had not been made by the hospital to the Department of Child, Youth and Family Services of the infant's further injury.

At this point, the Department of Child, Youth and Family Services social worker reports beginning "to think this was abuse" and discussed these concerns with the supervisor. The Department of Child, Youth and Family Services Kaitaia expressed concerns regarding the baby being discharged to the parents' care. They sought a copy of the medical notes under section 66 of the Children, Young Persons and Their Families Act 1989.

On 21 May 2004, a further bruise was noted on the baby's face. A paediatric Senior Health Officer assessed the baby at 11.30 pm that night. They noticed bruising on both cheeks the inferior aspect of the nose was bruised and red in appearance, petechiae on the cheeks and sub conjunctival haemorrhages of both eyes.

Subsequently, a management plan was drawn up by the hospital, which included: careful observation of the baby, excluding infectious origin, informing consultants on ward the next morning and the Paediatric Senior Health Officer to be called if any concerns were raised. The parents continued to have full access to the baby.

On the morning of 22 May 2004, after a review of the case by the paediatrician, a further notification regarding this baby was made by Northland District Health Board to the Department of Child, Youth and Family Services Whangarei. The paediatrician advised that in his opinion this was an extremely serious situation and that the injuries were consistent with an assault and a possible suffocation attempt. This was a potentially life-threatening situation.

As the child was in Whangarei Hospital, the Department of Child, Youth and Family Services Whangarei became involved immediately and took responsibility for the investigation. The CAT/SAT protocol was instigated, the Whangarei Police were fully involved, access by the parents to the child was stopped immediately and the father admitted causing the harm – which he later retracted.

On the 25 May 2004, the Department of Child, Youth and Family Services Whangarei applied to the court for, and was granted, a declaration that the child was in need of care and protection (s.67) an Interim Custody Order (s.78) and a Restraining Order (s.88) against the parents. The Northland District Health Board also advised that the response to this notification by Department of Child, Youth and Family Services Whangarei was completely different to the initial response from the Department of Child, Youth and Family Services Kaitaia. The notification was responded to immediately and dialogue between the two agencies began.

2.3 Comment

Once it was discovered that further injuries of an extremely serious and life-threatening nature had occurred to the infant while in hospital, the matter became very public. The media became involved and the Department of Child, Youth and Family Services appeared to be taken to task publicly for not providing adequate safety of the child whilst the child was in hospital. There was confusion around roles, and confusion around who had responsibility for the physical safety of the child and the resourcing required to support this.

As a result of the publicity, and a review of practices around this case, there was a strong willingness by all parties to ensure that it did not happen again. On 24 May 2004, the Department of Child, Youth and Family Services, Service Delivery Unit Manager Whangarei met with the Northland District Health Board to discuss strategies for better intersectoral collaboration and cooperation.

The Service Delivery Unit Manager and the Northland District Health Board identified their respective concerns and formulated draft policies, which made it clear and specific as to when to contact the Department of Child, Youth and Family Services and/or the Police, who should be contacted and the processes around achieving this when a child presents with suspected non-accidental injury.

Gaps in service and issues around the management of non-accidental injury or suspected non-accidental injury by both agencies, were identified and action was taken accordingly to remedy these gaps.

2.4 Changes in Place Since the Incident

Case A

Once the further injury occurred, both agencies worked together to address the issues that arose out of the incident. The following are the changes that have since taken place:

- The Department of Child, Youth and Family Services will apply for a Place of Safety Warrant for all cases of suspected non-accidental injury to safeguard the children until the assessment is completed and the perpetrator identified. This gives the Department of Child, Youth and Family Services, five (5) consecutive days to investigate (this can be extended by court order). A section 78 Interim Custody Order can also be applied for.
- A Child Protection Team initiated by the Police is now established and meets on a regular basis.
- All cases of suspected non-accidental injury presenting at any Northland hospital from will be referred to the Department of Child, Youth and Family Services Whangarei by Northland District Health Board.

- These will be given a 'critical' classification, which requires the Department of Child, Youth and Family Services to sight the child within 24 hours.
- On the point of discharge the child's case will be transferred to the nearest Department of Child, Youth and Family Services office where the child is to reside.
- There is now a Department of Child, Youth and Family Services liaison social worker in Whangarei whose role is to liaise between the Department of Child, Youth and Family Services Call Centre and their Whangarei office, hospital and Police.
- Additionally a direct call to the Service Delivery Unit Manager at Whangarei is in place any time (day or night) when non-accidental injury is identified at the hospital.
- There is now a Child Protection Team Coordinator at the hospital who is part of the Child Protection Team and whose role is also to liaise with Department of Child, Youth and Family Services and relevant agencies.
- There have been numerous physical changes to the security of the children's ward for example, double doors, identification required after hours, closed circuit TV in a room near to nursing station, etc.

2.5 Findings: Case A

The Children's Commissioner has found:

- That the Department of Child, Youth and Family Services Call Centre classified the notification incorrectly as 'urgent.' The nature of the injuries justified a 'critical' response.
- The supervisor and social worker disbelieved the professional advice, evidence and tools available to them, and relied on their own judgement and made decisions accordingly.
- That a 'rule of optimism' permeated any decision-making with this family by the professionals involved due to the baby being in traction in hospital, and the parents being co-operative and plausible.
- That Department of Child, Youth and Family Services Kaitaia did not communicate adequately with the hospital staff given the seriousness of the child's injuries.
- No formal mechanism or process, such as case conferencing, was in place to allow for effective communication between the hospital and the Department of Child, Youth and Family Services.
- There was a serious breach of the CAT/SAT protocol, in that the Department of Child, Youth and Family Services Kaitaia did not contact the Police as they are required to do.
- A formal supervision regime for the child, by either the hospital or the Department of Child, Youth and Family Services, was not immediately put in place despite the hospital staff suspecting non-accidental injury and also noting poor parenting skills.
- There were serious social work practice issues evident in the way the Department of Child, Youth and Family Services Kaitaia managed the case. These concerns have been forwarded to the Chief Executive of Department of Child, Youth and Family Services.
- Since the incident there has been a willingness and agreement to learn from the failures of this case. All staff at Northland District Health Board, Child, Youth and Family, and Police want clear protocols to follow in the future, to complete necessary training, and to work effectively together in order to keep children safe.

CASE B

2.6 Summary

The baby presented at Accident and Emergency, Nelson Hospital on Friday 18 June 2004 with a suspected broken arm. The paediatrician was informed and on examination suspected non-accidental injury. The paediatrician phoned the Department of Child, Youth and Family Services and the Department of Child, Youth and Family Services phoned the Police as set out in the CAT/SAT Protocol. All agencies visited the hospital that day.

X-rays were taken and it was discovered the baby had at least fourteen fractured ribs and a broken arm. These injuries were potentially life threatening. The paediatrician consulted a paediatric consultant Starship Hospital regarding the possibility of the broken bones being a bone disorder known as *osteogenesis imperfecta.*

The paediatric consultant was of the opinion that on the basis of the information presented, these injuries were highly unlikely to be accidental but this could not be ruled out until the second opinion was received.

The paediatrician was concerned about the mother's presentation. She was withdrawn and detached from the baby, and the paediatrician sought an assessment from the Mental Health Community Team. The Team's assessment did not indicate any significant mental health issues.

The parents were interviewed by the Police but no admissions were forthcoming. The parents stated they had no idea how the baby had been injured. On the day the child was admitted to hospital, the Department of Child, Youth and Family Services social worker, the paediatrician and the Police made a decision that access to the baby would be supervised. The parents were not to have access to the baby unless in the company of other professionals or the grandparents. At this point, the parents were co-operative and agreed to these conditions.

On Saturday 19 June 2004, a further meeting was held between the professionals including the Department of Child, Youth and Family Services legal advisor, regarding the issue of possible court orders being required. It was decided that as the parents were co-operative and plausible, that this would not be necessary and that the supervision plan was satisfactory at this stage. This would be reviewed on Monday 21 June 2004.

On 23 June 2004, the Department decided to apply for, and were granted, a section 78 Interim Custody Order. On this same day, the parents were found to be visiting the baby, unsupervised, and therefore in breach of the supervison plan. Further injuries were noted by the paediatrician, namely that the baby had received a further broken arm. The parents were interviewed and arrested and banned from the hospital. The baby was released on 28 June 2004 to Department of Child, Youth and Family Services caregivers.

2.7 Inter-Agency Involvement

Case B

On Friday 18 June 2004, the day of the baby's admission, the Nelson Marlborough District Health Board made a notification to the Department of Child, Youth and Family Services Call Centre (which was referred to Department of Child, Youth and Family Services Nelson) advising of the suspected non-accidental injury of the baby. Throughout the investigation by the Department of Child, Youth and Family Services there was a concerted effort by all professionals involved to work closely in the best interests of the baby and the family.

On the day of the notification, two Department of Child, Youth and Family Services social workers visited the hospital and met with the paediatrician. The key social worker advised the Police of the notification under the CAT/SAT protocol and invited them to attend a meeting of all involved. The Department of Child, Youth and Family Services social worker reported that initially, the paediatrician felt that the involvement of the Police was not necessary.

The Department of Child, Youth and Family Services social worker visited again that evening and met with another paediatrician, who advised that a further x-ray taken of the baby had shown at least 14 fractured ribs as well as the broken arm. There were also concerns about a possible knee avulsion. These injuries were approximately two – three weeks old. Non-accidental injury was the suspected diagnosis however the paediatrician consulted a paediatric consultant from Starship Hospital and sought further opinion on the possibility of the injury being *osteogenesis imperfecta* or brittle bone disease.

The parents and grandparents were advised of the baby's injuries by the paediatrician. The Police were again contacted by the Department of Child, Youth and Family Services social worker with this further information and they attended the hospital in the early evening to interview the parents.

The baby's mother appeared withdrawn and detached. The social worker and paediatrician were concerned about the mother's presentation and requested she be seen and assessed by the Mental Health Mobile Community Team. This assessment took place immediately and the mother was assessed as not having any significant mental health issues at that point.

During the weekend, the social worker kept in close contact with the paediatrician about the baby's condition. There was an after-hours consultation between the Department of Child, Youth and Family Services social worker, supervisor, the paediatrician and the senior staff nurse. A Department of Child, Youth and Family Services lawyer was also consulted regarding the necessity of taking any legal action e.g. a Place of Safety Warrant, to secure the baby's safety. As the parents were cooperative, this was not deemed to be necessary at the time. Supervised access had also been arranged.

The Department of Child, Youth and Family Services social worker consulted the family's GP, who did not have any concerns, and throughout the duration of the child's stay in hospital, the Practice Manager and Service Delivery Unit Manager were kept informed of progress throughout the investigation.

2.8 Comment

The injury to the Nelson baby happened within a matter of weeks of the incident that occurred in Whangarei. The notification made to the Department of Child, Youth and Family Services Call Centre was classified as 'critical' which requires that the investigation begin immediately and that the child must be sighted by the social worker within 24 hours of receiving the notification.

The Department of Child, Youth and Family Services social worker who was allocated the case, consulted and met with other professionals involved including a supervisor and practice manager, informed the Police as per the CAT/SAT protocol, drew up a supervision plan around the parents and grandparents regarding their access to the baby which was agreed to by all involved and a copy was placed on the baby's medical file.

Over the weekend, the Department of Child, Youth and Family Services social worker sought legal advice and followed this up on the 23 June 2004 by making application to the Court for a section 78 Interim Custody Order which was granted on the 24 June 2004. As neither parent admitted to the injuries, the Police interviewed and charged both parents.

In the opinion of the investigators, this case was handled appropriately by the Department of Child, Youth and Family Services social worker. The social worker followed the processes and procedures as outlined in the Department of Child, Youth and Family Services Care and Protection Handbook (1996) and most importantly, worked collaboratively with those involved.

However, the lack of a protocol between the Nelson Marlborough District Health Board and the Department of Child, Youth and Family Services meant that no one person or agency took ultimate responsibility for the 'safety' of the child.

The Nelson Marlborough District Health Board thought that as the Department of Child, Youth and Family Services investigation was underway, the Department of Child, Youth and Family was responsible for the safety of the child. The Department of Child, Youth and Family Services accepted that they had a 'duty of care' for the baby from the time of the notification but there was no clear understanding of what that actually meant (legally or otherwise) while the baby was in hospital.

Again a 'rule of optimism' featured in the decisions made by professionals in this case. The supervision plan that was signed by the parents and grandparents was, in hindsight, not adequate. The parents presented as cooperative, caring and plausible.

Further, supervision of the child in the hospital was clearly inadequate. Despite the grandparent's willingness to support the supervision plan, in effect the parents managed to have easy and unrestricted access to the baby. The hospital acknowledged they could not provide 24 hour supervision and together with the above this environment enabled the baby to be further harmed.

2.9 Changes in Place Since the Incident

Case B

Since the incident that occurred at Nelson Hospital the following changes have been made between the Nelson Hospital and the Department of Child, Youth and Family Services:

- A Family Violence Coordinator has been established at the hospital.
- Two child protection and family violence working groups have been established at Nelson and Wairau Hospitals.
- There has been active discussion of the Starship Hospital model initiated by the paediatrician with the Department of Child, Youth and Family Services.
- The need for mandatory training around family violence issues has been identified for all staff. This training will include relevant legislation e.g. Domestic Violence Act, Protection Orders, Trespass Orders and the Children, Young Persons and Their Families Act 1989.
- Case managers are available 24 hours a day, and within the Paediatric Service, an on call paediatrician is available 24 hours a day.
- SAT now meet regularly with Police and Department of Child, Youth and Family Services.
- Regular meetings are being held with the hospital and Department of Child, Youth and Family Services. This includes a liaison social worker for the Department of Child, Youth and Family Services whose role is to liaise directly with hospital.
- If the hospital makes a 'critical' notification they can ring either the after-hours social worker at the Department of Child, Youth and Family Services local office, or during the day, contact the liaison social worker to alert them to the notification. Either way the notification must still go through the national Call Centre.
- The hospital is currently developing protocols for identification and management of child abuse with referral pathways for staff with community frontline agencies.
- Family Violence Intervention Programme training is planned which will involve hospital security, after-hours security and telephonists.
- The hospital is looking at developing a formalised Memorandum of Understanding with the Police.

2.10 Findings: Case B

The Children's Commissioner has found:

- That obtaining a Place of Safety Warrant earlier would have given the Department of Child, Youth and Family Services a mandate to enable greater control of access, supervision and responsibility being placed with the Department of Child, Youth and Family Services.
- That the staff at the Department of Child, Youth and Family Services Nelson, Police and the Nelson Marlborough District Health Board did follow established guidelines according to the CAT/SAT protocol and departmental policy and procedures when non-accidental injury was suspected.
- At the time of notification, the Department of Child, Youth and Family Services were clear that they had responsibility for the supervision and safety of the child.
- Despite the Department of Child, Youth and Family Services stipulating supervised access in the form of a supervision plan with grand parents and parents, a further injury did occur. A lack of supervision in the hospital contributed to the further injury.

3 National Survey of Current Protocols In Place in Each District Health Board in New Zealand

In July 2004, the Ministry of Health surveyed all District Health Boards regarding the safety arrangements for children in New Zealand hospitals. The Children's Commissioner was provided with a copy of the completed report.

The survey was carried out in response to an increase in abuse notifications for infants, and where further abuse occurred whilst the infants were in hospital. All District Health Boards have been asked to reassess their child abuse policies and protocols in light of these events.

Like the Children's Commissioner, the Ministry of Health wanted to be reassured that all hospitals admitting children and infants to wards, outpatients or the Emergency Department have adequate arrangements in place to ensure children's safety. Safety and security factors identified were:

- Identification of parents, caregivers or family members who may pose a risk to the child who has presented or been admitted with suspected non-accidental injury.
- Protocols and agreements for liaison with the Department of Child, Youth and Family Services regarding safety issues for children.
- Protocols to support staff to limit access by such people to children at risk of non-accidental injury.
- Adequate and safe security arrangements for staff and children in the ward or outpatients departments.

The Ministry of Health found:

- Three District Health Boards indicated that staff did not have the ability to limit or deny access to parents/family if deemed necessary for either the child's or staff safety.
- Half the District Health Boards did not have a current arrangement in place with the Department of Child, Youth and Family Services for the provision of a Department of Child, Youth and Family Services 'watch'.
- Four District Health Boards could not reliably provide 24 hour hospital watches (security staff/nurses) for children suspected of non-accidental injury and thought to be at risk.
- Staff training in the recognition and assessment of children suspected of non-accidental injury occurred in all but five District Health Boards. Two out of the remaining five were reviewing this.

- Early consultation, assessment and involvement with the Department of Child, Youth and Family Services occurred in all District Health Boards.
- The majority of the District Health Boards surveyed indicated that their staff are prepared to instigate Care and Protection processes and/or Trespass Orders if there are high concerns for the safety of a child. One District Health Board had this under review.
- Security staff or orderlies were on-sites 24 hours a day every day, in all hospitals except one rural one.
- All District Health Boards had the facilities to make emergency calls for security or assistance when required.
- All District Health Boards can place children for whom there are concerns about safety in observable rooms where possible. A few District Health Boards stated this was their current practice but was it not documented in policy and was being reviewed.
- Wards are locked and secure at night in almost all District Health Boards. At the time of the incidents, two District Health Boards could not lock the paediatric ward but this has since been rectified with access cards now being required or entry from the main doors at night only. A small hospital commented that even though the ward could be locked visitors do let others in.
- A number of District Health Boards did not have the ability to instigate ward lock-down during daytime hours

In summary, the main areas of concern highlighted by the Ministry of Health were the lack of watchers or minders available either via arrangements with Department of Child, Youth and Family Services or hospital staff. Additionally, the lack of ability to access and instigate ward lock-down during the day for security is noted.

The report has highlighted that there are already key safety measures in place within most of the District Health Boards. Physical security arrangements have been or are being implemented. What was of significant concern was the apparent ease of access that parents, family or even the general public had to the children's ward. The report further highlights an absolute need for both the Department of Child, Youth and Family Services and District Health Boards to develop protocols to work cooperatively and collaboratively together in order to ensure the ongoing safety and protection of seriously at risk children.

4 Interagency Protocols and Policies for Managing Child Abuse

In 1989, the Children, Young Persons and their Families Act was passed into law. Social work practice is not only guided by this piece of legislation but also by various policies, protocols, and inter-agency guidelines.

The Department of Child, Youth and Family Services, District Health Boards and the Police throughout New Zealand have their own individual protocols and policies in place for managing cases of non-accidental injury, based on agreed national protocols between the Police, Ministry of Health and the Department of Child, Youth and Family Services. These are attached as Appendix 4.

5 Keeping Children Safe in Hospital in New Zealand

Literature and research available on the safety of children in hospitals in the United States, Australia, and the United Kingdom is limited. The only literature specifically about child safety in hospitals has been related to Fabricated and Induced Illness or what has previously been referred to as 'Munchausen Syndrome by Proxy'. A detailed literature review is attached as Appendix 5.

There appears to be very little reference to additional strategies or procedures in place to safeguard children from the possibility of them being further harmed by parents or caregivers. Examples such as security doors, having a 'minder' or person 'on watch' to supervise the child are not mentioned.

Research by David Southall, Michael Plunkett, Martin Banks, Adrian Falkov and Martin Samuels (1997) involving the use of covert video surveillance to monitor the parent's behaviour towards the child (when considered to be at high risk of further abuse by that parent while in hospital) is relevant to this investigation, but mostly in the sense of the issues the findings raise. These issues include the 'rule of optimism' in terms of professional practice and associated with this, professionals working with the family believing that apparently caring and cooperative parents can also abuse their children.

In New Zealand, some of the District Health Boards use closed circuit television in the children's ward. Since the incident in Whangarei Hospital, closed circuit television has been introduced as a safety measure. Closed circuit television was in place in Nelson Hospital before the incident. The hospital advises the equipment provides a monitoring capability only. In both places, parents are notified and informed of its use. There are also draft guidelines (dated 1998) about the use of closed circuit television in District Health Boards in New Zealand.

In the United States, it appears that the safety and supervision of the child rests with the hospital that has the legal custody of the child. This is unless the child, at admission, is already in the custody of the Department of Child Services, and if so, it remains their responsibility to safeguard the child and arrange supervision.

In the United States, United Kingdom and Australia, there are legal safeguards and orders available if there are concerns that the child might be removed from the hospital or the parent may harm the child, just as there is in New Zealand. There is no mention in any of the overseas research of additional safety procedures within the children's ward to safeguard a child admitted with suspected non-accidental injury from possible further abuse.

5.1 Discussion

It is the child's right to be protected from abuse, and any minimisation during the process of assessment by professionals working with the child and family, can easily place the child at further risk. Until the perpetrator is identified, caution must prevail in terms of who has access to the child and in order to fully safeguard the child, legal orders, in the Commissioner's view, are required. The child's right to safety should always be paramount.

There has been wide-ranging discussion around parental authority versus the child's rights to safety and protection. A mind shift is required which makes the child the primary focus, especially in respect of the family-centred approach adopted in children's wards throughout New Zealand. Not all children are safe in their families. These children have the right to be protected by the State.

This investigation has highlighted the confusion around who has the responsibility for carrying out the 'custodial' role when a child has been hospitalised with suspected non-accidental injury.

It is clear that the hospital is responsible for the general medical care for the injured child and in doing so, to provide a certain level of safety. The hospital's role is to provide the medical care and assistance for the child. They are not 'custodians'.

If, and when, the Department of Child, Youth and Family Services are granted legal custody of the child, they assume the authority to ensure that appropriate supervision of the child is provided. They also assume a duty of care for the injured child.

Unfortunately our investigation has shown that a number of influences can impact on this responsibility.

5.2 Rule of Optimism

Dingwall, Eekelaar and Murray (1983) from the United Kingdom developed the notion of a 'rule of optimism' in order to explain how social workers, on occasion, reduced, minimised or removed concerns for a child's welfare or safety, by taking an overly positive interpretation of the family's ability to provide appropriate care and protection.

The rule of optimism also known as 'natural love' was based on the societal premise that all parents 'love' their children. Given this perspective, Dingwall et al believed that social workers viewed, interpreted and made their decisions regarding child abuse based on the assumption of this natural love. This positive assumption about the nature of the parent-child relationship held such power that any investigation to identify incontrovertible proof of child abuse can become extremely difficult to prove.

The rule of optimism was only discounted when parents refused to cooperate with social workers and rejected their help; or if parents no longer seemed able to contain/control the social worker; or when more social workers became involved with the family and the need for a more statutory response became too great.

A paediatric consultant at Starship Hospital in Auckland, reports that in their experience, where there is non-accidental injury or children at risk of abuse, there are layers of issues to be considered and resolved. The paediatric consultant reports that in his opinion, there have been occasions when the Department of Child, Youth and Family Services social workers have not valued the diagnosis given by the paediatrician.

As evidenced in this report, social workers can operate in a culture that seeks overwhelming evidence of abuse before any formal action is taken. The social worker in Case A, tried to find other 'reasons' for the harm the child had suffered such as the 18 month old sibling having caused the initial injury.

In the context of this investigation, due to the parents' plausibility and cooperation, the social workers and other professionals involved in both cases, appeared to have difficulty believing that the parents were responsible for the infants' injuries. The parents denied causing the injuries and attended to their baby whilst they were in hospital.

When the subsequent bruising on the baby's face and the suspected suffocation occurred in Case A, the father admitted what he had done and has since been convicted with child abuse charges. In Case B, although neither parent admitted to the suspected abuse, both parents have since been convicted of child abuse charges.

Munro, (1999) assessed 'errors of reasoning' in child protection cases. Munro identified that professionals were slow to revise their opinions of families even when faced with evidence to the contrary. The family's outward appearance and situation was given a high priority and the more 'respectable' they appeared the less likely they were presumed to be 'abusers'.

Morrison, (1995) when identifying 'professional dangerousness,' highlights the manner in which practitioners may collude with parents and the system through their interactions with families. According to Morrison, in examining some of the deaths of children in the United Kingdom social workers failed to be sufficiently "suspicious of the manipulative acts of abusing parents" (p. 11). He points out that social workers tend to see the 'family' at times as the client, rather than the identification of the child themselves as the most vulnerable member of the family. Minimisation of the child's needs and experiences in this way, places them further at risk. Morrison states "the shared fantasy is the illusion of change, when in reality, a dangerous equilibrium is being maintained that satisfies the covert needs of both professionals and the family" (p. 25).

In respect of keeping children safe in New Zealand, it is the view of the Children's Commissioner that there needs to be a mechanism in place to challenge this rule of optimism and tendency by professionals to use this to explain injuries. In order to overcome this, agencies need to have clear lines of communication and be willing to accept that the abuse of children by parents and caregivers is always a possibility.

5.3 Duty of Care

The law imposes a 'duty of care', or in other words, an obligation to take reasonable care in the conduct of an activity or business in a number of contexts. Most commonly, a duty of care arises in contractual relationships; where one party is obliged to carry out duties for others (for example, because of statutory obligations), or where one party provides services to others. Case law has already established that the Department of Child, Youth and Family Services and/or District Health Boards owe a duty of care to any person in their care or custody.

In this situation, both the District Health Boards and the Department of Child, Youth and Family Services acknowledge that they owe a duty of care to children admitted to hospitals in the circumstances set out below.

The District Health Boards owe a duty of care to provide children (and other patients) with a professional standard of medical care. They also acknowledge that they owe a duty of care to keep children safe in hospitals, when they suspect a non-accidental injury.

From acceptance of a notification, the Department of Child, Youth and Family Services has a duty of care to take appropriate steps to investigate the facts and protect children who have been admitted to hospital with suspected or actual non-accidental injury. The exact steps required will differ, depending on the facts of the case. One of the obligations, however, will be to consider and make appropriate use of the statutory powers available to protect children.

5.4 Legal Protections

On receipt of a notification that a child is in need of care and protection, a Department of Child, Youth and Family Services social worker's responses and actions must be guided by the Children, Young Persons and their Families Act 1989 (the Act). The Act requires that in all matters affecting children, the rights, welfare and interests of the child must be paramount (s6).

This investigation has highlighted the necessity for legal action to be considered and taken when infants and children are admitted to hospital with non-accidental injury and the perpetrator is unknown. In taking this action, it is then clear for all those involved as to who has ultimate responsibility for the child and their safety.

Trapski's Family Law, (Vol 1, 1-257) states that "the power to protect children must be exercised in a responsible way, on a proper basis, and after full and informed consideration of all relevant facts".

The paediatricians attending to the children in Whangarei and Nelson identified very early into the investigation that, in their opinion, the injuries were not caused by any accident, but had been inflicted on them. Both hospitals sought 'second opinions' on their diagnoses, in order to rule out any other possibilities.

In terms of the paramouncy principle, there is a requirement that if a doctor has formed the belief that a child's injuries are highly likely to be the result of a non-accidental injury, and in conjunction with information gathered by the social worker in their investigation, this will be grounds enough for a social worker to seek warrant action.

This will ensure a clear message that the child's right to safety is the primary concern. This effectively means the child cannot be removed from hospital and that decisions about who can have access to the child no longer lie with the parents but with the social worker and the court.

Custody, in the context of this investigation and according to the Children, Young Persons and Their Families Act is defined as the "right to possession and care of a child or young person" (s2, Children, Young Persons and their Families Act 1989).

5.5 Section 39 – Place of Safety Warrants

For the Department of Child, Youth and Family Services or the Police to be able to remove, or detain a child, the authority of a Place of Safety Warrant is required in most cases. The warrant gives a social worker the power to remove or detain a child and to place them in the custody of the Chief Executive for no longer than five days.

A place of safety warrant can be applied for when a social worker or Police officer is satisfied that there are *reasonable grounds to suspect* that a child or young person is suffering or is likely to suffer ill treatment, neglect, abuse or harm (s39.1).

A Family Court Judge, a District Court Judge if the Family Court Judge is not available, or a court registrar only can grant the warrant. They must be satisfied that there are reasonable grounds to suspect abuse when considering and granting a warrant.

Before the warrant can be applied for by a social worker, they must have considered and determined a number of key issues relevant to the investigation such as the child's immediate safety, past knowledge of family, other concerns such as family violence and so on.

5.6 Custody Effects of a Place of Safety Warrant

A warrant is only valid for five (consecutive) days by which time:

- The child must be returned to those having the care previously, in which case a report must be forwarded to the Children's Commissioner advising the reasons for return; or
- the matter must have been taken to court to seek further orders, such as interim custody order, restraining orders; or
- in rare circumstances, an extension of time can be sought from the Court (s45).

Section 39 does refer specifically to the situation of a child in a hospital. In that circumstance, the police or social worker authorised by the warrant may direct the medical superintendent of a hospital in which a child is detained, to keep that child in that hospital (s39 (2)(3)(b)(ii)). Where a child is directed to be in hospital, the child is deemed to be in the custody of the Chief Executive of the Department of Child, Youth and Family Services (s39(4)).

The Place of Safety Warrant immediately invokes suspension of access for the parents. The Act clearly states that a parent or guardian will have no access to a child in the custody of the Chief Executive under a Place of Safety Warrant, unless access is granted by the Family Court (s44). This allows added protections for the safety of the child. If the child is removed unlawfully, the perpetrator can be imprisoned for up to three (3) months (s446). The parents can also face severe consequences if access is breached.

5.7 Section 139 Temporary Care Agreement

In carrying out this investigation, it has been found that the practice in some areas of the country, has been that where the hospital and the Department of Child, Youth and Family Services have serious concerns for a child, the parents or caregivers are requested to sign a section 139 Temporary Care Agreement to enable the Department to gain custody of the child in hospital.

In the Children, Young Persons and their Families Act 1989, a Temporary Care Agreement provides for a short-term or respite period of care for a child or young person whose parent or caregiver "is temporarily unable or unwilling to care for the child…" (s139 (1)).

A Temporary Care Agreement is an agreement between the parents and the Department of Child, Youth and Family Services and does not involve the court.

The Children's Commissioner does not recommend the use of a Temporary Care Agreement where a child presents with a suspected non-accidental injury and the perpetrator is unknown. This agreement is only temporary, time-limited and informal and provides little legal safety for the child. It deals with custody, but not necessarily access. This Agreement does not give the family the clear message that the Department is focussed primarily on the needs of the child and is removing legal responsibility from the parents. Further, the legal status of such an agreement is less clear. The penalty provisions do not apply if there is a breach.

In the view of the Children's Commissioner, in these circumstances the signing of a Temporary Care Agreement may not amount to informed consent, as neither party requires any legal assistance in making this agreement. In fact, it could be argued the consent is obtained under an implied threat of a formal care order.

A Temporary Care Agreement should not be used where there are serious ongoing care or protection concerns or where it is not expected that a child will return home at the expiry of the agreement.

5.8 Custody Effects of a Temporary Care Agreement

The Department of Child, Youth and Family Services policy states that the Temporary Care Agreement gives a social worker the same powers and responsibilities under a Temporary Care Agreement as if the Court had made a custody order in favour of the Chief Executive under section 101 of the Children, Young Persons and Their Families Act 1989.

Briefly, this means that the Department has the power to place the child with family/whanau, an approved Department of Child, Youth and Family Services caregiver or in a Departmental residence. The Department of Child, Youth and Family Services can change the placement and can uplift the child from the person having the care without a warrant. The agreement does not generally affect a guardian's rights.

Families/whanau must fully understand the effects of the agreement and the requirements for terminating the agreement. Practice and policy guidelines for the Department of Child, Youth and Family Services state that either party may terminate this agreement but a minimum of 72 hours notice is recommended. It must be stressed that this termination clause is a practice/policy guideline used by the Department of Child, Youth and Family Services only.

It is not known whether the use of a Temporary Care Agreement has ever been challenged in a court of law. It is the Commissioner's view that authority must be vested in someone other than the parent/s when a situation is clearly a suspected non-accidental injury. The Temporary Care Agreement does not provide this.

5.9 Section 78 Interim Custody Order and Other Orders

The Children, Young Persons and their Families Act 1989, contains provisions which can ensure the immediate protection and safety of a child pending the determination of a declaration that a child is in need of care and protection (s67).

Interim Custody Orders (s78) in favour of the Chief Executive can be sought when it is necessary to address the safety and protection of a child *in an urgent situation*. Subsequent orders such as interim restraining orders (s88), interim services order (s86A) and interim support orders (s92) can also be applied for at that time.

5.10 Resources and Funding

In the 'Breaking the Cycle' interagency protocols (1996) and the more recent Starship Hospital Model, responsibility for the provision of resourcing of children who have been admitted to hospital, is discussed. It would appear that children who are already in the care and custody of the Department of Child, Youth and Family Services as a result of abuse, will be resourced and funded by them.

If the child is already in the care and custody of the Department of Child, Youth and Family Services at the time of admission to hospital and the admission is for reasons *other than child abuse*, the Department will pay for supervised access if it has previously been deemed necessary.

The National Office of the Department of Child, Youth and Family Services is at present looking into a national protocol in which issues of responsibility for resourcing and funding will be clarified.

It is the view of the Children's Commissioner that once a non-accidental injury has been confirmed by the hospital, and the Department of Child, Youth and Family Services has taken warrant action to secure the child's legal safety, then clearly responsibility lies with the Department of Child, Youth and Family Services for determining costs and resources required to keep the child safe.

Whatever decisions are made these must be based on the child's needs, their safety and protection and the fact that these are paramount.

5.11 Communication Between Agencies

This investigation identifies similar practice failures as have been highlighted in other reports released by the Children's Commissioner, such as the ability of agencies to work effectively together.

In case B, the Department of Child, Youth and Family Services, Police and hospital worked cooperatively as set out in child abuse protocol (which existed at the time).

However, this was not so in Case A, where the Department of Child, Youth and Family Services worked in isolation from hospital staff and other agencies involved, which placed the child at even further risk.

In June 2000, the Commissioner for Children's report into the death of a child stated:

"The Department of Child, Youth and Family Services has, over time, been the focus of public and professional anger and criticism about children who are killed or harmed by abuse and neglect.

Whilst it is true that this agency has the statutory responsibility to administer the Children, Young Persons and Their Families Act, it is recognised by many that the agency is only one part of the wider care and protection system which should respond to children who are abused or neglected.

A strong care and protection system is evidenced by three main factors:

- *There ought to be a strong working relationship between all agencies involved with children, both government and non-government so that crucial information is shared.*
- *There ought to be high levels of community and professional knowledge about care and protection, so that child abuse is recognised and reported appropriately*
- *There ought to be fundamental and operational adherence to the care and protection legislation and clear, strong links between the policies and practices of other jurisdictions, so that in all matters the best interests of the child are of paramount concern (p.25)."*

While there have been some improvements in the manner in which agencies respond to cases such as these, it is of concern that this investigation carried out in 2005, continues to identify similar practice issues which were evident in the June 2000 investigation.

6 Best Practice Model

As part of the investigation, the key agencies involved, that is, the Department of Child, Youth and Family Services, the Police and the District Health Boards in Nelson and Whangarei, were asked about a best practice model and what would their vision of a 'best practice model' be.

The following ideas and solutions were suggested:

1. Communication was emphasised as vital between key agencies.
2. Safety of the child is emphasised as a priority.
3. A formal briefing meeting is held within 24 hours (or as soon as practicable) between the Department of Child, Youth and Family Services, the Hospital and the Police to confirm each other's roles and establish a plan to investigate the situation.
4. In order to safeguard the child while an investigation is underway, a section 39 Place of Safety Warrant (or section 42) should be sought by the Department of Child, Youth and Family Services or the Police.
5. Parents and family are interviewed within 24 hours by the Department of Child, Youth and Family Services and the Police and the process is explained to them clearly and in a way that is understood.
6. Arrangements for supervised access, where appropriate, are put in place for parents and family.
7. Key agencies need to have clearly defined roles and responsibilities and good working relationships.
8. Each agency needs to understand the 'essence' of each other's roles e.g. nurses and social workers, so that 'boundaries' do not become blurred or crossed.
9. A flow chart of procedures relevant to non-accidental injury exists in each agency and is clearly visible to all staff.
10. A liaison person/social worker (Department of Child, Youth and Family Services) to liaise between the Department of Child, Youth and Family Services, the hospital and the Police and attend Child Protection Team meetings.
11. There are training programmes for staff in key agencies to cover topics such as identifying abuse, defining each other's roles, and how to deal with parents in these circumstances.
12. A Child Protection Team is established to meet regularly to discuss issues or cases
13. A case conferencing approach is adopted for immediate care and protection cases.

7 Recommendations

As a result of an investigation into the safety of children who have been hospitalised for a suspected non-accidental injury, the perpetrator is unknown and who have been subsequently further harmed, the Commissioner recommends the adoption of the following:

1. That in every instance of an admission for suspected non-accidental injury, the hospital notifies the Department of Child, Youth and Family Services and the Police.
2. That in all cases where a child is hospitalised as a result of suspected non-accidental injury and there is no clear indication as to who the perpetrator is, a Place of Safety Warrant is obtained by the Department of Child, Youth and Family Services. This does not preclude the Department from taking any other court action they may see fit, such as seeking a section 78 Interim Custody Order.
3. That the child is kept physically safe in the hospital through the adoption of security measures that protect the child 24 hours a day every day from unscheduled or unsupervised access.

4. That there is a liaison social worker appointed in the Department of Child, Youth and Family Services whose role it is to liaise between the Department of Child, Youth and Family Services, Hospital and the Police.

5. That a multi-disciplinary team approach is adopted and that a formal meeting between the Department of Child, Youth and Family Services, the District Health Board and the Police (within 24 hours or as soon as is practicable) is held to discuss the situation, share information, and clarify roles and tasks.

6. That the multi-disciplinary team communicate collaboratively and effectively. Discussion must include issues such as supervision of the child, access arrangements and arrangements for payment of supervision costs.

7. That there be ongoing training of staff in all key agencies to up-skill staff on the recognition and management of child abuse; and to provide opportunities to openly discuss practice issues, examine attitudes particularly around the child's rights to safety and protection versus the parents rights to contact in these situations.

8. The National Office of the Department of Child, Youth and Family Services, the Police and the Ministry of Health formulate Memoranda of Understanding which clearly establish responsibilities, processes and procedures in every hospital.

9. If an occasion arises in the future where a child is further injured while in hospital, there shall be an investigation conducted by independent reviewers (to the case) to consider practice issues, identify any problem areas and, if necessary, revise or formulate protocols and/or guidelines to address those problem areas.

10. Any such investigations shall be reported to the Children's Commissioner, both at the outset of commencing the investigation, and at the conclusion of the investigation process.

Dr Cindy Kiro

Children's Commissioner

APPENDIX 1

TERMS OF REFERENCE

Objective:

1 (i) to determine what protocols are in place between District Health Boards, the Department of Child, Youth and Family Services and Police, that will ensure children are safe when they have been placed in hospital following allegations of abuse; and

(ii) to clarify who has responsibility for the safety and well being of the child at this time.

2 to identify guidelines, using examples of best practice, for an effective protocol that can be implemented in each District Health Board.

The review will include:

- A review of two recent incidents of children alleged to have been assaulted in hospital, to determine what took place, the effectiveness of the protocols between Department of Child, Youth and Family Services, District Health Board and Police at that time and any changes that have been implemented since then.
- An analysis of current protocols in place in each District Health Board.
- A review of overseas procedures to protect children in hospital.
- An analysis of best practice models, both nationally and internationally, in order for guidelines to be developed by the agencies concerned.
- A report to the Department of Child, Youth and Family Services, District Health Boards and Police on the findings of this investigation.

APPENDIX 2

The following Articles are taken from the United Nations Convention on the Rights of the Child, and are specific to this investigation.

ARTICLE 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.
3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

ARTICLE 4

States Parties shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognised in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

ARTICLE 6

1. States Parties recognise that every child has the inherent right to life.
2. States Parties shall ensure, to the maximum extent possible, the survival and development of the child.

ARTICLE 9

1. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.
2. In any proceedings pursuant to paragraph 1 of the present article, all interested parties shall be given an opportunity to participate in the proceedings and make their views known.
3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests.
4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the well-being of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

ARTICLE 19

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

ARTICLE 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own best interests cannot be allowed to remain in that environment, shall be entitled to special protection and assistance provided by the State.
2. States Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the desirability of continuity in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

ARTICLE 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers;

(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;

(f) To develop preventive health care, guidance for parents and family planning education and services.

3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

ARTICLE 25

States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

APPENDIX 3

Hospital Investigation

Questions for visits with the Department of Child, Youth and Family Services, District Health Board and the Police.

After the investigators introduced themselves, outlined the purpose of the investigation, and confirmed the Terms of Reference the following questions were asked, but were not limited to:

Q1 Request for their version of events. What happened?

Q2 What are the changes that have happened as a result of this incident? How is it different now? Do you feel children are safer as a result of these changes? What makes you think/feel that?

Q3 Are you aware of the Ministry of Health Intervention Guidelines for Child and Partner Abuse? Have you used these?

Q4 Does your area have a Child Protection Team? Is this working? Are roles clear? Are responsibilities clear?

Q5 Can you tell us who manages the parents when the diagnosis is a non-accidental injury?

Q6 What would be your vision of a Best Practice Model? What legal information could assist with this?

Q7 Is there anything further you wish to add/say?

APPENDIX 4

A description follows of protocols, policies and interagency guidelines which have existed since 1989, currently in use or are in the process of being modified to manage cases of child abuse and neglect.

CAT/SAT Protocol

With the advent of the Children, Young Persons and Their Families Act, 1989, and a number of procedural and legislative changes, protocols around the investigation and assessment of child abuse, were developed between the Department of Child, Youth and Family Services and the Police. The purpose being "to promote a consistent and effective interagency approach to the investigation of child sexual abuse and serious child physical abuse (Breaking the Cycle: Interagency Protocols for Child Abuse Management, 1996)".

CAT/SAT protocols are defined as:

- SAT refers to the Serious Abuse Team within the Department of Child, Youth and Family Services. Each Service Delivery Unit Manager throughout the country must ensure that each Unit establishes a SAT to meet its obligations under this protocol.
- CAT refers to the Child Abuse Team within Police. Police District Commanders must ensure that all districts establish CAT at appropriate locations in their district to meet their obligations under the protocol.

At a local level, these Teams determine the ways in which they will operate and who is to be involved. Regular meetings are meant to be held between the Teams to ensure that ongoing planning and review of investigations is carried out, and very importantly that interagency cooperation and communication is effective.

These protocols are vital in ensuring that when a notification is made to the Department of Child, Youth and Family Services or the Police about a child being sexually abused or seriously physically abused, that there is a process in place to assess the safety, care and protection of the child (Department of Child, Youth and Family Services responsibility); as well as to investigate the offence/s and where appropriate the prosecution of offenders (Police responsibility).

Ministry of Health (ex-Crown Health Enterprises) and Department of Child, Youth and Family Services Protocol

The national protocol agreed by Crown Health Enterprises and the Department of Child, Youth and Family Services and signed in 1996, is a negotiated document the purpose of which is to promote a consistent and comprehensive approach to the care and protection of children, particularly within a health/hospital setting.

The comprehensive protocol outlines the kaupapa/philosophy around the paramouncy principle (s6) of the Children, Young Persons and their Families Act 1989. It identifies the reporting protocol, the legal positions hospitals, etc are required to consider when working with children and families, investigation and management of the child in hospital.

In particular, the protocol discusses the issue of 'safety' for a child in hospital. The national protocol states that 'safety is the responsibility of the statutory agencies (the Department of Child, Youth and Family Services and the Police)'. An assessment of safety should be made in conjunction with approved Crown Health Enterprise staff.

The protocol states that it is important to 'remember that simply admitting a child to hospital does not ensure their safety'. A Flowchart is provided along with a Pre-Discharge List to be competed before a child is discharged. ('Breaking the Cycle': Interagency Protocols for Child Abuse Management, CYFS 1996: pp3.1)

Starship Hospital

The Starship Hospital protocol for managing cases of child abuse has become a model for other hospitals to follow throughout New Zealand. The focus of the Starship Hospital Model is primarily on the rights and interests of the child.

Starship Hospital protocol was based on:

> 'Breaking the Cycle': Interagency Protocols for Child Abuse Management' CYFS (1996) and 'An Interagency Guide to Child Abuse' CYFS (1997) (also referred to as 'Lets Stop Child Abuse Together' CYFS 2001)

The Guidelines are to be read in conjunction with the Auckland District Health Board policies on child abuse, bi-cultural policy, legal issues and informed consent.

The Starship Hospital Abuse and Neglect Policy has a special section on the safety of the child while in hospital, called 'Supervision of at-risk in patient children – inter agency guidelines'. These guidelines refer to children and young people who have probable or definite abuse. The objective of these guidelines are to provide efficient and clear instructions to staff about the management of supervised access and /or 24 hour supervised access of children and young people who are admitted to hospital and are felt to be at risk due to care and/or protection concerns.

The Starship Hospital policy states "admitting the child to hospital does not ensure the child's safety (it may temporarily reduce the risk)". In the case of probable and even definite abuse, at the time of admission it is usually not clear who has caused the injuries. The protocol currently advises that, "hospital staff do not have the statutory authority to prevent a child's removal from hospital, (except in extreme circumstances), nor to prevent the visit by suspected offenders".

The Department of Child, Youth and Family Services involvement with Starship Hospital

If child abuse is the clear diagnosis on admission to hospital, then the Department of Child, Youth and Family Services must be notified at once. The Department of Child, Youth and Family Services will treat this as a 'critical' referral. The Department of Child, Youth and Family Services have the statutory responsibility for the safety of the child and are the lead agency throughout any investigation. It is their responsibility to assess the safety of the child or young person and to ensure other children or young people are not at risk.

Hospital policy states that it is up to the Department of Child, Youth and Family Services to make arrangements to ensure that the child is only visited by adults who are likely to be safe. This may mean that they have to arrange supervision of the access by visitors. If the child is considered to be at risk, the hospital, in consultation with the Department of Child, Youth and Family Service may arrange for a Place of Safety Warrant.

In selected situations, Starship Hospital may provide a special nurse overnight in the role of 'watch' or 'minder' to supervise access. The nurse should receive clear written instructions on her role and record all observations on the Auckland District Health Board Watch Record Sheet. After the first 24 hours however, it is expected the Department of Child, Youth and Family Services will resource supervised access.

Policy further states that if child abuse is possible or probable (but not certain) it may be unsafe to admit the child and caregiver to the ward without some arrangement to ensure increased levels of supervision. Common practice is to place the child close to the nurse's station with an unobstructed view of the room. Family should be given reasons for increased supervision so as to encourage cooperation and working together in the interests of the child.

In the case of non-accidental injury, the direction from Starship Hospital is to contact the Department of Child, Youth and Family Services via the National Call Centre. However, if the Department of Child, Youth and Family Services cannot be contacted, they recommend directly calling the Police.

As well as being responsible for the safety of the child, it is the Department of Child, Youth and Family Services role to attend a case conference on the child's situation within 24 hrs of referral. At that meeting supervision of the child and access issues will be discussed and if supervision is required then the Department of Child, Youth and Family Services will arrange to pay for this. It is important in this protocol that the Department liaise with Starship Hospital staff at all times regarding the case, right to the point of discharge.

Police Involvement with Department of Child, Youth and Family Services and Starship Hospital

Starship Hospital policy states that when a child presents with any form of definite abuse or potentially fatal injuries, the Police must be notified along with the Department of Child, Youth and Family Services immediately.

This decision to involve the Police is made by the child's medical consultant after discussion with the charge nurse and social worker. Policy further states that in cases when the abuse is definite or highly probable it is important to involve the Police from the onset.

Even though the Police may not be able to interview family members at this stage, they can inspect the scene of the injury which may be critical to identifying who caused the injury. By agreement, the Police and the Department of Child, Youth and Family Services should notify each other of any cases of probable or definite child abuse.

ALERT System at Starship

Starship Hospital, as do other District Health Boards, have an ALERT signal on their computer system which alerts staff to any care and protection concerns for this child and their family in the past, and prompts a thorough assessment to ensure that indicators of abuse are not missed. This is available for any child up to the age of 17 years.

Ministry of Health Guidelines for Child and Partner Abuse (2002)

In response to community concerns around the apparent levels of domestic violence in the community and the safety of women and children, the Ministry of Health, in consultation with numerous government and non-government organisations and input from Maori and Pacific Island communities, created the 'Family Violence Intervention Guidelines: Child and Partner Abuse (2002)'.

The Department of Child, Youth and Family Services National Office endorsed the Guidelines, but this information does not appear to have been passed on to front line social workers. Neither the Department of Child, Youth and Family Services Whangarei or Kaitaia, nor the Department of Child, Youth and Family Services Nelson were aware of these Guidelines.

The document contains helpful information around the recognition of child and partner abuse, how hospitals and clinics must respond to suspected and/or actual child abuse or partner abuse, and the appropriate steps for practitioners to take when abuse is suspected. It also includes the points at which the Department of Child, Youth and Family Services and the Police must be contacted when there is suspected or actual abuse. It provides appropriate supports or agencies in the community, who may help individuals break the cycle of family violence.

Assessment of risk regarding children is classified under three categories if abuse or neglect is a possibility. For each of these categories there are clearly set down procedures for staff to follow:

- If the risk to the child is extreme, call Department of Child, Youth and Family Services or Police.
- If there is strong suspicion of abuse, refer to the Department of Child, Youth and Family Services for assessment and a safety plan to be devised by hospital, Department of Child, Youth and Family Services, Police and other agencies (multi disciplinary team).
- If the child is exposed to partner abuse but no threat to self, refer to appropriate services.

While this provides a model for identifying and protecting children from abuse or neglect, there is nothing specific in the guidelines about protecting children in hospital. The guidelines place the Department of Child, Youth and Family Services as responsible for the child's safety. If concerns for safety increase for the child, then the guidelines direct the Police to be involved. What is also significant in the guidelines is that as children are assessed so are the parents. There is clear evidence linking partner abuse with an increased risk of child abuse.

The guidelines identify various barriers, which may impede a more proactive response to family violence by healthcare providers. These include:

- Lack of comfort with the issues.
- Lack of comfort with training and information on the prevalence and impact of family violence.
- Lack of formal protocols and institutional support for responding.
- Perceived lack of time to address the problem.
- A lack of confidence in the referral agencies.

These barriers, in particular a lack of comfort with the issues, training needs and the lack of a formal protocol in place, have all been identified as issues of concern throughout this report.

APPENDIX 5

A Review of Overseas Literature and Research Into the Safety of Children in Hospitals

Most research located on the topic of safety of children in hospital when suspected of abuse, is in respect of video surveillance of children when the child is suspected of having Fabricated or Induced Illness. This is also known as Munchausen Syndrome by Proxy[2]. While the research into this, especially that completed by David Southall, Michael Plunkett, Martin Banks, Adrian Falkov, and Martin Samuels (1997) is relevant to this investigation in the sense of the issues it raises, there appears to be very little other research/literature on the safety or protection of children (with non-accidental injury) in hospital once they have been admitted.

Reference to protocol and policies regarding the management of child abuse and neglect cases for overseas hospitals, contain few guidelines on keeping the child safe from abuse once admitted to hospital. There are statutory procedures for extreme cases such as when there is concern the parent or caregiver may remove the child from the hospital, or harm the child or staff.

In New Jersey, in the United States of America, Connie Ryan and Irene Webber (n.d.) have prepared a manual titled 'Guidelines on the Management of Child Abuse and Neglect Cases in Hospitals.' The information in the manual is based on several sources of protocol and guidelines written and composed by other hospitals and departments in New Jersey.

The purpose of the manual is provide guidelines to assist medical and hospital staff meet their responsibility in identifying, treating and protecting victims of child abuse and neglect. In managing cases of child abuse and neglect, Ryan and Webber make the following points:

- Firstly that child abuse is a multi dimensional problem that requires a multi disciplinary team.
- In a hospital setting it requires the cooperative intervention of these three major disciplines: Department of Youth and Family Services; medical (physician, nurse and hospital social worker) and law enforcement (Police) services all working together.
- There should be a liaison person such as a social worker whose role it is to communicate between hospital and key

[2] Sometimes referred to as IIS (Illness Induced Syndrome) or FII (Fabricated and Induced Illness).

services, to include the police to ensure consistency and continuity in case management.

- Cases involving non-accidental injury should be given priority and handled immediately even if not a medical emergency.
- Children and parents are interviewed separately so that the child has the opportunity to say what happened.
- That parents are kept informed of the medical condition of the child, of the process taking place within the hospital to include any referrals to the Department of Youth and Family Services – to encourage cooperation and reduce hostility by parents or family while the assessment is being completed.
- Hospitalisation of the child with non-accidental injury may occur and/or if the parents are not cooperative.
- If there is any concern about the safety of the child in terms of the parent removing or harming them, then a Hospital Hold Warrant can be sought. This gives the hospital the protective custody of the child for up to three days but can be extended upon. Only a doctor or hospital administrator can initiate a Hospital Hold Warrant. The Department of Youth and Family Services are not able to but can recommend one.
- During this time the hospital has the responsibility of the child's safety. Visitation for the parents is granted at the discretion of the Child Abuse Team. When there is a difference of opinion the final decision rests with hospital since it has the legal custody of the child – unless the Department of Youth and Family Services has the custody prior to the child coming into hospital and then it is their decision.
- If abuse is confirmed, then the police have a clear role to perform but should continue to work with the Child Abuse Team.

These guidelines indicate that in the State of New Jersey, the responsibility for the child's safety when admitted with non-accidental injury is with the hospital.

While the Department of Youth and Family Services is involved immediately as part of the child abuse assessment, the role of the Department of Youth and Family Services social worker is very much delegated to the care of the child in the community and home situation. It is specifically their role to investigate, interview the child and parents (with the police), assess the home situation, consult with other professionals, and maybe file litigation with the Court.

Ryan and Webber (n.d.) raise the issue, of the importance of professionals believing that abuse may be a possibility when a child presents and that there are parents who can harm their child yet remain plausible.

This is referred to by Dingwall R, Eekelaar J and Murray T (1983) as the 'rule of optimism'. In the case of Fabricated and Induced Illness, he comments that excessive reliance on parents when they are lying is extremely dangerous. Further, it is imperative that the hospital and/or statutory organisation responsible for child protection take over the care of the child. Dingwall et al (1983) recommend that in these circumstances the case should be given priority and handled immediately even if not a medical emergency.

The research completed by David Southall et al (1997) involves children who were specially chosen for the study because they were considered highly at risk of apparent life threatening events (ALTE) in their parents company, and had all been previously diagnosed with Fabricated and Induced Illness.

Southall et al (1997) raises many issues relevant to this investigation. Firstly, the issue of using covert video surveillance as a tool to observe or monitor the parent's behaviour with the child. Covert video surveillance is a practical tool which Southall et al (1997) used in this study to detect abuse and monitor the safety of children being cared for by a parent while in hospital.

While both Southall et al (1997) and Colin Morley (1998) see covert video surveillance as a useful tool when there is reasonable concern for the child's safety, there are limitations and some ethical issues associated with its use which need

to be taken into account. For example, the rights of the parent being observed in a covert way and whether they are informed. In Southall`s et al (1997) study, parents were informed that they were being observed due to concerns about the child's physical health and the occurrence of apparent life threatening events the parents had all reported happening.

Morely (1998) notes that "if covert video surveillance is used for safety reasons in respect of the child, it is not an infringement of the child's rights". He also reports, that if covert video surveillance is used, it is important that there is someone monitoring the video full time (for safety reasons) and an alarm procedure in place so that the child is not unnecessarily further harmed. Both Southall et al (1997) and Morely (1998) conclude that covert video surveillance can be helpful in detecting abuse and/or detecting the identification of the abuser.

With cases of suspected abuse, Southall et al (1997) stressed the importance of "close and focused collaboration between health professionals, social workers, psychologists, and the police" in detecting abuse and making safe decisions for children. He further reports that this is particularly difficult with parents of Fabricated or Induced Illness children because they commonly lie and are deceitful over their child's medical well being. Southall et al (1997) comments that when parents fail to acknowledge that deceit, then the relationship between hospital staff and parents becomes fraught and one cannot rely or trust them (the parents) to protect the child.

Another important issue raised by Southall et al (1997) is the difficulty many health professionals, relatives and others have in accepting the possibility that parents would deliberately abuse their children. He further comments that in his experience with cases of Fabricated and Induced Illness, professionals and members of the judiciary who have not seen abuse in action (as shown by covert video surveillance) may be almost unable to acknowledge that such acts can be, and are, committed by apparently caring parents and stepparents. These parents present as caring and plausible yet when out of sight are doing harmful actions to their child. This can easily misguide staff who are working with the family.

Associated with this is also the tendency for some professionals to deny the possibility of abuse-as part of that disbelief (above) that parents could do this to their children. Connie Ryan and Irene Webber (n.d.) also comment on the issue of professional disbelief which when it occurs, is extremely undermining of the subsequent safety of the child.

Guidelines for dealing with child abuse and neglect, as documented in a manual titled, 'Identification and Reporting of Child Abuse, Neglect, Sexual Abuse, Adult Abuse and/or Victims of Violent Crime' (dated 2002) Vanderbilt University Hospital, Tennessee, in the United States, are generally similar to those recommended by Ryan and Webber. Policy in the manual complies with Tennessee law, and in that state it is mandatory to report any cases of child abuse or suspicions of abuse to the Department of Child and Family Services.

As Ryan and Webber's manual advocates, there is a Child Abuse Team within the hospital as well as a liaison social worker who liaises between the hospital and key services. The Child Abuse Team assesses and evaluates all cases of suspected abuse and provides guidelines for management of non-accidental injury. They also provide training to hospital staff and keep them up to date with protocol and policy on the management of child abuse as well as monitoring staff compliance to the policy.

Further, the Vanderbilt University Hospital manual, as indicated by Ryan and Webber, stipulates that the responsibility for the safety of the child remains with the hospital. The hospital can take the child into custody if there is a belief that returning the child to the parents may endanger the child's physical or mental health (but Department of Child Services must be notified).

A document called 'Working Together to Safeguard Children' published by the Department of Health (1999) in the United Kingdom sets out procedures which are used in respect of managing cases of child abuse and neglect.

Local authorities throughout the United Kingdom have what is referred to as an Area Child Protection Committee which consists of a designated team of professionals. Each Area Child Protection Committee provides an inter agency forum for agreeing how different services and professional groups should cooperate to safeguard children where abuse has occurred

or is suspected, and in making sure there are good outcomes for children.

National Health Trusts and Primary Care Group Trusts have over all responsibility for services to children and parents in hospitals. Each hospital has a child protection officer whose role it is to inform and train all staff in the hospital about child abuse procedures and protocol. Each National Health Trust and Primary Care Group Trust is recommended to nominate a doctor, nurse or midwife to take the professional lead within the trust on child protection matters, which include non-accidental injury. Their role incorporates being an important source of advice and expertise to other professional agencies involved such as the Department of Social Services.

This document strongly supports a multi disciplinary approach to managing cases of child abuse and neglect effectively and also stresses the importance of professionals being always 'alert' to the possibility of child abuse or neglect with children presenting to the hospital. Staff should be thoroughly informed and confident of procedures to follow in such cases and open to believing parents who appear caring and cooperative may also have caused the injury to the child.

It is interesting to note that in the United Kingdom there is a child protection register available at each Local Authority which enables 'at risk' children to be readily identified by the hospital or medical practices within that area. It also states if children from the same house hold present frequently with even minor injuries, then staff should act on any concerns in accordance with protocol. In practice this means informing the Primary Care Group Trust and any other professionals involved such as the school nurse or GP.

Like New Zealand, there are various legal orders which can be obtained by authorities or agencies if a child is at risk or that serious harm may happen to that child. These include, an Exclusion Order under the Family Law Act 1996; an 'Emergency Protection Order under s.44 of the Children's Act 1989 and a Police Protection Powers Order under s.44 of the Children's Act 1989.

The importance of professionals working collaboratively and effectively in the United Kingdom has been emphasized by Reder, P., Duncan, S. and Gray, M. (1993) in 'Beyond Blame: Child Abuse Tragedies Re-visited.' Their research highlights the need for professionals to have appropriate boundaries, to have a key or lead worker, and to be clear about their own and others roles in order to foster a transparent exchange of information between them.

The World Medical Association (1995) offers guidelines on the management of child abuse cases. General guidelines set down are very similar to those in New Zealand and other overseas countries (referred to above). The World Medical Association emphasises the importance of the role of the first physician who admits the child in having the initial responsibility of diagnosing possible non-accidental injury. Physicians must "support enactment of legislation which will effectively identify and protect abused children" in all countries of the World (World Medical Association Statement on Child Abuse and Neglect).

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