Australasian College
for Emergency Medicine

Child at risk

V4 P35

December 2024

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Document Review

Timeframe for review:	Every two years, or earlier if required
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Council of Advocacy, Practice and Partnerships
Document maintenance:	Department of Policy and Strategic Partnerships

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	July-2005	Approved by Council
V2	–	Content revised, approved
V3	Nov-2019	Content revised, approved
V4	Dec-2024	Content revised, approved

1. Purpose and scope

This policy relates to the issues of awareness, detection and management in the emergency department (ED) of children at risk of abuse or neglect.

The policy is applicable to EDs in Australia and Aotearoa New Zealand.

2. Acknowledgement

ACEM acknowledges that the legacy of colonialism and continuing systemic racism and cultural bias contributes to the disparity and disproportionate rates of first nations child removals from family and community.

In Australia, Aboriginal and Torres Strait Islander children are 11 times more likely to be placed in out-of-home care than non-Aboriginal and Torres Strait Islander children.[1]

In Aotearoa New Zealand Oranga Tamariki (Ministry for Children) has reported that tamariki (children) Māori are consistently more likely to be reported to Oranga Tamariki than non-tamariki Māori.[2]

To effectively identify a child at risk and intervene, ED staff need to ensure that their actions and decision making does not perpetuate stereotypes based on social determinants of health (for example, poverty is not bad parenting).

3. Definition

Abuse

The term abuse encompasses any form of coercion or control and is included here to extend the definition beyond physical and sexual violence. Exposure to family and/or domestic violence may put a child at risk.

Child/Tamariki

Child means any person under the age of eighteen (18) years as defined by the Convention on the Rights of the Child. [3]

Children at risk of abuse

Children at risk of abuse refers to children, tamariki and young people who have suffered or are likely to suffer as a result of an act of violence or neglect, or a failure of protection by an adult responsible for their care.

Emotional abuse

Emotional abuse refers to a parent or caregiver's inappropriate verbal or symbolic acts toward a child, or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability.

[1] Australian Institute of Health and Welfare (AIHW). Child protection Australia 2021–22 web report (catalogue number CWS 92). 2024 [accessed 19 September 2024] www.aihw.gov.au/getmedia/2cecbc62-8c65-4031-a6df-5fec9422b0cf/child-protection-australia-2021-22.pdf?v=20240516104741&inline=true

[2] Oranga Tamariki, ministry for Children. Disparities and disproportionality experience by tamariki Māori. [published 23 August 2023]. https://www.orangatamariki.govt.nz/about-us/research/our-research/report-on-disparities-and-disproportionality-experienced-by-tamariki-maori/

[3] Assembly UG. Convention on the Rights of the Child. United Nations, Treaty Series. 1989 Nov 20;1577(3):1-23.

Family and Domestic Violence and Abuse

There is no definition of family violence or domestic violence that is consistent across all jurisdictions. These terms are used interchangeably across the relevant laws in each State and Territory. This document uses the combined term family and domestic violence and abuse (FDVA) to refer to violence and abuse that occurs between people who have any family or domestic relationship.

Harm

Harm means any detrimental effect on a child's physical, psychological, or emotional wellbeing. Harm may be caused by financial, physical, or emotional abuse, neglect and/or sexual abuse or exploitation whether intended or unintended.

Ill-treatment

Ill treatment means disciplining or correcting a child in an unreasonable and seriously inappropriate or improper manner; making excessive and/or degrading demands of a child; hostile use of force towards a child; and/or a pattern of hostile or unreasonable and seriously inappropriate degrading comments or behaviour towards a child.

Neglect

Neglect means the failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted as being essential for their physical and emotional development and wellbeing.

Parent/guardian

Parent/guardian means the person that holds legal responsibility for a child or young person. ACEM acknowledges that caregivers, whānau, and extended family members who do not hold the legal responsibility for a child or young person may accompany the child or young person to the ED.

Physical abuse

Physical abuse means the use of physical force against a child that results in harm to the child.

Sexual abuse

Sexual abuse means the use of a child for sexual gratification by an adult or significantly older child or adolescent.

Social determinants of health

Social determinants of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.

Trauma-informed practice

Trauma informed practice considers trauma (broad psychological and neurobiological effects of an event, or series of events, that produces experiences of overwhelming fear, stress, helplessness, or horror) in all aspects of healthcare. It does not necessarily require health professionals to elicit disclosures of trauma; rather, it requires recognition of the lived experiences of individuals and awareness of triggers which can lead to re-traumatisation and that efforts are made to minimise re-traumatisation.

Young person

The United Nations defines young people as those people between the ages of 15 and 24 years. [4]

[4] United Nations. World Program of Action for Youth. 1995. Division for Inclusive Social Development

4. Policy

4.1 ED clinicians should always consider the possibility of child abuse and neglect when evaluating paediatric patients, and children accompanying adult patients, especially those who present with injury, failure to thrive or behavioural problems. They should also be aware that children at risk may present with a wide range of complaints and can be subject to more than one type of maltreatment.

4.2 Failure to consider the possibility of abuse and neglect when appropriate may result in a child being returned to an abusive or unsafe environment. Vulnerable children and young persons should not be discharged from the ED until their safety can be ensured. However, clinicians should be mindful that chronic risk does not always signal an immediate risk of harm.

4.2.1 The medical evaluation of children who are suspected of having been abused should be performed by clinicians skilled in both paediatrics or paediatric emergency medicine and child abuse evaluation.

4.2.2 Health care cannot be clinically safe, unless it is also culturally safe. Health services should provide staff with explicit and rigorous training in anti-racism and provide systems to support clinicians to provide culturally safe care.

4.3 ED clinicians should have completed appropriate training on child protection, family violence and cultural safety and possess the skills necessary to identify, report and manage concerns appropriately.

5. Procedure and actions

5.1 Hospital responsibilities

Hospitals will:

5.1.1 Advocate for and participate in interdisciplinary approaches to child protection that include protocols and policies for identification, assessment, reporting, trauma-informed care and intervention. In doing so, hospitals will recognise that child abuse and neglect is a complex problem, and more than one type of treatment or service may be needed to support children and their whānau, family and carers.

5.1.2 Ensure that staff are educated in the detection and evaluation of children at risk of abuse or neglect, and that staff are aware of the legal requirements and whether mandatory reporting is required in their jurisdiction, including what constitutes 'reasonable grounds' for reporting a concern. A referral and notification system must exist, that is compliant with legal/regional guidelines, and staff must be mandated to refer actual or suspected abuse or neglect via this system.

5.1.3 Set and maintain documentation standards for clinicians recording and documenting concerns, and allow clinicians protected time and adequate resources to undertake this important clinical work

5.1.4 Provide staff with appropriate access to advice on difficult situations involving consent, confidentiality and sharing of medical information, to cover ethical and legal matters appropriate to the ED environment and jurisdictional laws.

5.1.5 Ensure quality improvement processes are in place to identify opportunities for learning and improvement.

5.2 ED responsibilities

EDs will:

5.2.1 Provide frequent in-house collaborative training for all clinicians to increase the capacity to identify, report and manage children at risk of abuse, neglect or family and domestic violence.

5.2.2 Provide appropriate care for victims of abuse or neglect based on legislation, local protocols and referral patterns, and provide appropriate educational resources.

5.2.3 Implement systems that facilitate appropriate documentation and reporting of all suspected cases of child abuse or neglect, including systems that identify children attending frequently and those with known child at risk status.

5.2.4 Increase vigilance by encouraging all clinicians to actively look for and be open to the possibility that a paediatric patient or the child of an adult patient may be at the risk of abuse, neglect or family and domestic violence and by actively educating staff to be aware of the variable presentations that indicate a child of abuse or neglect.

5.2.5 Encourage and actively seek frequent interdisciplinary communication with local child protection authorities, other EDs and interested groups, to create a multilevel information exchange around process, feedback, outcomes and advice.

5.2.6 Ensure patients and their whānau, family and/or carers are treated in a culturally appropriate and sensitive manner, seeking support from First Nations Health Officer /Aboriginal Hospital Liaison Officers / Māori Liaison Officers where possible. If language barriers exist; an interpreter must be used. Care should be taken if the interpreter is from the same community as the child, to safeguard against privacy concerns.

5.3 Clinicians

Emergency medicine clinicians will:

5.3.1 Be vigilant in considering the possibility of child abuse, neglect or family and domestic violence.

5.3.2 Maintain professional education and knowledge of local processes and procedures to support child protection.

5.3.3 Ensure documentation includes appropriate language and be aware that clinical notes may form part of future legal processes.

5.3.4 Provide trauma informed care and avoid negative stereotyping and consider the cultural and spiritual needs of children, young people and their families.

6. Related documents

- Australasian College for Emergency Medicine. *Hospital emergency department services for children and young persons*. Melbourne: ACEM; 2019.
- Australasian College for Emergency Medicine. Quality Standards Toolkit. Melbourne: ACEM.
- Australasian Health Infrastructure Alliance. Australasian Health Facility Guidelines. Part B – Health Facility Briefing and Planning. HPU 300 Emergency Unit. Revision 7.0. Sydney: AIHA; 2016.
- Children's Hospitals Australasia (CHA) and the Paediatric Society of New Zealand. Charter of Tamariki/Children's and Rangatahi/Young People's rights in Health Services in Aotearoa New Zealand. A consensus statement by Children's Hospitals Australasia (CHA) and the Paediatric Society of New Zealand. https://www.cdhb.health.nz/wp-content/uploads/6ae48470-charter-on-the-rights-of-tamariki.pdf
- International Federation for Emergency Medicine. Standards of Care for Children in Emergency Departments. Melbourne: IEMC; 2019.
- National Safety and Quality Health Service Standards (NSQHS). Guide for Acute and Community Health Service Organisations that Provide Care for Children. Sydney: NSQHS; 2018.
- Starship Clinical Guidelines. *Abuse and neglect*. Auckland: Starship; 2016.
- Royal Australian College of Physicians. Standards for the Care of Children and Adolescents in Health Services. Sydney: RACP; 2008.
- The Royal Children's Hospital Clinical Practice Guidelines. Child abuse: additional resources. Melbourne: RCH; https://www.rch.org.au/clinicalguide/guideline_index/Child_abuse__Additional_resources/

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