Australasian College
for Emergency Medicine

Child at risk

Policy P35

v3.0 December 2019
acem.org.au

Document review

Timeframe for review:	every three 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
1.0	July 2005	Approved by Council
2.0	-	Content revised, approved
3.0	November 2019	Content revised, approved

Related documents

Royal Australian College of Physicians. *Standards for the Care of Children and Adolescents in Health Services*. RACP, Sydney, 2008.

Australasian College for Emergency Medicine. *Emergency Department Design Guidelines*. ACEM, Melbourne.

International Federation for Emergency Medicine. *Standards of Care for Children in Emergency Departments*. IEMC, Melbourne, 2019.

Australasian Health Infrastructure Alliance. *Australasian Health Facility Guidelines. Part B – Health Facility Briefing and Planning. HPU 300 Emergency Unit. Revision 7.0*. AIHA, Sydney, 2019.

1. Purpose and scope

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

'Children at risk of abuse' refers to children 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.

The Policy is applicable to emergency departments in Australia and New Zealand.

Note: The legal definition of each varies between jurisdictions across Australia and New Zealand but 'child' is considered under the age of 14-16, and 'young person' is considered under the ages of 17-18.

2. Policy

Emergency departments play an important role in identifying, reporting and managing children at risk of abuse. They are frequently the first place where children who have been exposed to physical abuse, emotional abuse, sexual abuse or neglect come into contact with health services.

a Failure to consider the possibility of abuse when appropriate will result in the child being returned to an abusive environment without any protection. Vulnerable children and young persons should not be discharged from the ED until a place of safety is identified.

b Emergency department clinicians should always consider child abuse as a possible differential diagnosis when evaluating paediatric patients 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.

c 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.

d Emergency department clinicians managing victims of family violence should be aware that children in the care of such a victim may be at risk, and that all family violence interventions must have a child protection perspective.

Emergency department clinicians should possess the skills necessary to identify, report and manage potential cases appropriately.

3. Procedure and actions

3.1 Emergency departments

Emergency departments will:

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

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

c 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.

d 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 or neglect, and by actively educating staff to be aware of the variable presentations that indicate a child of abuse or neglect.

e 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.

f Ensure patients are managed in a culturally appropriate and sensitive manner; if language barriers exist, an interpreter must be used in safeguarding cases. Care should be taken if the interpreter is from the same community as the child, to safeguard against privacy concerns.

3.2 Hospitals

Hospitals will:

a Advocate for and participate in interdisciplinary approaches to child abuse that include protocols for identification, assessment, reporting 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 help abused children and their families.

b 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 of mandatory reporting in their jurisdiction, including what constitutes 'reasonable grounds' for reporting a concern. A referral and notification system must exist, which is compliant with legal/regional guidelines, and staff must be mandated to refer actual or suspected abuse or neglect via this system.

c 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 the state/country's laws.

3.3 ACEM

ACEM will include education and evaluation around child abuse and neglect in its examinable curriculum.

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