Department of Health Government of Nunavut	NURSING POLICY, PROCEDURE AND PROTOCOLS **Community Health Nursing**	
TITLE:	**SECTION:**	**POLICY NUMBER:**
Child Welfare Policy	Communications	06-016-00
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APPLIES TO:		
Registered Nurses (RN); Licenced Practical Nurses (LPN); Registered Psychiatric Nurses (RPN); Nurse Practitioners (NP); Registered Midwives (RM); Mental Health Consultants; Advanced Care Paramedics (ACP); Primary Care Paramedics (PCP)		

1. BACKGROUND:

The Child and Family Service's Act (CFSA) is the legislative authority for child protection in Nunavut. Its fundamental guiding principle is the safety and well-being of children and youth. Decisions concerning child welfare should be made in accordance with the best interests of the child, with a recognition that differing cultural values and practices must be respected (Government of Nunavut, Consolidation date: 2021). Health Care Providers (HCP) working in remote and isolated Indigenous communities should be aware of the on-going legacy of colonialism and systemic racism and how this relates to the overrepresentation of Indigenous children and youth in child maltreatment investigations.

The CFSA contains the Duty to Report a child needing protection: "A person who has information or reasonable grounds to believe that a child needs protection shall, without delay, report the matter (a) to a Child Protection Worker; or (b) if a Child Protection Worker is not available, to a peace officer or an authorized person."

In keeping with the values of Pijitsirniq (serving and providing for family or community, or both); Qanuqtuurniq (being innovative and resourceful); Piliriqatigiiniq or Ikajuqtigiinniq (working together for a common cause); Aajiiqatigiinniq (decision making through discussion and consensus); Inuuqatigiitsiarniq (respecting others, relationships and caring for people); and Tunnganarniq (Fostering good spirit by being open welcoming and inclusive), The Department of Health (Health) provides the following policy and guideline in alignment with the Child and Family Services Act and Surusinut Ikajuqtigiit in matters relating to child protection.

2. POLICY:

Mandatory Reporting for Patients Under the Age of 16

2.1. A healthcare provider (HCP) who believes, on reasonable grounds, that a child (defined as less than 16 years old) has suffered or is at risk of suffering abuse or neglect, must report their concerns to a Community Social Services Worker (CSSW) on call as soon as safely possible. Refer to **Appendix A: Circumstances which Require Reporting to Family Services.**

2.1.1 If the CSSW is unreachable, the HCP will report their concerns to RCMP.

2.2. Mandatory reporting is required for any known sexual contact outside the age of consent for sexual activity in a child under the age of 16 (Refer to Table 1.).

Voluntary (not compulsory) Reporting Family Services for Patients Aged of 16-18

2.3. There is no mandatory reporting to family services for youth (defined as 16-18 years old).

However, a HCP who believes, on reasonable grounds, that a youth who has suffered or is at risk of suffering abuse or neglect, may voluntarily report to CSSW at the discretion or if:

- Under the care of Family Services (i.e. due to an intellectual disability);
- The suspected perpetrator is the legal guardian, or
- Any known sexual contact outside the age of consent (Refer to Table 1.). A 16-18 year old cannot consent if the partner is in a position of power, trust or authority or the SA Survivor is in a relationship of dependency on that person.
- The youth does not meet the criteria to be considered a mature minor and requires medial treatment, but the legal guardian is refusing to provide consent.

Table 1. Age of Consent for sexual activity: According to the Criminal Code of Canada, consent to sexual activity is based on the age of a person and the age of the partner (applies to both males and females)

Under the age of 12	No consent is possible
12 – 13 years old	Consent possible if partner less than 2 years older and there is no relationship of trust, authority or dependency or any other exploitation of the young person.
14 – 15 years old	Consent possible if partner is less than 5 years older and there is no relationship of trust, authority or dependency or any other exploitation of the young person.
16 – 18 years old	Consent is possible with anyone older unless the partner is in a position of power, trust or authority or the SA survivor is in a relationship of dependency on that

2.4. Duty to report is a personal obligation and cannot be delegated to another individual.

3. PRINCIPLES:

3.1. Children and youth are entitled to protection from abuse, harm, and neglect as well as the threat of abuse, harm, and neglect.

3.2. Under the CFSA no action will be taken against any Health employee for reporting information in accordance with said act unless the report is done with malicious intent.

3.3. The HCPs are not required to prove abuse or neglect. This will be investigated by the CSSW.

4. **DEFINITIONS**:

Child Maltreatment: The World Health Organization defines child maltreatment as abuse and neglect of children under 18 years of age. It includes "all types of physical and/or emotional ill-treatment, sexual abuse, neglect, negligence and commercial or other exploitation which results in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

Emotional/Psychological Abuse: Actions including verbal comments and behaviours by caregivers that cause a child to feel humiliated, rejected, afraid or threatened.

Neglect: Neglect is an omission in care that leads to actual or potential harm of a child. Neglect can be physical (including nutritional and supervisory), emotional, educational and or medical.

Physical Abuse: Consists of a parent or caregiver causing injury or trauma to a child. It involves a caregiver inflicting physical harm or engaging in actions that create a high risk of harm to a child.

Sexual Abuse: The involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.

Medical Child Abuse (also known as Munchausen by proxy): Occurs when a child receives medical care which is unnecessary and harmful/potentially harmful. The can include a caregiver's/parent's action's such as exaggeration of symptoms, lying about the history or fabricating physical findings or intentionally inducing illness in a child.

Child: A person who is, or in the absence of the contrary, appears to be under the age of 16 years.

Youth (Adolescent): A person over 16 years but younger than the age of majority (19 in Nunavut).

Health Care Provider: Registered Nurse, Licenced Practical Nurse, Registered Psychiatric Nurse, Nurse Practitioner, Registered Midwives, Advanced and Primary Care Paramedics, Mental Health Consultants

5. CULTURAL SAFETY AND TRAUMA INFORMED CARE CONSIDERATIONS

5.1. In line with the principle of "do no harm', healthcare providers should seek to minimize additional trauma and distress for children and adolescents.

5.2. A trauma informed approach emphasizes safety, control and choice for the person who is seeking help; enhancing their strength and resilience; minimizing re-traumatization and promoting physical and emotional safety.

5.3. Timely information, presented in easily understood terms, is one of the most basic needs of victims of crime.

5.4. The HCP shall ask the patient and/or guardian which language they would be most comfortable with and shall contact a suitable interpreter in accordance with *Policy 06-013-00 Interpreter Services,* as necessary. The use of family or friends to act as interpreters is strongly discouraged for reasons of confidentiality and bias, but can be used as a last option if no interpreter is available.

6. GUIDELINE FOR REPORTING TO FAMILY SERVICE AND IMMEDIATE INTERVENTIONS:

6.1. When the HCP suspects that a child or youth who may be the victim of abuse will immediately ensure that the patient is safe. This may require asking one or more adults to leave the examining area or requesting an additional team member to be present.

6.2. The HCP will contact a CSSW/RCMP as per 2.1 and 2.2.

6.2.1. If the HCP is uncertain about maltreatment, they will seek advice from the SHP, NP or MD.

6.3. Ensure trauma informed and culturally safe care is provided.

6.4. A SHP, CHN, ACP or NP will assume the care as the most responsible provider, will receive handover from the HCP and will complete a thorough physical examination of the child.

> **Note:** The HCP must not interview the child/youth or the family members, caregivers, guardians involved, regarding suspected abuse or neglect. The HCP must confine their interview to clinical or medical history questions only.
>
> *Only the CSSW or an RCMP officer trained in this procedure has the authority to complete a forensics interview with the client and family.

6.5. If sexual abuse is suspected or reported, the SHP, CHN, ACP or NP will follow **Policy 07-046-00 Guidelines for the Care of Pediatric Sexual Assault Survivors in Community**.

6.6. The SHP, CHN, ACP or NP will assess and treat any acute and urgent/emergent medical conditions associated with suspected abuse or neglect, including referrals to further support and treatment as required.

6.6.1. The safety and stabilization of the child or youth is the top priority.

6.6.2. The SHP, CHN or NP will consult an MD promptly for any severe presentation that require medical evacuation for suspected or confirmed cases of child maltreatment.

6.6.3. ACPs will be required to consult an NP or MD for all cases.

6.7. HCPs will ensure that the client and their families have access to both mental health treatments and supports.

6.8. The SHP, CHN, ACP or NP will not discharge the client from the health centre until they have received clearance from the CSSW.

6.8.1. If a CSSW was not available/reachable to approve discharge, the 'Family Services Contact List/Fan Out List' will be used to escalate the next contact available.

7. PROCESS FOR REPORTING TO FAMILY SERVICES

7.1 Reporting to CSSW is to be completed immediately and verbally along with in writing on the *Family Services Reporting Interdepartmental Referral Form*. Refer to Appendix B for the **Family Services Reporting Interdepartmental Referral Form.** This referral form is to be password protected and emailed to the CSSW and cc the SHP. Refer to Table 1. for required information to include with mandatory reporting. The referral form is to be filed in the patient's paper chart.

Table 1. Required Information to Include with Mandatory Reporting

Mandatory Reporting Must Include:

- Your name, telephone number/GN email, relationship to the child/youth;
- Your immediate concerns about the child/youth's safety;
- The child/youth's name, age, gender and location;
- Information about the situation;
- Information about the family, caregivers;
- Other children/youth who may be affected; and
- Any other relevant information

7.1.1 If a CSSW is not reachable, the HCP shall review the 'Family Services Contact List/Fan Out List' to escalate to the next available contact. If no one from Family Services is reachable after escalation attempts, RCMP needs to be contacted.

7.1.2 The HCP must advise the Supervisor of Health Programs (SHP) via email when a concern has been reported and verbally within the soonest regular working day.

7.8 The duty to report child welfare concerns applies to all information gathered even if it is confidential or privileged as the wellbeing of the child or youth is seen to be paramount.

8 DOCUMENTATION

8.1 The HCP will document in the client's health record as per Policy 06-008-00 *Documentation Standards* and ensure documentation is detailed, accurate, timely, firsthand knowledge captured verbatim, etc.

8.2 Document the reason the patient was brought to the health centre.

8.3 Document the physical examination highlighting physical injuries are detailed and being observant of signs and symptoms that may indicate abuse such as difficulty sitting or

walking, bruising and/or injuries at various stages of healing.

8.4 Document observations between the child/adolescent and caregiver.

8.5 Document any spontaneous comments by a child should be recorded verbatim.

8.6 Document all investigations and treatments.

8.7 Document all consultations with CSSWs or RCMP and MD/NP.

8.8 DO NOT document on subjective impressions (i.e. “child had been abused” and instead not observations of injuries and bruises)

9 **Related Policies, Protocols and Legislation:**

Policy 06-001-00 Confidentiality

Policy 06-005-00 RCMP Investigations

Policy 06-008-00 Documentation Standards

Policy 06-013-00 Interpreter Services

Policy 07-046-00 Pediatric Sexual Assault in Community

Child and Family Services Act (S.Nu. 2013, c.15, s.6.)

10 **References**:

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Approved By: 	Date: 09-10-2024
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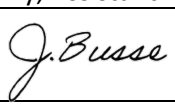
Approved By: 	Date: Nov 11, 2024
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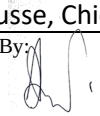
Approved By: 	Date: Nov 11, 2024
Dr. Francois de Wet, Chief of Staff	

APPENDIX A: CIRCUMSTANCES WHICH REQUIRE REPORTING TO FAMILY SERVICES:

The following list provides examples of situations in which the HCP is required to report abuse or suspected abuse to the CSSW.

*This list provides examples, however there may be reportable situations outside this list. The HCP who suspects that a child is at risk and may have suffered abuse, no matter what the circumstances, is obligated to report.

The child has suffered or is at substantial risk to suffer physical harm inflicted by the child's parent or caused by the parent's unwillingness or inability to care and provide for or supervise and protect the child adequately.
The child has been or is at substantial risk to be sexually molested or sexually exploited by the child's parent or by another person where the child's parent knew or should have known of the possibility of sexual molestation or sexual exploitation and was unwilling or unable to protect the child.
The child has tested positive for a sexually transmitted infection (STI) which could not have been transmitted through the gestation or birthing process.
The child has demonstrated or is at substantial risk for severe anxiety, depression, withdrawal, self-destructive behaviour, or aggressive behaviour towards others, or any other severe behaviour that is consistent with the child having suffered emotional harm, and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of, services, treatment or healing processes to remedy or alleviate the harm.
The child suffers from a mental, emotional, or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of, services, treatment, or healing processes to remedy or alleviate the condition.
The child's health or emotional or mental well-being has been harmed or is at substantial risk to be harmed by the child's use of alcohol, drugs, solvents or similar substances and the child's parent is unavailable, unable, or unwilling to properly care for the child.
The child requires medical treatment to cure, prevent or alleviate serious physical harm or serious physical suffering and the child's parent does not provide, or refuses or is unavailable or unable to consent to the provision of the treatment.
The child suffers from malnutrition of a degree that, if not immediately remedied, could seriously impair the child's growth or development, or result in permanent injury or death.
The child has been abandoned by the child's parent without the child's parent having made adequate provision for the child's care or custody and the child's extended family has not made adequate provision for the child's care or custody.

The child's parents have died without making adequate provision for the child's care or custody and the child's extended family has not made adequate provision for the child's care or custody.
The child's parent is unavailable or unable or unwilling to properly care for the child and the child's extended family has not made adequate provision for the child's care.
The child is less than 12 years of age and has killed or seriously injured another person or has persisted in injuring others or causing damage to the property of others, and services, treatment or healing processes are necessary to prevent a recurrence and the child's parent does not provide or refuses or is unavailable or unable to consent to the provision of, the services, treatment or healing processes

APPENDIX A: FAMILY SERVICES REPORTING INTERDEPARTMENTAL REFERRAL FORM

Department of Health and Family Services Referral Form

Interdepartmental Referral Form

Client Identifiers	Referring Provider's Information
Clients Name: Click or tap here to enter text. **Community:** Click or tap here to enter text. **DOB:**Click or tap to enter a date. **Gender:** Click or tap here to enter text. **Name of Parent/Guardian:** Click or tap here to enter text. **Patient/Parent or Guardian Contact information, include phone number, address:** phone number and address.	**Name:** Click or tap here to enter text. **Designation:** Click or tap here to enter text. **Work Location:** Click or tap here to enter text. **Phone number:** Click or tap here to enter text. **Date:** Click or tap to enter a date. **Time referral sent:** Click or tap here to enter text.

Reason for Referral
Reason for Referral: Choose an item.
Relevant Social History: Living situation, previous referrals, or involvement with Family Services.
Relevant Medical History: Click or tap here to enter text.
Presenting problem: Identify concern. Who is involved?
Is client or parent/guardian aware of referral? Choose an item. **Is client or parent/guardian agreeable to the referral?** Choose an item.
Indicate Service Need Priority Choose an item.