

Child Protection – recognition and management of abuse

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Baby Peter

-died aged 17months 3rd August 2007

Summary of GP involvement and recommendations

Reference: Care Quality Commission

Review of the involvement and action taken by health bodies in relation to the death of baby P May 2009

Period 1st March 2006 to 3rd August 2007

- 14 recorded visits – last visit 26 July 2007
- 46 other contacts with health/social care professionals
- December 2006 GP referred to Whittington Paediatric Emergency Clinic for suspicious bruising (3rd recorded concern of bruising by GP in 3 months)- referred to social care
- Theme emerged of non-attendance by HC professionals at CP case conferences

Continued..

- GP criticised as “central medical record holder” – therefore could have identified trends in repeat hospital admissions as an indicator of abuse – pivotal role of GP identified in original SCR
- January 2009 GP involved in care of baby Peter suspended from Haringey Teaching PCT.
- The case referred to GMC whose Interim Orders Panel suspended the GP from the register for 18 months while an investigation into the conduct takes place.

Themes from CQQ Health Review

- Lack of communication
- Shortage of staff
- Lack of training
- Absence of CP supervision
- Lack of awareness of CP procedures
- Inadequate governance

CQC Review findings- commissioned in response to Baby Peter findings

- 50% NHS staff up-to-date with basic CP training
- 1 in 3 GPs up-to-date with level 2 training as recommended by the RCPCH (in 2007/8 1 in 10 consultations with GP were with children under 14)
- A tenth of Trusts non compliant with CRB statutory requirements
- *“GPs should be prepared to raise alerts, take initiative in identifying trends and causes for concern. It is important that GPs and all staff working in a practice, including administrative and reception staff, are familiar with the principles of CP and with their own role in safeguarding - Each practice should have a nominated lead and deputy lead to promote this work”*

Case Study

Baby A

No concerns highlighted in a/n period. On review routine DA screen missed.

Aged 2w Visit by HV – no concerns

Same day Visit to GP – concerned baby vomiting
Reassured

4 days later Home visit by HV to grandmother's –
supportive family, breast feeding well

Aged 3w Visit to GP FU from visit previous week

Aged 5w A&E attendance – Oral thrush, oral bleeding

Aged 7w 1st imms and 6/8 week review. No concerns

Continued....

Aged 11w 2nd imms – bruise noted on chest. Seen by staff nurse. Parents unable to recall how could have happened. Mother certain no possibility of injury. Practice Nurse and GP requested to look at. NAI not considered. GP however requested to review

Aged 12w Planned review with GP. All marking now gone. No maternal concerns

Aged 15w 3rd imms. Mother asked if necessary to undress baby. Bruising on abdomen observed by staff nurse. Mother asked about bruising and told boy friend did it.

HV/GP informed. Social care immediately informed.

Baby found to have multiple injuries, 3 fractured rib and fractured ankle.

What should have happened?

What are the barriers?

- Non-mobile child with bruising should ring alarm bells. Needs to be referred immediately to paed

Obstacles

should not stop you acting to prevent harm

- concern about missing a treatable disorder
- fear of losing positive relationship with a family already under care
- divided duties to adult and child patients and breaching confidentiality
- an understanding of the reasons for the maltreatment, and no intention to harm the child
- losing control over the child protection process and doubts about its benefits
- stress, personal safety, fear of complaints

What to do?

- Consider and suspect abuse
- STOP and THINK and RECORD
- Refer – “ I’m not sure - I would like a hospital colleague to have a look”
- SHARE information
- It is not your job to investigate – but additional background information is essential

Recommendations from Climbie enquiry

- “The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially fatal disease”

Think of child under 1 with suspected NAI in the same way as meningococcal septicaemia

Some facts about child abuse

- Every week at least 1-2 children are **killed** through abuse or neglect (<12 m most at risk)
- 7% children experience physical abuse
- There are 200 children with a Child Protection Plan in Oxon
- There are at least **110,000** convicted **child sex offenders** in this country – each paedophile abuses on average 100 times before they are caught, 26% of **rape victims** are children
- 11% adults report that they were sexually abused as children

Definitions

- **Child abuse and neglect** – somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Child may be abused in a family, institutional or community setting, by those known to them or more rarely by a stranger, and by an adult or a child.

Defintion - Physical abuse

- Physical injuries to a child as a result of an act or an omission on the part of the parents or guardians
- Includes anything from a handslap to death by suffocation
- Injuries may be caused by blows, punches, kicks, shakes, bites, belts, scalds, burns, suffocation, drowning or poisoning
- Injuries may be
 - Soft tissue - bruising laceration
 - Bony - fracture
 - Intra-cerebral injury
 - Intra-abdominal, mouth, intra-orbital
 - Illness fabricated by carers

Defintion – Emotional abuse

- persistent emotional ill-treatment such as to cause severe and persistent adverse effects on child's emotional development
 - may include making child feel worthless, unloved, inadequate
 - parents having inappropriate expectations
 - child feeling frightened, in danger
 - exploitation

Defintion -Neglect

- Persistent failure to meet a child's basic physical and/or psychological needs which is likely to result in the serious impairment of the child's health and development
 - Failing to provide adequate food, shelter, clothing
 - Failing to protect a child from physical harm or danger
 - Failure to ensure appropriate medical care or treatment
 - Unresponsiveness to a child's basic emotional needs

Signs of neglect

- Physical - FTT, short stature (in older children), severe nappy rash, dirty unkempt condition, inadequately clothed, cold, frequent infections
- Development - general delay - esp speech and language, LD in older children, inadequate social skills and poor socialisation
- Behavioural and emotional - attachment disorders, indiscriminate, aggressive, impulsive, disturbed peer relations, self harm

Other facts

- Overlap in the abuses
- All children are emotionally abused when assaulted or witness domestic violence
- Sexual and physical abuse coexist in 1 in 6 children
- Consequence of living in a home “consistently low in warmth and high in criticism” is harmful and damaging.

Patterns of injury which should
raise concern

Patterns of injury which should raise concern

- Bruising in non-mobile child, multiple bruises/ clusters, bruises similar shape and size, in non-boney sites, facial bruising and implement or grip marks and bites (normal bruising - forehead toddlers and shins in older children)
- Head injuries in infants
- Burns and scalds
- Fractures in young children, skull fractures in infants, fractures of different ages, rib fractures and metaphyseal fractures

Circumstantial factors which
should raise concern

Circumstantial factors which should raise concern

- Implausible, inadequate or inconsistent explanation of injury
- Delay in seeking medical advice
- Lack of parental concern or denial about the extent or severity of the injuries
- Reluctance to give info, failure to mention previous injuries
- Frequent presentation with minor injuries
- Explanation based on cultural practice (this should not justify hurting child)

Other circumstantial factors

- Parental mental ill health, alcohol or drug abuse
- Domestic violence
- Unrealistic expectations by parents
- Parents request child to be removed, can't cope (consider age of child, pressures of caring for number of children)
- Parents were abused themselves
- Past history of child abuse in the family

Differential diagnosis of bruising

- Mongolian blue spots, haemangioma, café au lait - do not fade
- Bleeding disorder -ITP, haemophilia, von Willebrand's disease
- Infection and post infectious - meningococcal septicaemia, Henoch Schoenlein purpura
- Allergy -periorbital swelling
- Skin disease - Ehlers Danlos
- Accident

Patterns of bony injury in abuse

- Multiple fractures in various bones, different stages of healing
- Metaphyseal - epiphyseal fractures at the end of long bones (often multiple after violent shaking and assoc with head injury)
- Rib fractures
- Skull fractures - esp wide, complex with intracranial injury

Differential diagnosis of fractures

- Accidental (including birth trauma)
- Non-accidental
- Normal variants, pseudofractures (aberrant sutures on skull Xray)
- Osteogenesis imperfecta
- Rickets
- Others - osteoporosis, malignancy, infection, Caffey's disease

Fractures and bony injury

- High index of suspicion in first year of life
- Between 13 and 50% fractures in infants are caused by abuse
- Majority of abusive fractures occur in infants and pre-school children
- In non abused children 85% fractures occur over the age of 5 years
- In genuine accidents - child is usually presented promptly, child in pain and has loss of function

Contact burns

- Objects commonly causing contact burns are - domestic irons, fire or fire surrounds, cookers, radiators, tools, pokers, cigarettes
- Shape of the burn conforms to the object
- Frequently a delay in presenting the child
- Site of burn important eg burn on back of hand likely to be abusive

Investigations

mostly instigated by Paed team

- Fbc and clotting screen for bruising and unusual marks. Further tests such as platelet dysfunction and full coagulation screen may be needed
- Xray relevant affected area if fracture suspected
- Skeletal survey
- Photographs, with measure place by mark - need parents consent
- In infants - Head CT scan and ophthalmol review
- Later consider OI gene in fractures

Defintion - Sexual abuse

- Involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening
- Physical contact including penetrative or non-penetrative acts
- Non-contact activities -looking at or being in the production of pornographic material, or watching sexual activities

Presentation of sexual abuse

Presentation of sexual abuse

- Disclosure by a child, usually to a friend or an adult, before professional involvement
- Behavioural changes (sudden change, sexualised) may occur - but not in most
- Physical evidence - most show no physical signs
- Male and female children may be abused
- Abuser is often a member of the family or known to the family

Physical evidence of sexual abuse

- Pregnancy, STDs, positive forensic swabs, multiple anal tears, vaginal tear - **HIGHLY SIGNIFICANT**
- Genital bleeding -can be caused by - accident, early puberty, lichen sclerosus, CSA, tumour
- Rectal bleeding - can be caused by fissure, infective diarrhoea, IBD, polyp or tumour, CSA
- Vulvovaginitis
- Bruises/scratches on lower abdo and thighs, sadistic burns

Vulvovaginitis

- Symptoms -soreness, itchiness, burning on micturition, discharge
- Causes - poor hygiene, sensitivity to bubblebath/soaps, threadworms, eczema, CSA(trauma and secondary infection), STD, other infections -strep, staph, Hib candida, rarely foreign body(?CSA)

Psychosomatic indicators

- Maybe only way child shows distress, but many factors can stress children - CSA should be thought about
- Recurrent abdo pain, headaches, anorexia, constipation, soiling and encopresis, enuresis

What to do if child abuse is suspected

What to do if child abuse is suspected

- Record your observations in the child's notes including date and time, what is said and by whom, and record injuries on a body map if possible. Notes should be contemporaneous
- Discuss with other members of your team
- Check the if child has record of Child Protection plan
- Anonymous consultations for doubtful cases
- Urgent referral to hospital - if needs urgent medical treatment, or referral to Community Paeds - esp CSA
- Referral to social services (inform parents) - written within 48 hours

Serious Case reviews in Oxford 1

- Mother long-standing history of relationships with unsuitable men, domestic violence, alcohol and drug abuse
- 4 children long-standing concerns about neglect- filthy, hungry, home in terrible state, drug usage in front of children
- SWs and HVs made enormous efforts to encourage mother to get help. Mother lied and hoodwinked them into thinking things would improve

Serious Case reviews in Oxford 1

- Numerous agencies involved. CP conferences focused on how to help mum, and needs of children diminished. Serious absence of core group working.
- Known sex offender moved in next door, and despite warnings from police and SS, mother allowed the boys contact. A worldwide paedophile operation discovered images of the sex offender with one of the boys.

Lessons Learned SCR 1

- Thresholds for referral (early history)
- Information sharing
- Working with chronic neglect
- Working with difficult and deceptive people
- Participation in CP case conferences and core groups
- Involving and listening to children
- (Health should continue to have ownership and challenge SS if we feel more should be done)

Serious Case reviews in Oxford 2

- 15 yr old looked after girl, hung herself in small independent children's home in Hants
- Had been in care for 2 years. Had moved at least 18 times, 7 organised by SS, including spells in in-county residential care and a secure unit. Had absconded 30 terms and 31 recorded incidents of self harm
- SS, education and CAMHS had made significant attempts to help her and her family

Serious Case reviews in Oxford 2

- Secure accom provided most stability - but placement terminated - controversial decision.
- Agencies' efforts weren't coordinated, info about moves wasn't shared
- Care planning was reactive
- Whilst in Oxon - self harm episodes requiring admission had appropriate input - CAMHS, and SS informed. Assessed as low suicide risk.
- Following move to Hants - health did not know her history and referrals weren't made to CAMHS for self harm

Lessons learned SCR 2

- Lack of integrated multi-agency approach
- Too much responsibility on individuals for day to day management with insufficient joint agency strategic oversight for a complex case
- (Health to formalise care pathway for those admitted with self harm. Link with other services about these complex young people-esp those in care)

What else should GPs do?

- Attend case conferences –especially first ones – or ensure report is sent
- Ensure practice is aware of families with child with child protection plan
- Share information
- Challenge Social Services- if ongoing concern
- Safeguarding lead within each practice
- Ensure child protection case is discussed as one of your 12 significant event analyses

Conclusions

- Think about it
- Be aware of patterns of injury associated with abuse and other contributing factors
- Keep good records
- Share information
- Seek appropriate advice
- Appropriate referral to hospital, Comm Paeds and social services

Conclusions

- The investigation and management of a case of possible deliberate harm to a child must be approached in the same systematic and rigorous manner as would be appropriate to the investigation and management of any other potentially **fatal disease**

Information

- www.oscb.org.uk Oxfordshire Safeguarding Children's Board
 - Procedures manual – has all the information you need - plus contact tel nos
- www.nicw.org.uk/CG89 When to suspect child maltreatment - quick reference guide
- Use your designated professionals
- Paeds referrals to
 - Acute paed (JR 01865 741166) for significant injuries and bruising in non-mobile child
 - Community Paediatrics (01865 231994) for minor physical abuse, neglect and sex abuse

Fabricated or Induced Illness

- a condition whereby a child suffers harm through the deliberate action of her/his main carer and which is attributed by the adult to another cause.
 - Fabrication of signs and symptoms, including fabrication of past medical history (seizures –common)
 - Falsification of hospital charts, records, letters and documents and specimens of bodily fluids
 - Induction of illness by a variety of means
 - Harm from unnecessary or invasive medical treatment, that are performed because of above points

Fabricated or Induced Illness

- Typically presents to health professionals
- Identification can be challenging (need to distinguish between abnormally anxious parents and FII)
- Rare – 1/100,000 – more in <1y
- Significant morbidity and occasional mortality

Concerns

- Symptoms and signs are not explained
- Investigation results don't tally with history
- Inexplicably poor response to treatment
- New symptoms are reported on resolution of previous ones
- Reported symptoms and found signs are not observed in the absence of the carer; or
- Child is repeatedly presented with a range of symptoms to different professionals in a variety of settings; or
- Child's normal, daily life activities are being curtailed beyond that which might be expected

Action –if fabricated illness suspected

- Discuss with peers/colleagues
- May require careful medical evaluation
- Say no explanation found, needs further assessment – to parents
- DO NOT share concern re fabricated illness
- May need confidential notes
- Refer paed
- If refer SS – do not routinely discuss with parents