

# **Child Protection Companion**

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Royal College of Paediatrics and Child Health

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## Foreword

Child protection is an important part of every doctor's business. It is a core activity for paediatricians and one which, if we get it right, can make a real difference to the health and well being of a child. If we get it wrong it can cause untold misery for the child, the family and professionals involved. The purpose of this Handbook is to bring together the best available current guidance as to how we should act when faced with a child who may have been abused. It complements official guidance from the Health Departments and should be used in conjunction with these documents. The Handbook gives guidance on how to recognise that a child may have been abused. Suspicions may eventually prove to be unfounded but if we have any reasonable suspicion then procedures should be followed. It is much better to err on the side of safety for the child and, indeed, the law demands that we do so. If we do raise concerns, and act in good faith, then we are protected in law for any repercussions of our actions.

When things have gone wrong in the past it has usually been because correct procedures have not been followed. This Handbook has been written by leading experts in the field and has been extensively and externally reviewed both from a medical and legal standpoint. The general procedures for the clinical investigation of child abuse should be universal. However, legal procedures do differ across the UK. This publication has been written primarily from the standpoint of procedures in England and Wales but there are variations in Scotland and Northern Ireland where the Law and other issues may be somewhat different.

Child protection is not something that should be a burden to paediatricians. It should be a satisfying area of clinical practice with a good and measurable outcome for the child, either restored to his/her own family or in alternative care arrangements. There can be few greater achievements than to see a child restored to an environment where they can grow and develop in safety. We expect this Handbook will give paediatricians the confidence to undertake one of their most important core functions - protecting children and promoting their health and well being.

**Professor Sir Alan Craft**  
**President of the Royal College of Paediatrics and Child Health**

**2006**

The College recognise that terminology referred to throughout this document is based on English Law and practice. Those working in Scotland, Wales and Northern Ireland should refer to their country specific legal terminology and legislation.

## About this document

The aims of this document are:

- (i) To raise awareness that safeguarding children is everyone's business.
- (ii) To assist doctors in their daily practice, so they are able to recognise and manage child abuse and neglect in order to safeguard children's welfare.
- (iii) To assist with the process of management of children who have been abused or neglected.
- (iv) To promote multi-disciplinary and multi-agency working.

We hope that it will thereby contribute to the following broader objectives:

- (i) To promote and safeguard the welfare of children.
- (ii) To improve the well being of children.
- (iii) To increase knowledge.
- (iv) To support professionals in this difficult area of work.

### Target audience

This document is aimed at paediatricians, but the editorial group acknowledge that other health professionals may also find it useful.

### Disclaimer

We urge clinicians to use their own clinical judgment in each individual case, as each is different and needs to be considered carefully on its own merits. This may mean reading references referred to in this document in their entirety in order to use them appropriately. It is always important for clinicians to work within their own competencies and to seek support and advice when they have doubts or concerns. Such assistance may be provided by other medical colleagues or other professionals, such as the Police or Children's Social Care. The Named and Designated Nurses and Doctors within each Trust will be available to offer support and guidance in this complex and difficult process. It is incumbent upon every individual who may come across children in these circumstances to be aware of how to contact Named and Designated Doctors and Nurses.

### Evidence base

Throughout this document, where evidence exists, it has been referenced. However, it is recognised that there is a paucity of high-quality, evidence-based research on child abuse and neglect. At the time of publication these are the best guidelines based on clinical experience and published literature. We would anticipate that as new research evidence becomes available these guidelines will be revised.

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## **Editorial group**

Dr Margaret Crawford	Consultant Paediatrician, Boston, Lincolnshire
Dr Sara Ghulam	Consultant Paediatrician, Folkestone, Kent
Dr Jean Herbison	Consultant Paediatrician, Glasgow
Dr Chris Hobbs	Consultant Paediatrician, Leeds
Dr Jacqueline Mok	Consultant Paediatrician, Edinburgh
Dr Alison Mott	Consultant Paediatrician, Cardiff
(Chair) Dr Jean Price	Consultant Paediatrician, Southampton

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Dr P. Barnes  
Dr R. Brooks  
Professor H. Carty  
Dr P. Davis  
Dr F. Forbes  
Dr D. Glaser  
Ms J. Gray  
Dr C. Hall  
Dr C. Heritage  
Professor J. Horwath  
Dr A. M. Kemp  
Dr Y Khan  
Dr S. Kinsey  
Professor M. Lynch  
Dr S. Maguire  
Dr R. A. Minns  
Dr V. Prior  
Dr M. Samuels  
Professor J. R. Sibert  
Dr R. Shakespeare  
Dr R. Skelton  
Dr A. Thomas  
Mr P. Watts  
Dr D. Whitaker



# 1

## What to do and not to do

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### 1.1 Do

- Do listen and talk to the child.
- Do assess suspected harm with the same thoroughness and attention to detail as you would a life threatening illness e.g. a brain tumour or acute bacterial meningitis.
- Do consult and communicate widely both within the health service and with other agencies outside the health service.
- Do remember the child's welfare is always the paramount concern. Don't let other concerns get in the way of your responsibility to the child.
- Do remember other children in the family may be at risk of harm.
- Do keep clear, contemporaneous records including telephone and other communications you have.
- Do obtain previous records.
- Do take a detailed social and family history together with history of events leading to presentation.
- Do ensure adequate and appropriate follow up is arranged.

### 1.2 Don't

- There is no need to make a firm diagnose of child abuse prior to a referral to Children's Social Care.
- Don't assume that someone else will raise the concern or deal with it.
- Don't conduct your own investigation or keep the problem to yourself.
- Don't discharge a child from hospital when you have suspicions s/he may have suffered harm unless it has been agreed with the statutory agencies and the Consultant Paediatrician that it is safe to do so.
- A junior doctor should not confront or accuse parents of abusing their child, but calmly explain their concerns and the reasons for them.
- Don't conduct interviews and examinations without having another professional person present with you.

# 2

## Basic principles of working together: The multi-agency approach

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### 2.1 Introduction

These medical procedures must be read in conjunction with Local Safeguarding Children Boards' (LSCBs) *Inter-Agency Safeguarding Children Procedures*, which are available in every hospital, community children's department and GP practice.

Promoting children's wellbeing and safeguarding them from harm is the responsibility of all staff working with children. (DoH, 2003)

*Working Together to Safeguard Children* (HM Government, 2006) is a guide to inter-agency working to safeguard and promote the welfare of children and:

- 2.1.1 Emphasises that safeguarding and promoting the welfare of children and in particular protecting them from significant harm depends upon effective joint working between agencies and professionals that have different roles and expertise.
- 2.1.2 Summarises some of the lessons learned from research and experience to date on the nature and impact of abuse and neglect, and how best to operate child protection processes.
- 2.1.3 Sets out the roles and responsibilities of different agencies and practitioners.
- 2.1.4 Sets out the role and functions of Local Safeguarding Children Boards (LSCBs).
- 2.1.5 Outlines the way in which joint working arrangements should be agreed, implemented and reviewed through the mechanism of LSCBs.
- 2.1.6 Sets out the processes which should be followed when there are concerns

about a child's welfare, and the action which should be taken to safeguard and promote the welfare of children who are suffering, or at risk of suffering, significant harm.

- 2.1.7 Provides guidance on safeguarding and promoting the welfare of children in specific circumstances, including children living away from home.
- 2.1.8 Outlines some important principles which should be followed when working with children and families.
- 2.1.9 Sets out the processes which should be followed if a death or serious injury occurs, in order to learn lessons and make any necessary improvements in practice to safeguard children.
- 2.1.10 Sets out the processes to be followed for responding rapidly to the unexpected death of a child and for reviewing deaths of all children.
- 2.1.11 Discusses the importance of multi-agency training, and considers training requirements for effective safeguarding of children's welfare.

## 2.2 The role of guidance and procedures

Processes and procedures are never ends in themselves, but should be used as a means of bringing about better outcomes for children. No guidance can, or should attempt to, offer a detailed prescription for working with each child and family. Work with children and families where there are concerns about a child's welfare is sensitive and difficult. Good practice calls for effective co-operation between different agencies and professionals, sensitive work with parents and carers in the best interests of the child and the careful exercise of professional judgement, based on thorough assessment and critical analysis of available information. To help with the process of assessment, this guidance is complemented by the document, *Framework for the Assessment of Children in Need and Their Families* (DoH et al. 2000).

## 2.3 Legal background

- 2.3.1 *Working Together to Safeguard Children* (HM Government 2006):
  - (a) Reflects the principles contained within the United Nations Convention on the Rights of the Child, ratified by the UK Government in 1991.
  - (b) Takes account of the European Convention of Human Rights in particular Articles 6 and 8.
  - (c) Takes account of other relevant legislation at the time of publication, but is particularly informed by the requirements of the *Children Act 1989* and the *Children Act 2004*.
- 2.3.2 The *Children Act 1989* (or equivalent - Scotland and Northern Ireland) places two specific duties on agencies to co-operate in the interests of vulnerable children:
  - (a) **Child in Need** (HMSO 1989. *Children Act 1989*, Section 17:10). Section 17 provides that a Local Authority may request help from any:

- (i) Local Authority.
- (ii) Local Education Authority.
- (iii) Local Housing Authority.
- (iv) Strategic Health Authority, National Health Service Trust, or equivalent (Scotland/Northern Ireland).
- (v) Person authorised by the Secretary of State in exercising the Local Authority's function under Part III of the Act.

This part of the Act places a duty on Local Authorities to provide support and services for children in need, including children looked after by the Local Authority and those in secure accommodation. The Authority whose help is requested in these circumstances has a duty to comply with the request, provided it is compatible with its other duties and functions.

- (b) **Child is suffering or likely to suffer significant harm** (HMSO 1989 *Children Act 1989*, Section 47) provides that a Local Authority may request help from any:

- (i) Local Authority.
- (ii) Local Education Authority.
- (iii) Housing Authority.
- (iv) Strategic Health Authority or National Health Service Trust or equivalent for Scotland/Northern Ireland.
- (v) Person authorised by the Secretary of State.

This part of the Act places a duty on the Local Authority to make enquiries, or cause enquiries to be made, where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm. The Authority whose help is requested has a duty to comply with the request.

## 2.4 Interagency Working

Working together is about sharing responsibility:

- 2.4.1 This depends crucially upon effective information sharing, collaboration and understanding between agencies and professionals.
- 2.4.2 Agencies and professionals need to work in partnership with each other and with service users (children and families) to plan comprehensive co-ordinated children's services.
- 2.4.3 Individual children, especially some of the most vulnerable children and those at greatest risk of social exclusion, will need co-ordinated help from health, education, social services, the voluntary sector and other agencies, including the youth justice service.
- 2.4.4 Working with adult services, especially mental health services.

- 2.4.5 For children who are suffering, or at risk of suffering significant harm, joint working is essential, to safeguard the child(ren) and, where necessary, to help bring to justice the perpetrators of crime against children.

## 2.5 Demands on agencies and professionals

All agencies and professionals should:

- (a) Be alert to potential indicators of abuse or neglect.
- (b) Be alert to the risks which individual abusers, or potential abusers, may pose to children.
- (c) Share and help to analyse information so that an informed assessment can be made of the child's needs and circumstances.
- (d) Contribute to whatever actions are needed to safeguard the child and promote his or her welfare.
- (e) Regularly review the outcomes for the child against specific shared objectives.
- (f) Work co-operatively with parents unless this is inconsistent with the need to ensure the child's safety.

## 2.6 Designated and named professionals

All Trusts should have a Named doctor and Named nurse for child protection. They will take a professional lead within the Trust on child protection matters. Their responsibilities include education, support and supervision. These are the appropriate people to contact with any child protection concerns which are not otherwise being addressed.

Each Area should have a Designated doctor and nurse for child protection who work closely with the named professionals in supporting all activities within Trusts. They are also available for advice on child protection matters.

## References

- DoH et al (2000) *Framework for the Assessment of Children in Need and Their Families*. Department for Education and Skills and The Home Office. London: The Stationery Office.
- DoH (2003) *Getting the Right Start; National Service Framework for Children, Young People and Maternity Services. Standard for Hospitals*. Department of Health.
- HM Government (2006) *Working Together to Safeguard Children*. Department for Education and Skills. London.
- HMSO (1989) *Children Act 1989*. Department for Education and Skills and the Home Office. London: The Stationery Office
- HMSO (2004) *Children Act 2004*. Department for Education and Skills and the Home Office. London: The Stationery Office
- European Convention of Human Rights (2003) <http://www.echr.coe.int>
- United Nations Convention on the Rights of the Child (1989) <http://www.ohchr.org>

# 3

## Responsibilities of doctors

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(See Appendix 1, *What to do if you are worried a child is being abused*).

- 3.1** All doctors who see children have a responsibility to recognise abuse or neglect and refer to those who can provide assessment.
- 3.2** The involvement of health professionals is important at all stages of work with children and families.
- 3.3** There are designated doctors and nurses for child protection covering an area, as well as Named doctors and nurses within every Trust. These personnel are available for advice and support. Make sure you know who they are and how to contact them.
- 3.4 All doctors who see children must:**
  - 3.4.1 Be able to recognise the symptoms and signs of child abuse or neglect.
  - 3.4.2 Recognise children in need of support and/or safeguarding, and parents who may need extra help in bringing up their children (HMSO 2004 *Children Act 2004*, Section 17).
  - 3.4.3 Contribute to enquiries about children within the framework for assessment (see Appendix 2) and child protection process.
  - 3.4.4 Have access to local safeguarding children procedures and be familiar with their contents.
  - 3.4.5 Be familiar with local procedures for making contact with the child protection register.
  - 3.4.6 Act upon any child protection concerns that they have about children in accordance with Section 47 of the *Children Act 2004* (or equivalent).

- 3.4.7 Be aware of the referral pathways to those with the specialist paediatric skills to assess children where child abuse or neglect is suspected.
  - 3.4.8 Know when and how to contact the Children's Social Care department.
  - 3.4.9 Maintain their training in child protection to a level that is specified by local and national policy. (RCPCH 2004)
- 3.5** "Investigation and management of a case of possible 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". (HMSO 2003 *The Victoria Climbié Inquiry 2003: Report of an Inquiry by Lord Laming*. Para. 11.53).

**All paediatricians must:**

- 3.5.1 Be able to take a history, examine and investigate children where child abuse or neglect is suspected.
- 3.5.2 Be able to make an evidence based diagnosis of child abuse or neglect on the balance of probability.
- 3.5.3 Be aware of the family structure and identify other children who may be at risk of abuse or neglect and require assessment.
- 3.5.4 Participate in strategy meetings and child protection conferences.
- 3.5.5 Work with the interagency child protection team in the assessment and management of children where child abuse is suspected.
- 3.5.6 Write reports for child protection conferences, statements for the police and reports for court.
- 3.5.7 Be prepared to attend child protection conferences or reviews and court to give evidence as requested. It is recognised that there are difficulties in attending at short notice.
- 3.5.8 Participate in assessing the needs of the child, the planning and provision of support for vulnerable children and families.
- 3.5.9 Play a part, through implementation of the child protection plan, in safeguarding children from significant harm.
- 3.5.10 Contribute to serious case reviews where a child has died as a result of abuse or suffered serious abuse.
- 3.5.11 Contribute to reviewing child deaths.

**References**

- DoH et al (2003). *What To Do If You Are Worried A Child Is Being Abused*. London
- HMSO (1989) *Children Act 1989*. Department for Education and Skills and the Home Office. London: The Stationery Office

HMSO (2003) *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming.* London: The Stationery Office.

HMSO (2004) *Children Act 2004.* Department for Education and Skills and the Home Office. London: The Stationery Office

RCPCH (2004) *A Framework of Competencies for Basic Specialist Training in Paediatrics.* Royal College of Paediatrics and Child Health. London.



# 4

## Definitions of abuse or neglect

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Child abuse involves acts of commission or omission, which result in harm to the child.

Abuse or neglect may occur in the family, a community or an institution (e.g. home, school, hospital, street).

### 4.1 Physical abuse

*'Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child they are looking after'* (HM Government 2006).

### 4.2 Emotional abuse

*'Emotional abuse is the persistent emotional ill-treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of ill-treatment of a child, though it may occur alone.'* (HM Government 2006).

### 4.3 Sexual abuse

*'Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or*

oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways.’ (HM Government 2006).

#### 4.4 Neglect

*‘Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. It may involve a parent or carer failing to provide adequate food, shelter and clothing, shelter including exclusion from home or abandonment, failing to protect a child from physical harm or danger, failure to ensure adequate supervision including the use of inadequate care-takers or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child’s basic emotional needs.’* (HM Government 2006)

#### 4.5 Significant harm

4.5.1 Significant harm is the threshold, which justifies compulsory intervention in family life. It is established by the Courts and advice is obtainable from Local Authorities Legal Departments.

4.5.2 **Under Section 31(9) of the Children Act 1989:**

- (a) ‘Harm’ means ill-treatment or the impairment of health or development; including for example, impairment suffered from seeing or hearing the ill-treatment of another.
- (b) ‘Development’ means physical, intellectual, emotional, social or behavioural development.
- (c) ‘Health’ means physical or mental health.
- (d) ‘Ill-treatment’ includes sexual abuse and forms of ill-treatment which are not physical.

4.5.3 **Under Section 31(10) of the Act:**

*‘Where the question of whether harm suffered by a child is significant turns on the child’s health and development, his health or development shall be compared with that which could reasonably be expected of a similar child’.*

#### 4.6 Child in need

4.6.1 **A child shall be taken to be in need if:**

- (a) He is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority.
- (b) His health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services.

- (c) he is disabled.

(DoH et al. 1999. See also Appendix 2, *The assessment framework*).

**4.6.2 Situations of possible impairment to children's health and development which need to be assessed:**

- (a) Social exclusion/poverty/deprivation.
- (b) Domestic violence (children may witness or be aware) with serious effects on child's emotional development and possibility of actual physical violence to child.
- (c) Mental ill health of parent or carer. Has a variable effect. Linked to neglect and sometimes to profound neglect, serious injury or death of child.
- (d) Learning disability in parent or carer.
- (e) Drug and alcohol misuse. Variable effects and risks include neglect, dangers of overdose, intermittent parental withdrawal, and parents driving under influence of alcohol or drugs.
- (f) Children in care (looked after children).
- (g) Children in custody, temporary accommodation, hostels or families seeking asylum.

**References**

- DoH et al. (1999) *Framework for Assessment of Children in Need and Their Families*. Department of Health. London: The Stationery Office.
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# 5

## Consent and confidentiality

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(See also Appendix 3, *Confidential medical record consent form*)

### 5.1 Consent for medical examination

Examination without consent may be held in law to be an assault.

#### 5.1.1 Valid consent (RCPCH 2004):

- (a) Must be informed.
- (b) Must be freely given.
- (c) Written consent is advisable. If a child is brought, without parents, by Police or a social worker and they inform you that verbal consent has been obtained, this should be recorded in your notes and signed
- (d) Attendance at a medical examination usually means implied consent but you should always seek permission from the parents and it is also good practice to ask the child. Written consent is currently optional and can be obtained using the example provided in Appendix 3. If the child is seen for 'child protection assessment' you should inform the parent that a report will go to Children's Social Care.
- (e) As with consent (see paragraph 5.1.4 (b)), the discussion with the child will depend upon his or her age: it will be unnecessary in a small baby, good practice with a young child and essential with the older "Fraser competent" child (Gillick v Wisbech and West Norfolk 1986).

#### 5.1.2 Additional consent is recommended for:

- (a) Genital and anal examination.

- (b) Photographs (including an option for use in teaching).
- (c) X-rays, blood and other laboratory tests where abuse is suspected.

### 5.1.3 Practical considerations

Hospitals should follow the Department of Health guidance and the associated report (DoH 2001) and (DoH 2003) on consent.

- (a) “In a case of possible deliberate harm to a child in hospital, permission for the investigation or treatment of the injuries must be sought by a doctor above the grade of a SHO (2nd Year SpR from 2007). (HMSO 2003 *The Victoria Climbié Inquiry 2003: Report of an Inquiry by Lord Laming*. Para. 10.73). Formal consent for investigations by a doctor of greater seniority than SHO is required. Junior doctors must always inform and involve a senior doctor. Consultants should always be informed and in most cases be involved.
- (b) Parents must be told that investigations are to search for other or hidden injury.
- (c) Request card must indicate that abuse/Non-Accidental Injury (NAI) is being considered.
- (d) Forensic tests are usually requested by Police but consent should also be sought.
- (e) If consent is refused for essential investigations, legal advice must be sought. The welfare of the child takes priority. If consent is refused for non-essential investigations (e.g. photography), this needs to be clearly documented and discussed with other authorities. Legal advice may need to be sought.

### 5.1.4 Who can consent (DoH 2001)

- (a) A child of 16 years and over can give their own consent.
- (b) Young people under the age of 16 years, who are able to fully understand what is proposed and its implications, are competent to consent to medical treatment regardless of age (*Gillick v Wisbech* 1986). The more serious the medical procedure proposed a correspondingly better grasp of the implications is required. If a young person is not Gillick competent, consent from a parent or carer with parental responsibility is necessary but the child can still refuse to be examined.
- (c) If a child is subject to an interim care order, emergency protection order or child assessment order, the Court will give consent (the Local Authority will transmit request). If proceedings are ongoing, the Family Courts may also order the nature of an examination and which doctor or doctors jointly will perform it. Do not examine without this direction unless an emergency situation pertains. This instruction should be in writing and kept on file.
- (d) In the case of a child on a care order the Local Authority can give consent.
- (e) A child can be examined without consent only if the child is in need of

urgent medical treatment.

- (f) Never examine an older child against their wishes but discuss with them and invite them to re-attend after further support and counselling has been given.

#### 5.1.5 What to do if consent is refused:

- (a) A child or teenager refuses examination:  
The examination should not be done. Further explanation and reassurance may help to allay anxieties and allow the examination to proceed. An examination must never be forced on a child.
- (b) Refusal for photograph to be taken:  
This should be respected and documentation to this effect should be made. Detailed and accurate notes should be accompanied by careful line drawings to illustrate findings.
- (c) Refusal for letters or reports:  
The reason and need for these must be explained.

## 5.2 Chaperones

### 5.2.1 Examination of children should be done in the presence of a suitable chaperone to:

- (a) Safeguard the child.
- (b) Make the child more at ease.
- (c) Safeguard the doctor.
- (d) Assist the doctor.

Ideally, in child protection assessments, the chaperone should be an experienced member of staff who is familiar with the special aspects of these examinations (including relevant investigations, the psychological support of the child and family, and an understanding of anogenital examination and colposcopy). Parents or social workers may not be suitable chaperones.

## 5.3 Interpreters

If there is any suggestion of any language or communication difficulty it is essential that the formal interpreter service be used. Other members of the family are not appropriate interpreters for child protection consultations. It is good practice for interpreters to have training in child protection.

## 5.4 Confidentiality

- 5.4.1 Doctors must share information with other agencies on a need to know basis. Confidentiality must not be allowed to stand in the way of child protection.
- 5.4.2 Medical reports should be headed 'Private and Confidential' and distributed as required and to other agencies as appropriate. They should not be photocopied or given or shown to another party without the author's consent. They may be used at child protection conferences.
- 5.4.3 Care should be taken not to disclose third party information in front of parents.

*'Professionals can only work together to safeguard children if there is an exchange of relevant information between them.'* (DoH 2006)

### **Case History 1**

*Lucy told the nurse looking after her on the ward that she had a bad secret and if she told her would she keep the secret too? Wisely the nurse thought ahead and promised that if the secret meant that Lucy might come to harm then she would have to tell.*

## **5.5 Consent for disclosure of information to Children's Social Care or Police**

### **5.5.1 The Common Law Duty of Confidence**

- (a) Personal information about children and families held by professionals and agencies is subject to a legal duty of confidence, and should not normally be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information necessary to safeguard a child or children in the public interest: that is, the public interest in child protection may override the public interest in maintaining confidentiality. Disclosure should be justifiable in each case, according to the particular facts of the case, and legal advice should be sought in cases of doubt.
- (b) Children are entitled to the same duty of confidence as adults. It will sometimes be necessary to break that confidence and the test for that will be when the best interests of the child demand it and the doctor is unable to persuade the child to agree to the parents being told.
- (c) In exceptional circumstances, it may be believed that a child seeking advice, for example on sexual matters, is being exploited or abused. In such cases, confidentiality may be breached where the professional is satisfied it is in the best interests of the child. It will usually be appropriate for there to be discussion with the patient before any confidentiality is breached.

### **5.5.2 The General Medical Council advice to doctors**

*'If you believe a patient to be a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, you must give information promptly to an appropriate, responsible person or statutory agency, where you believe that disclosure is in the patient's best interests. If, for any reason, you believe that disclosure of information is not in the best interests of an abused or neglected patient, you should discuss the issues with an experienced colleague. If you decide not to disclose information, you must be prepared to justify your decision.'*

### **5.5.3 Disclosure to the Police without consent may be necessary**

*'Where a disclosure may assist in the prevention of a serious crime. Serious crimes in this context will put someone at risk of death or serious harm, and will usually be crimes against the person, such as the abuse of children. You should inform those with parental responsibility about the disclosure. If for any*

*reason you believe that disclosure of information is not in the best interests of the abused or neglected patient, you must still be prepared to justify your decision and record your responses contemporaneously'. (GMC 2004)*

### **Case History 2**

*Irene is 13 and goes on her own to see her GP about a vaginal discharge. In response to gentle questioning she reveals that her stepfather has been sexually abusing her for the past four years. Irene is competent to consent for herself to the treatment of the discharge and wishes to keep the consultation confidential, as she does not wish to upset her mother. However she clearly wishes the abuse to stop. After listening to Irene talk about her experiences, her GP sympathetically explains to her that in view of the harm that Irene is suffering, she must involve the child protection team in order to help stop the abuse. The GP helps Irene to understand that this is the best and safest thing to do in the circumstances and reassures Irene that she will continue to offer her support during the process.*

### **References**

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## 6

# Recognition of maltreatment

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Throughout this document, where evidence exists, it has been referenced. However it is recognised that there is a paucity of high-quality evidence-based research on child abuse and neglect. At the time of publication these are the best guidelines based on clinical experience and published literature. We would anticipate that, as new research evidence becomes available, these guidelines will be revised.

## IF YOU DON'T THINK, YOU WON'T DIAGNOSE

There are a number of features in both children and parents that may increase the risk that there has been harm to a child (See Appendix 4A)

### 6.1 Physical abuse - history

- 6.1.1 The presence of an injury in an infant frequently indicates more severe abuse. The possibility of other internal injuries must be considered e.g brain, abdomen. Appropriate investigations will be required.
- 6.1.2 A suspicion of physical abuse may be aroused when there are concerning features on presentation either in the history or examination, or both, and confirmed or refuted by a more thorough history, examination and investigations. There are very few diagnostic signs, but the following is a guide to the features of childhood injury that should raise suspicion (see Appendix 4B).
- 6.1.3 **Concerning features of history:**
  - (a) Vague, unwitnessed, inconsistent, discrepant history.
  - (b) History does not make sense, fails to explain the injury, is not appropriate to the child's development, and/or is not consistently given by the same or different parents/carers. Do not be afraid to ask for further history (e.g. 2 month old child rolling off sofa has a fractured skull, could there have been another incident?).

- (c) History of inappropriate parent/carer response (e.g. time delay without appropriate explanation, unconcerned or aggressive carers).
- (d) History of inappropriate child response (e.g. didn't cry, felt no pain).
- (e) Presence of other injuries.
- (f) Child/family known to Children's Social Care/ on Child Protection Register/ previous concern about child care. For this or another child.
- (g) Age of child – infants who are immobile rarely have accidental injuries and are at high risk of severe injury.
- (h) Previous history of unusual injury.
- (i) Repeated attendance may be due to neglect or abuse.

### Case History 3

*John, aged 3, was admitted from casualty with scalds to both feet. An alert surgical junior doctor noted that he was withdrawn and refused to speak to any of the staff looking after him. The paediatrician, who was called, noted weight below the 0.4<sup>th</sup> centile and a frozen watchful expression. The scalds extended around the feet and ankles 'like a sock'. Forced immersion injury was suspected and children's social care and the police child protection unit were called.*

## 6.2 Bruises

*'Those who don't bruise rarely bruise'* (Maguire et al 2005a; Sugar, Taylor & Feldmen 1999)

### 6.2.1 Introduction

- (a) Non-abusive bruising in children has a direct correlation to the developmental stage of the child under 5 years (Carpenter 1999; Sugar, Taylor & Feldmen 1999; Wedgewood 1990). Non-mobile children should not have bruises without a clear and often observed explanation. All such bruises should be carefully assessed.
- (b) Boys and girls have equal rates of non-abusive bruising (Carpenter 1999; Sugar, Taylor & Feldmen 1999; Tush 1982)
- (c) Certain areas are rarely bruised accidentally at any age, including neck, buttocks and hands in children less than 2 years (Sugar, Taylor & Feldmen 1999). Common and important sites for non accidental bruises are:
  - (i) Buttocks and lower back.
  - (ii) Slap marks on side of face, scalp and ears.
  - (iii) Bruises on external ear.
  - (iv) Neck, eyes and mouth.
  - (v) Trunk including chest and abdomen.
  - (vi) Lower jaw and mastoid.

- (d) Two black eyes may follow blood tracking down from the forehead from a substantial injury. This may involve the skin around the eyes but not the orbit. If this is accidental, there should be a consistent account of an accident / incident a few days before (i.e. a memorable event).
- (e) Bruises associated with sexual abuse include lower abdomen bruises, grip mark patterns around buttocks, thighs, knees and genitalia.
- (f) The face is the most commonly bruised site in fatally abused children (Atwal et al. 1998; De Silva & Oates 1993).
- (g) Clustering of bruises or those which show a negative or positive image of an implement are very significant (Brinkman et al 1979; Ellenstein NS 1979; Sussman et al 1968; ).
- (h) Accidental injuries predominantly affect bony prominences and the front of the body (Carpenter 1999; Sugar, Taylor & Feldmen 1999; ).
- (i) No site in itself is pathognomonic, and a careful history should be taken in all cases. (Maguire et al 2005a).

No site in itself is pathognomonic, and a careful history should be taken in all cases. (Maguire et al 2005a).

#### 6.2.2 Type

Look for patterns, slap marks, implement (e.g. belt, flex, stick) and bruises which do not fit the history.

#### 6.2.3 Ageing and number of bruises

- (a) The key point is to assess the bruises in light of the history, child's developmental stage and ability.
- (b) "*The statements on ageing bruises in many review articles and textbooks are not based on any scientific evidence*" (Maguire et al 2005b). Research has shown that it is not possible to accurately age bruises with the naked eye. The existing literature is conflicting in its findings and based on tiny numbers of children. Recent studies amply demonstrate the wide variation in intra and interobserver variability, both in-vivo and in photographs (Barciak et al 2003; Carpenter 1999; Maguire et al 2005b; Munang et al 2002; Stephenson & Bialas 1996; ).

#### 6.2.4 Differential diagnosis – depends on careful history.

A full family history of coagulation disorders is needed

- (a) Meningococcal sepsis – rarely localized.
- (b) Coagulation disorder: including Haemophilia, Christmas Disease, Factor VIII / IX deficiency/Von Willebrand disease.
- (c) Henoch Schoenlein Purpura/ITP, Idiopathic Thrombocytopenic Purpura (ITP)
- (d) Connective tissue disorders (e.g Ehlers Danlos Syndrome).
- (e) Asphyxia - this may be accidental or non-accidental.

- (f) Drugs – accidental or deliberate poisoning (e.g aspirin, NSAIDs and warfarin).
- (g) Birth marks – mongolian blue spot, some haemangiomas.
- (h) Cultural practices e.g coining or cupping - but some cultural practices may be abusive.
- (i) Photosensitive dermatitis and contact dermatitis (either of these may have a patterned mark which may be mistaken for the imprint of a weapon).
- (j) Artefact – dirt, dye or paint.
- (k) Self-inflicted injuries, which should not be accepted as an explanation without a careful assessment.
- (l) Striae – particularly in older children.

#### 6.2.5 **Coagulation/clotting disorder and non-accidental injury**

- (a) Parents may say, 'he bruises easily' but this is rarely of value on its own.
- (b) Where a child presents with inadequately explained bruises, it is prudent to undertake tests to exclude a bleeding disorder. Such disorders are rarely diagnosed, especially in babies.
- (c) Both inflicted injury and bleeding disorder may co-exist (O'Hare & Eden 1984) and the diagnoses are not mutually exclusive. Abused children who also have a disorder of coagulation are at increased risk from the effects of injury.

#### 6.2.6 **Assessment:** (See Appendix 5 for flow chart)

- (a) History including family history – any bleeding after surgery/delivery, immunisations or dental care.
- (b) Drug history – especially warfarin/aspirin/NSAID.
- (c) Careful documentation – take time, use body plans/drawings. Measure each and every bruise.
- (d) Formal photography of bruises may be required (Use a medical or forensic photographer).
- (e) Less than 2 years consider skeletal survey. Absence of bruising does not exclude a fracture, particularly rib fractures, of which up to 80% will have no associated bruising (Merten, Radkowski & Leonidas 1983; see also section 6.4.11).
- (f) First line blood investigations (Thomas 2004):
  - (i) Full blood count, white cell count, haemoglobin, platelet count.
  - (ii) Film to be reviewed by haematologist – must be specifically requested.

- (iii) Coagulation screen.
  - Prothrombin time (PT).
  - Activated partial thromboplastin time (APTT).
  - Thrombin time.
  - Fibrinogen.
- (iv) These tests will not exclude a platelet function defect. If there is any suspicion of a platelet problem (e.g. family history), then discuss with a haematologist and proceed to second line investigations.
- (v) If any of the above are abnormal or borderline discuss with haematologist and consider second line investigations.
- (g) Second line blood investigations (*discussion with Haematologist is essential before further investigations are done* Thomas 2004). Possible options are:
  - Von Willebrand screen.
  - Factor assays.
  - Platelet aggregation studies.
  - Bleeding time.

Thomas recommends that all should have a Von Willebrand screen (Thomas 2004).

## 6.3 Bites

6.3.1 Bites are always inflicted injuries. They can be animal or human – adult or child.

6.3.2 Bite marks are marks made by teeth either acting alone or in combination with other mouth parts. 'Love bites' are suction marks caused by the mouth with or without teeth marks, and can appear as petechial hemorrhages.

### 6.3.3 Animal bites:

- (a) Domestic dogs have 4 very prominent canine teeth that are considerably longer than the incisor teeth. Therefore, the dog bite consists of opposing pairs of triangular or rounded puncture wounds from the canine teeth. In addition dog upper and lower dental arches are V-shaped.
- (b) Human dental arches are U-shaped. Also human canine teeth are not prominent and the human bite marks consist of canines and incisors together. The upper and lower 12 front teeth may produce curved arcades forming a circle or oval injury.

### 6.3.4 Adult or child?

- (a) Human bites are mostly paired crescent shaped arches of bruises. In the most aggressive bites the skin may be broken. Individual teeth marks may

be seen. The marks may be distorted by the contours of the area bitten.

- (b) The differences between adult and child bites are subtle. For example, the intercanine distance (measurement across the mouth between the third tooth on each side) is more than 3 cm in the adult and less than 3 cm in the young child with primary teeth. It may be impossible to distinguish between a bite made by a child or one made by an adult.

#### 6.3.5 Approach to assessment of bite marks (Appendix 6):

- (a) Measure and document bite mark.
- (b) Contact forensic odontologist. The Named doctor or the Police should have contact details or see odontology website (see the *Useful websites* section at end of chapter 6).
- (c) Swab skin over bite for DNA profile using plain swab moistened with sterile water. Do not swab vigorously or the victim's DNA will confuse perpetrator's DNA.
- (d) Photography: photographs are best taken by a medical or forensic photographer
  - (i) Serial photographs at 12–24 hour intervals are advisable for assessment of evolving bites.
  - (ii) Incorporate a mm rule in the photographs, a right angle rule is ideal.
  - (iii) Position the scale parallel to the injury.
  - (iv) Have the camera film plane parallel to the injury (with the axis of the lens perpendicular to the injury).
  - (v) If on a curved surface – take photographs 'around' the curve.
  - (vi) A more distant photograph of the bite should be taken for orientation of anatomical parts.

## 6.4 Fractures

It takes considerable force to produce a fracture in a child or infant. All fractures require appropriate explanation and this must be consistent with the child's developmental age. Abusive fractures are frequently occult, particularly rib fractures (Merten, Radkowski & Leonidas 1983). Assessment requires interface between paediatrician, paediatric A&E, paediatric radiology and paediatric orthopaedics wherever possible (see RCPCH/RCR 2006).

### 6.4.1 Age

- (a) The younger the child the greater the likelihood of abuse. 80% of abused children with fractures are less than 18 months old, whereas 85% of accidental fractures occur in children over five years (Leventhal et al 1993; Worlock, Stower & Barbor 1986; ).

- (b) Infants less than four months of age with fractures are more likely to have been abused (Skellern et al 2000).

**The following fractures are more suspicious of abuse:**

**6.4.2 Humerus**

- (a) Spiral fractures of the humerus are uncommon and strongly linked with abuse. Any humeral fracture other than a supracondylar fracture is suspicious of abuse in children (Leventhal et al 1993; Strait, Seigel & Shapiro 1995; Thomas et al 1991; Worlock, Stower & Barbor 1986).

All humeral fractures in a non-mobile child are suspicious if there is no clear history of an accident.

**6.4.3 Multiple fractures**

- (a) Multiple fractures are significantly commoner in abused children, (Worlock, Stower & Barbor 1986).

**6.4.4 Ribs**

- (a) In the absence of underlying bone disease or major trauma (such as a road traffic accident), rib fractures in very young children are highly specific for abuse (Barsness et al 2003), and may be associated in some cases with shaking.
- (b) Posterior rib fractures have never been described following resuscitation. Anterior or costochondral rib fractures have been described extremely rarely, in 0.5% of resuscitated children (Bush et al 1996; Betz & Liebhardt 1994). If fractures are present on a chest x-ray after resuscitation they must be investigated on the basis that they occurred before admission. Dating of the fractures may be crucial in this assessment but the evidence suggests that this cannot be done with accuracy (Prosser et al 2005). Remember anterior rib fractures may also occur in child abuse (Barsness et al 2003; Cadzow & Armstrong 2000).
- (c) Posterior rib fractures are relatively more common in abuse and must be looked for carefully, as they are easily missed (Kleinman et al 1988). A skeletal survey must include oblique views of the ribs to maximise detection (Ingram et al 2000).

**6.4.5 Femur**

- (a) Femoral fractures in children who are not independently mobile are suspicious of abuse, regardless of type (Schwend, Werth & Johnson 2000).
- (b) Once a child is able to walk, they can sustain a spiral fracture from a fall while running. A transverse fracture of the femur is the commonest presentation and can be found in accidental and non-accidental injuries.

**6.4.6 Spinal fractures**

- (a) Spinal fractures most commonly occur in the cervical or lower thoraco-lumbar

area, emphasising that it is vital that full views of the spine are required. They are frequently accompanied by head injury.

- (b) Cervical spinal fractures can occur if an infant is vigorously shaken (Gille et al 1980; McGrory & Fenichel 1977).
- (c) Compression fractures or fracture with anterior dislocation of T12/L1/L2 are seen with either hyperflexion or a direct blow, or forcibly placing the child on the bottom or feet (Carrion et al 1996; Faure et al 1979; Gabos et al 1998).
- (d) It is vital to consider spinal fractures early, as the child may require urgent surgery (Diamond, Hanson & Christofersen 1999).

#### 6.4.7 Metaphyseal fractures

- (a) These are relatively rare fractures. In the neonatal period, they can be related to birth injury, physiotherapy or casting of talipes, but outside the neonatal period, under the age of two years, may indicate abuse (Kleinman & Marks 1996 Feb, May, Dec; Kleinman & Marks 1998), particularly if femoral.
- (b) Metaphyseal fractures will only be found if looked for carefully (consider coned views of the metaphyses in live children, and specimen radiography in post mortem cases) and will need a paediatric radiological opinion.

#### 6.4.8 Skull fractures

- (a) Like other fractures, skull fractures require considerable force. A linear parietal fracture is the commonest accidental and non-accidental fracture.
- (b) Other skull fractures require a greater degree of force, which should be reflected in the history. Skull fractures are of particular concern (Hobbs 1984):
  - (i) Occipital – this is a large solid bone, which rarely fractures.
  - (ii) Depressed fractures.
  - (iii) Growing fracture.
  - (iv) If the fracture is complex or multiple in severely injured or fatally injured children, it is twice as likely to be due to abuse (Hobbs 1984).
  - (v) Wide fracture (width on x-ray 3.0mm or more).
  - (vi) A fracture which crosses the suture line, is multiple or bilateral (Meservy et al 1987).
  - (vii) A fracture with associated intra-cranial injury.
  - (viii) A history of a fall less than 3 feet – rarely produces a fracture.
- (c) Up to 88% of abusive skull fractures occur under one year of age (Leventhal et al 1993; Meservy et al 1987; Merten, Radkowski & Leonidas



1983). This is also the commonest age for accidental skull fractures.

- (d) It is important to assess the height, force of fall, and the exact surface that the child lands on, and not be didactic about the height of the fall.

#### 6.4.9 Differential diagnosis of fractures

- (a) Normal variant.
- (b) Accidental Injury.
- (c) Birth injury – these usually heal within a few weeks. Calcification will be visible within 11-14 days (Cumming 1979). A good obstetric history may help.
- (d) Physiological: when a (bilateral) periosteal reaction is seen.
- (e) Infection (including syphilis), malignancy, Caffey's disease.
- (f) Osteogenesis imperfecta:
  - (i) Type I is mild.
  - (ii) Type II is lethal.
  - (iii) Type III is severe with progressive bone deformities.
  - (iv) Type IV is intermediate between I and III and usually has white sclera.

Ligamentous laxity, blue sclerae, wormian bones and dentinogenesis imperfecta are seen in varying combinations in each of the types. It is important to take a family history of fractures

- (g) Osteopenia - premature, chronic illness, severe failure to thrive.
- (h) Nutritional: copper deficiency is now extremely rare. Vitamin C, vitamin A, vitamin D (rickets) deficiency are all very rare.
- (i) Iatrogenic (e.g. interosseous needle insertion in tibia), may appear as diffuse periosteal reaction.

#### 6.4.10 Investigations (see RCPCH / RCR 2006)

- (a) Skeletal survey if child is less than 2 years. An oblique view of ribs is needed. (British Society for Paediatric Radiology draft guidelines on website (See *Useful websites* section at end of chapter 6).
- (b) Consider a bone scan after discussion with radiologist, particularly if skeletal survey is negative. Single skeletal survey or bone scan alone will miss fractures ([www.core-info.cf.ac.uk](http://www.core-info.cf.ac.uk)).
- (c) If bone scan is not conducted in addition to skeletal survey, consider repeat skeletal survey after 11-14 days. May exclude skull on second imaging.
- (d) Consider Computed Tomography (CT) head scan in infants. It is increasingly thought this should be part of a skeletal survey. It should be done in all

infants whenever there are neurological symptoms. Remember CT may not detect skull fracture.

- (e) Ca, PO<sub>4</sub>, alkaline phosphatase, FBC, vitamin D should be considered.
- (f) Cu and ceruloplasmin should be considered in children who have been preterm babies and have received parenteral feeding. (Barber and Sibert 2000).
- (g) If bone density is questioned (e.g ex pre-term infant less than 6 months of age, chronic malabsorption etc), consider DEXA scan in discussion with paediatric radiologist. However, there is limited normal data for children less than 3 years of age, and exact correlation with fracture risk in this age group is lacking. Check the neonatal notes for the mode of delivery and neonatal progress. Where appropriate look for biochemical and radiological evidence of bone disease. however one should be aware that non-accidental injury and metabolic bone disease can co-exist.

#### 6.4.11 Skeletal survey

- (a) Indications:
  - (i) Presence of a fracture which suggests abuse. 60% of children who presented with an abusive fracture had further occult fractures (Belfer, Klein & Orr 2001).
  - (ii) Suspected physical abuse – all children less than 12 months.
  - (iii) Suspected physical abuse – most children less than 2 years and may be prudent up to 3 years.
  - (iv) Severe inflicted soft tissue injury in an older child.
  - (v) Localised pain, limp or reluctance to use limb in abused child.
  - (vi) Previous history of skeletal trauma in child suspected of abuse.
  - (vii) Unexplained neurological presentation.
  - (viii) Child dying in suspicious or unusual circumstances (request specimen radiography to maximise detection of rib and metaphyseal fractures).
  - (ix) Twin of infant (or sibling less than 2 years) with evidence of physical abuse. Consider screening siblings if there is any suspicion of abuse.
  - (x) Intracranial injury.

If a child has a fracture and is less than 2 years or there are any unusual features, discuss with radiologist.

- (b) Aims:
  - (i) To detect and date fractures (Prosser et al 2005).
  - (ii) To check bones are normal.
  - (iii) To detect any other bony injury.

#### 6.4.12 Repeat x-rays/skeletal survey

- (a) Repeat x-ray/skeletal survey after 11-14 days has been found to provide additional information in suspected physical abuse and may increase the yield by up to 27% (Kleinman et al 1996). It can also assist in dating the injury or clarifying normal variants. However, there may be considerable logistic difficulties in getting the child back and the child protection process may be delayed.
- (b) Indications:
  - (i) To check suspicious or unconfirmed findings on initial survey.
  - (ii) To look for additional injury when first survey was positive (in particular, rib fractures).
  - (iii) To investigate clinically suspicious findings when earlier x-rays are negative or uncertain.
  - (iv) Original skeletal survey equivocal and bone scan not performed.

#### 6.4.13 Options (See RCPCH / RCR 2006)

- (a) Full repeat survey.
- (b) Repeat films of suspicious areas.
- (c) Repeat chest x-ray for rib fractures only.

Formal consent from those with parental responsibility obtained by a doctor of greater seniority than an SHO / SpR Year 2 is required.

Parents/carers must be told that the investigation is to search for other injury or bone disease.

The request card must indicate that abuse / NAI is being considered. It is good practice for the paediatrician to discuss possible diagnosis with the radiologist.

Whilst we must always be cautious of exposing a child to excessive radiation, if a child is at risk of harm, this must take precedence.

### 6.5 Non-accidental head injury (NAHI) (See Appendix 7)

This is based on the conventional medical views of the causation and mechanisms resulting in the clinical findings described in this section. We have not attempted to resolve the current controversies on head injuries.

- 6.5.1 Head injury is the commonest cause of death in physical child abuse. 95% of severe head injury in the first year of life is inflicted.
- 6.5.2 NAHI is most commonly seen in infants under 6 months of age but also occurs in older children.
- 6.5.3 The mortality from NAHI is up to 30%. Half of the survivors have residual disability of variable severity.
- 6.5.4 Infants with NAHI present to hospital with a variety of symptoms ranging from poor feeding, lethargy, fits and respiratory difficulty to sudden death. In some cases the absence of either a history or external signs of injury may delay diagnosis. Not all infants are acutely ill, others present for example with an enlarging head. Children with chronic subdural haemorrhage or effusions present a diagnostic problem because many lack a clear history of symptom onset and corroborative findings are usually absent.
- 6.5.5 The diagnosis of NAHI must be considered in any infant or young child who inexplicably collapses. The paediatrician must maintain a low threshold for considering this diagnosis.
- 6.5.6 **Important features of NAHI**

Such injury arises from impact to the head or as a result of severe repetitive rotational injury with or without additional impact. Combinations of mechanisms frequently occur.

The consequences may include:

- (a) Bruising/abrasions or lacerations to the head including scalp or face.
- (b) Skull fracture(s) usually with overlying haematoma.
- (c) Intracranial bleeding – subdural, subarachnoid or intraventricular/parenchymal. Extradural haemorrhage is rare.
- (d) Subdural collections are often bilateral, and common sites are over the convexity of the cerebral hemisphere, along the falx or in the posterior fossa. In the acute stage they are typically small and do not cause mass effect.
- (e) Brain injury – includes hypoxic - ischaemic injury and direct traumatic injury of the brain substance.
- (f) Retinal haemorrhage in one or more usually both eyes.
- (g) Neck and cervical spinal cord injury.
- (h) Skeletal injury – fractures of ribs where the child is grasped, long bone fractures when child is held, swung or limbs flail. Vertebral injury is rare.
- (i) Bruising to body or limbs.

**6.5.7 History**

It is important to take a careful history of the timing of the onset of the child's symptoms, any previous or recent injury, birth history, developmental milestones, and vitamin K status. In most cases where a history of injury is given, it is of a minor nature and is not consistent with the severity of the infant's condition.

- (a) When was the child last well? What were the events which led up to the admission?
- (b) Past medical history.
- (c) Is there a history of injury, no matter how minor? If so how did it occur, when, where and who was present? What effect did it appear to have on the child?  
If a fall is alleged, from what height and on to what surface?
- (d) What did the parent/carer do next?
- (e) Social and family history should ascertain family composition including the presence of other children.
- (f) Have there been previous child protection concerns or involvement with Childrens Social Care or Police?
- (g) Identify name of GP & health visitor.

**6.5.8 Examination**

- (a) Assess need for resuscitation / conscious level.
- (b) Look for signs of external injury including the mouth.
- (c) Does the child look neglected? Is the child failing to thrive?
- (d) Check fontanelle and head circumference.
- (e) Think of abdominal injury. N.B. absence of bruising over the abdomen does not exclude this.

**6.5.9 Ophthalmology examination**

Do examine the fundi yourself but always arrange for an ophthalmoscopic examination by an experienced ophthalmologist as soon as possible in order to exclude eye injury including retinal haemorrhage.

**6.5.10 Neuroimaging**

- (a) This is the definitive diagnostic investigation and should be performed where NAHI is suspected. This includes infants or young children with unexplained sudden collapse, neurological symptoms or signs, enlarging head or persistent uniform CSF bloodstaining.
- (b) In any infant under 2 years of age in whom a skeletal survey has been

performed for suspected non-accidental injury, it is recommended that a CT head scan will be included.

- (c) First line investigation in suspected NAHI is CT head scan followed by MRI where available. Head ultrasound is unreliable as a means of detecting SDH. MRI is a more sensitive method of detecting small intracranial collections, especially in areas less well seen on CT. Cerebral oedema and ischaemic changes are also well demonstrated by diffusion weighted MRI.
- (d) Radiology guidelines (Jaspan et al 2003; RCPCH 2006): Where there is a high clinical suspicion of NAHI the following has been suggested:
  - (i) Day of presentation: head CT – as soon as child stabilised after admission.
  - (ii) Day 1-2 skeletal survey including skull films and head ultrasound.
  - (iii) Day 3-4 If initial CT brain abnormal, perform MRI of head or if not available repeat CT head. Include cervical spine (preferably whole spine) images.
  - (iv) Follow up CT or MRI, where an earlier abnormality was detected, may be required at around 10 days and possibly later, 2-3 months after the initial injury.

#### 6.5.11 Skeletal Survey

This is essential in all cases of suspected NAHI to exclude skeletal injury, present in around half the cases. Difficult injuries to detect include rib and vertebral fracture although the latter is uncommon. Repeat survey should be undertaken after 11-14 days in accordance with the recommendations in Section 6.4.12.

#### 6.5.12 Laboratory investigations

- (a) Full blood count repeated after 24-48 hours may demonstrate a rapidly falling and low haemoglobin level.
- (b) Coagulation studies will exclude major bleeding disorder.
- (c) Septic screen will exclude infection. Subdural collections can be associated with meningitis.
- (d) Urine for toxicology and metabolic screen.

#### 6.5.13 Differential Diagnosis

- (a) Retinal haemorrhages are common after birth. Most disappear rapidly within the first few days of life with occasional larger subhyaloid and intraretinal haemorrhages lasting up to 6 weeks. Subdural haemorrhage may occur in the perinatal period associated with birth trauma and present severe symptoms or may be discovered incidentally in asymptomatic infants. The latter resolve within 4 weeks (Whitby, Griffiths & Rutter 2004).
- (b) Both retinal and subdural haemorrhages may uncommonly be associated with severe accidental head injury (e.g. following road accident).

- (c) Both retinal haemorrhage and subdural haemorrhage can occur in bleeding disorders (e.g. haemophilia, haemorrhagic disease of the newborn - vitamin K deficiency).
- (d) Other rare causes of SDH include cranial malformations, glutaric aciduria type 1, post-operative complication of open-heart surgery or neuro-surgery, hypernatraemic dehydration. Glutaric aciduric type I is nearly always accompanied by frontal lobe hypoplasia and there is often no accompanying skull fracture. The biochemical tests are confusing and unreliable (Morris et al 1999).
- (e) Retinal haemorrhages are very unlikely to follow resuscitation or epileptic fits.

#### 6.5.14 Team approach and multi-agency working (see Appendix 7)

The diagnosis of NAHI is usually made following a careful medical and social history and examination supplemented by appropriate investigations. Where NAHI is considered possible a strategy discussion involving police and Children's social care should be initiated to decide whether to initiate S47 enquiries and a criminal investigation. Children are frequently referred to a specialist centre where paediatric neuroscience resources are available. It is important that such specialists are supported by general paediatricians who are able to liaise with local and statutory child protection teams and participate fully in safeguarding children procedures (Brown & Minns 1993; Hobbs et al, 2005; Kemp 2002).

## 6.6 Intra-abdominal injury

Intra-abdominal injury is very uncommon, typically occurs in young children aged under 3 and has a high mortality rate (Ledbetter et al 1988, Barnes et al 2005) especially if diagnosis is missed or delayed.

Diagnosis can be difficult with delay in presentation and no history of trauma provided by the parent/carer.

Hollow viscous injury particularly of the small bowel is common. The liver seems to be the commonest solid organ injured (Barnes et al 2002–3; Ledbetter et al 1988). However any organ may be injured including haemorrhage from a major vessel. Small bowel injury is more common in young children who have been abused than in falls or road traffic accidents.

### 6.6.1 Features

- (a) A child may present with unexplained collapse/severe abdominal pain/sepsis.
- (b) Clinical signs may be difficult to elicit particularly when retro-peritoneal structures are injured.
- (c) There may be no signs of external injury or development of bruising may be delayed. Up to 25% may have no bruises.
- (d) Free gas may be found.

### 6.6.2 Investigation (Hobbs et al 1999)

- (a) Clinical abdominal examination:
  - (i) Is there distension? Serial girth measurements are useful. Is there tenderness? Are bowel sounds altered or any masses palpable?
  - (ii) Insert nasogastric tube, empty the stomach. Is blood, food or bile obtained? Does distension remain?
  - (iii) Examine the ano-rectal area. Are there signs of injury? (Sexual abuse can perforate the rectum in infancy.) Is there blood or anterior tenderness?
  - (iv) Petechiae can be an indication of significantly raised intra-abdominal pressure.
- (b) Laboratory investigations:
  - (i) Serial FBC/haematocrit for blood loss.
  - (ii) Serum amylase (pancreatic or splenic injury).
  - (iii) Liver enzymes - transient elevation may be the only marker in clinically silent hepatic trauma (Coant et al 1992).
  - (iv) Urinalysis for haematuria.
- (c) Radiology:
  - (i) CT scanning is the most sensitive method of identifying injury in blunt abdominal trauma (Kirks 1983; Ledbetter et al 1988).
  - (ii) Ultrasonography can be helpful.
  - (iii) Chest x-ray to look for rib fracture, pneumothorax, and pleural fluid.
  - (iv) Abdominal and chest x-rays (supine and erect) to look for free air and fluid levels.
  - (v) Plain x-rays may appear normal despite significant injury.

### 6.6.3 Management

(a) Detailed discussions with radiology and paediatric surgical colleagues are required. Other techniques may be useful, for example nuclear scintigraphy, contrast examination of the GI tract.

(b) Management may be conservative but urgent laparotomy may be required following treatment of any associated shock/sepsis.

#### *Case History 4*

*A moribund 15 month old with ventricular tachycardia was brought to hospital with a history of sudden collapse at home. Bruising to the side of her face alerted the A&E staff to possible physical abuse. There was no bruising over her abdomen but after initial resuscitation scans revealed extensive liver laceration with overlying rib fractures.*



## 6.7 Thermal injury

A systematic review on burns and scalds is ongoing by the Welsh Child Protection systematic Review Group and the completed work will be available on their website, [www.core-info.cf.ac.uk](http://www.core-info.cf.ac.uk).

6.7.1 Burns and scalds to children are common. The majority of burn or scald injuries result from non-intentional injury, which involves varying degrees of parental inattention, but also include some cases of neglect. A smaller number involve deliberate abuse. Staff in accident and emergency, plastic surgery and children's burns units see the more severe injuries at the time of presentation and their records and observations are vital to assessment. Paediatricians need to liaise with those responsible for treatment of the burns. Less severe injuries may not be seen in hospital but may present to GPs, health visitors and school nurses or are discovered, for example, by nursery nurses or school teachers.

Most accidental burns and scalds in childhood occur in pre-school children and should be preventable.

### 6.7.2 Prevalence – accidental injury

11% of all accidental deaths were the result of burns or scald injuries including inhalation of smoke from house fires (Jackson 1985).

The following statistics are obtained from the Child Accident Prevention Trust website:

In 2002 in the UK:

- (a) Over 42,000 children under 15 were injured in burn and scald accidents.
- (b) The majority (over 28,000) were under 5 years old.
- (c) 95 per cent of thermal injuries to children happened at home.
- (d) Over half of all severe burns and scalds happened in the kitchen.
- (e) 32 children under 15 years died as a result of house fires.

### 6.7.3 Scalds

Hot liquids cause 70 per cent of all thermal injuries to children. The most common single cause of scalds is hot drinks. Babies and toddlers are particularly at risk when they grasp cups and mugs of hot tea or coffee. Other common causes include steam or water from kettles and hot oil or fat. Children may also be scalded by hot tap water.

### 6.7.4 Burns

Children can suffer burns after contact with heaters, open fires, cookers, barbecues, irons, fireworks, matches, cigarette lighters, candles or any other hot surface. Young children are also particularly vulnerable to sunburn.

### 6.7.5 Abuse

Deliberately inflicted burns and scalds are found in variable proportions of all burn and scald cases depending on the series. Figures from 1–29% as a proportion of burns caused by abuse or neglect have been described (for example Raine & Azmy 1983, Hight et al 1979, Feldman et al 1978, Bennet & Gamelli 1998). In view of the wide discrepancy between the various studies it is likely that many cases are not recognized or reported. The average incidence for US studies is around 20%. There are no recent UK studies, the older ones generally showing low incidence figures of 1-2%. A study from 14 French burns centres identified abuse in only 2% of 937 patients although immersion scalds were common and frequently involved the buttocks and legs (Mercier & Bond 1996). 47% of cases were toddlers aged 1-3 years. In contrast, a recent study from the USA (Bennet and Gamelli 1998) found that 93 of 321 (29.8%) pediatric burn admissions were reported to child protection services. 79 of those cases were substantiated as having elements of abuse or neglect. The cases included flame, scald, electric, chemical, thermal (contact) and other. Scalds, flame and thermal accounted for most cases.

Many cases are not recognized and reported because of the difficulties of diagnosis. In the absence of other injuries diagnosis of abuse may not be suggested. There are no simple formulae for recognizing abuse. The doctor's experience of abusive thermal injuries is important in accurate ascertainment of abuse.

### 6.7.6 Features of childhood thermal injury:

- (a) Accidents follow brief lapses in protection, neglect is part of a pattern of inadequate parenting, and abuse occurs when injury is deliberately inflicted.
- (b) When burns are old or become infected they are difficult to differentiate from a primary infected lesion. Precise ageing of injuries is also very difficult although experienced staff in the care of burns can make an approximate estimate in some cases of the age of an injury.
- (c) Significant points in the history of abusive burns and scalds include:
  - (i) The injury does not fit the history (Showers & Garrison 1988).
  - (ii) Delay in seeking treatment.
  - (iii) Surprising lack of pain described.
  - (iv) History incompatible with the developmental level of the child (Andronicus, Oates and Peat 1998).
  - (v) Vague or changing histories (Hight and Bakalar 1979).
  - (vi) Speculative accounts of what happened, unwitnessed burn (Hobbs 1986).
- (vii) Inadequate supervision and admission of guilt (Showers & Garrison 1988).
- (viii) Denial that a lesion is a burn (Hobbs 1986).

- (ix) Burn attributed to sibling.
- (x) Child contradicts history (Rosenburg NM, Marino 1989).

In Showers and Garrison's review (1988) of 139 cases over a 4 year period, 20% were under 1 year of age, 56% were aged 1-2years and only 6% were of school age. More than 2/3rds of the alleged perpetrators were female, the majority being mothers. Legs (35%), feet (25%) and hands (23%) were the commonest injured body locations. Bilateral burns occurred in 32% of cases. Contact burns accounted for 56%, scalds for 38% and flame 4%. Overall burns were present in 12% of all physical abuse cases and abusive burns constituted 10% of all admissions to the burn unit. Half the children had other injuries in addition to the burns.

- (e) Differential diagnosis includes other skin pathology, especially infections. Staphylococcus aureus infection can cause "the scalded skin syndrome" which resembles a scald and impetigo. Burns can occur when cars are left in the sun (e.g. from a car seat or belt).
- (f) There is an association between sexual abuse and burns (Hobbs & Wynne 1990).
- (g) Repeated non-inflicted burns are a dangerous form of neglect.

**6.7.7 Common patterns of abusive burn and scald injuries:**  
(Peck & Priolo-Kapel 2003; Lenoski 1977)

- (a) Contact burns - clearly outlined mark from contact with hot objects  
(e.g. clothes iron (Gaffney 2000)), fire grid, cooker hot plate, hot fork, hot spoon, cigarettes and cigarette lighters. These are the most common non-accidental burns in UK community surveys (Hobbs 1986; Keen, Lendrum and Wolman 1975).
- (b) Deep, cratered, circular burns from cigarettes, which heal to leave scars. (1/3 of contact burns were from cigarettes (Showers & Garrison 1988).
- (c) Immersion scalds most usually from hot water. Sometimes there are glove and stocking circumferential scalds of limbs/ parts of limbs/ buttocks from forced immersion. Clear waterlines may be visible where the child has been held in the water. Splash marks may be absent. Most occur in the bathroom, kitchen or bedroom (Showers & Garrison 1988; Yeoh et al 1994).
- (d) Scalds from poured or thrown liquids.
- (e) Friction or carpet burns e.g from dragging child across the floor.
- (f) Bilateral burns are more commonly associated with abuse. They occurred in 32% of Showers and Garrison's cases (1988).

**6.7.8 Common sites of non-accidental thermal injury:**

- (a) Feet and hands especially the backs of hands.
- (b) Legs and buttocks.
- (c) Face.

**6.7.9 Assessment** (see Chapter 8, '*The medical assessment*', Appendix 8 and Hobbs, Hanks and Wynne 1999):

- (a) The burn must be examined by the paediatrician, during dressing changes, to assess details of the injury including the pattern and extent.
- (b) Detailed drawing of the burn including measurements, site, pattern (consider position child was in at the time of injury), depth of injury (in conjunction with surgical team) and age. Is there sparing and if so where? (e.g. soles/palms in immersion injury). Consider effects of clothes.
- (c) Photograph the injuries providing close-up and distant views to enable the overall pattern to be appreciated. Use a medical or forensic photographer.
- (d) Assess child's development and ability to act in the way stated (e.g. can this child turn on a tap or climb into a bath?).
- (e) Include genital and anal inspection (N.B. obtain consent) as child sexual abuse can occur with burns and scalds.
- (f) Request home visit from Police (or even visit the home with the Police) to:
  - (i) Examine appliance/heater alleged to have injured the child.
  - (ii) Assess height of bath or sink, water depth and materials from which bath or sink are made of.
  - (iii) Assess the likely temperature at time of alleged injury.
  - (iv) Assess the material alleged to have caused the injury, (e.g. bleach).
  - (v) Photograph injury scene and any appliances.
  - (vi) Examine any clothing worn (consider keeping clothing).
  - (vii) Re-enact the scene according to the parent/carer's description. (N.B. scientific advice, manufacturer's data etc. may be required).
- (g) Contribute to strategy discussion, work closely with Police, children's social care and surgical team. Information must be freely shared and discussed.

### 6.7.10 Depth of burns and scalds

The depth of burns depends on the temperature and duration of exposure. In the case of hot water immersion for adults in thin areas of skin, the following provides an approximate guide to times (DHSS 1977):

#### 6.7.11 Relationship between temperature and time to produce injury in adults:

Temperature (°C)	Partial thickness burn (seconds)	Full thickness burn seconds)
65	1	20
60	5	80-100
54	35	700-800
50	60	

Above 60°C (140°F) children's skin burns in one quarter of the time of adult skin. The temperature of hot water in many homes as it leaves the tap is as high as 60°C (140°F), thus increasing the risks of injury to children. In 1985 the Child Accident Prevention Trust suggested that the temperature should be set at 54°C. However, under the present BS 5546 specification for the installation of gas hot water supplies for domestic purposes, the maximum temperature of the cylinder thermostat and the BS 5549 maximum for forced circulation systems are both set at 60°C. In the United States new hot water heaters are set at 120°F (48.8°C).

Transfer of heat from hot water is more predictable than in other situations (e.g. contact burns from hot objects). Obviously maintenance of close contact, with air excluded, will be prevented by rapid reflex withdrawal of the part, which cannot occur in the same way with a scald. For this reason the mechanism by which contact was maintained must be ascertained in anything other than minor contact burns. Deep contact burns are likely to occur only when enforced contact has taken place.

#### Case History 5

*A 13 month old boy had a history of a fall against a fire but no help was sought for 2 days: he had contact burns to abdomen, ear and neck. A heated screwdriver, which fitted the pattern, was discovered by the police. Scratches, bruises, penile abrasions and torn frenulum were also noted. The child showed a pattern of failure to thrive and was found to have bilateral unexplained forearm fractures.*

### 6.8 Other non-accidental injuries

A variety of other injuries are encountered in physical abuse. These include:

- (a) Scratches, abrasions, incised wounds.
- (b) Mouth injuries – examine the mouth in all cases.
  - (i) Teeth – fractured, luxated, intruded or avulsed .
  - (ii) Lacerations and bruises to lips and tongue.

- (iii) Torn labial frenum in infant or toddler although there is no evidence in the literature that this is pathognomonic of abuse.
  - (iv) Palate/pharynx – burns from hot food, lacerations from cutlery / objects forced into mouth.
  - (v) Signs of neglect may also be found in the mouth – decayed, unfilled teeth, poor dental hygiene.
- (c) Injuries to nails – avulsed or broken, subungual haematoma, object pushed under nails.
- (d) Injury to hair – traumatic alopecia (distinguish from alopecia areata, self inflicted hair loss, tinea capitis).
- (e) Marks from tourniquets, ligatures. Strangulation – associated with facial petechiae and sometimes external bruising to neck.
- (f) Injuries from insertion of needles – superficial needle marks, deep insertion into tissues or head in bizarre abuse (visible on x-ray).
- Injection of material into skin e.g. faeces to produce skin infection in fabricated/induced illness.
- (g) Induction of hyperthermia or hypothermia.
- (h) Deliberate drowning is often a difficult diagnosis and may depend on parent/carers admission. Accidental bath drowning typically occurs between 8 and 24 months. Incidents outside this range, with previously normal developments, should give rise to concern either for deliberate drowning or epilepsy (in older children) (Kemp et al 1994).

The procedures for investigation of children who present with the above injuries where abuse is suspected are along similar lines to other forms of abuse ( See Chapters 7 *What to do if you are concerned that a child may be abused* and 8 *The medical assessment*).

## 6.9 Emotional abuse

Emotional abuse is probably the hardest form of abuse for a paediatrician to detect. It is important to involve CAMHS and psychology colleagues at a early stage

- 6.9.1 Emotional abuse is one of the most damaging forms of abuse and almost always accompanies other forms of abuse. It includes persistent criticism, denigration, rejection and scapegoating.
- 6.9.2 Emotional abuse refers to a relationship rather than to an event and a carer-child relationship that is characterized by patterns of harmful interaction, requiring no physical contact with the child (Glaser 2002). If chronic and persistent, this can cause severe and adverse effects on the child's emotional development.

**6.9.3 Children at risk or emotional abuse may be:**

- (a) The wrong sex, unwanted, disabled, abused as child, rejected.
- (b) Seen as ill or difficult.
- (c) Born into difficult situations – marital difficulty, separation, violence.
- (d) Born to vulnerable parents – alcohol or drug abuse, depressed, mentally or otherwise ill.

**6.9.4 Symptoms and signs are non-specific, and include the following:**

(a) Babies:

- (i) Feeding difficulties, crying, poor sleep patterns, delayed development.
- (ii) Irritable, non-cuddly, apathetic, non-demanding. Described as: 'difficult infant, not belonging to me', 'doesn't love me', 'spoiled'. Also 'greedy, attention seeking, lazy, in control of mother'.

(b) Toddler and pre-school child:

Head banging, rocking, bad temper, 'violent', clingy. Spectrum from overactive to apathetic, noisy to quiet. Developmental delay especially language and social skills.

(c) School child:

Wetting and soiling, relationship difficulties, poor performance in school, non-attendance, antisocial behaviour. Feel worthless, unloved, inadequate, frightened, isolated, corrupted and terrorized.

(d) Adolescent:

Depression, self harm, substance abuse, eating disorder, poor self-esteem. Oppositional, aggressive and delinquent behaviour.

**6.9.5 Additional detail on physical examination**

- (a) Growth (height and weight) – underweight and / or stunted.
- (b) Emotional signs: many possible signs but none specific (e.g. sad, withdrawn, over-affectionate, angry, apathetic).
- (c) Behavioural signs: a wide range, e.g restless, frozen and non-moving, destructive, very active, distant, over-friendly.
- (d) Development – signs of failure to achieve milestones, failure to thrive, academic failure, under achievement.

**6.9.6 The power of description**

At all times, and especially where there is hesitancy in diagnosing emotional

abuse or neglect, simple description of observations of child/parent relationship is a powerful tool.

#### 6.9.7 Three tiers of concern

Research has demonstrated that there are three tiers of concern in emotional abuse and neglect. These are:

- (a) Harmful parental attributes (predominantly mental ill-health, substance misuse and domestic violence).
- (b) Harmful interactions, which actually comprise the ill-treatment (which often exists without the presence of harmful attributes).
- (c) Indications of child impairment.

Any of these should draw attention to the possibility of emotional abuse or neglect. Recognition of one should draw attention to the possible presence of the other two (Glaser & Prior 2002).

#### 6.9.8 Categories of ill-treatment within emotional abuse and neglect

- (a) Emotional unavailability, unresponsiveness and neglect:
  - (i) The primary carers are usually preoccupied with their own particular difficulties such as mental health (including post-natal depression) and substance abuse or with overwhelming work commitments. They are unable or unavailable to respond to the child's emotional needs, with no provision of an adequate alternative.
  - (ii) Extremely little or no emotional or psychological interaction between the carer and the child (emotional unavailability).
  - (iii) The carer fails to respond to the child's overtures or attempts to interact with the child (unresponsiveness).
- (b) Negative attributions and misattributions to the child:
  - (i) Hostility towards, denigration and rejection or humiliation of a child, who is perceived as deserving these.
  - (ii) The child is repeatedly harshly criticised or blamed by the carer.
  - (iii) The child is 'scapegoated' by the carer.
  - (iv) The child is described by the carer as having the 'bad genes' or the negative traits of a disliked or hated person.
- (c) Developmentally inappropriate or inconsistent interactions with the child:
  - (i) Expectations of the child beyond her/his age and developmental capabilities.
  - (ii) Over-protection and limitation of exploration and learning, for example keeping child in pushchair for prolonged periods.



- (iii) Exposure to confusing or traumatic events and interactions, for example domestic violence, numerous changing partners, drug and alcohol abuse.
  - (iv) The parents/carers lack knowledge of age-appropriate care giving and disciplining practices and child development, often because of their own childhood experiences. Their interactions with their children, while harmful, are thoughtless and misguided rather than intending harm.
  - (v) The child is given responsibility which he/she is developmentally unable to fulfill, for example parenting younger children or caring for their own parents, or which impedes their development, for example education, peer relationships, own protection.
  - (vi) The child is treated in a punitive, harsh or inappropriate manner as a result of the carer's lack of awareness or understanding.
  - (vii) The child is exposed to confusing, distressing, disturbing or bizarre behaviour (e.g. intrafamilial (domestic) violence and parental (para) suicide).
- (d) Failure to recognise or acknowledge the child's individuality and psychological boundary:
- (i) Using the child for the fulfillment of the parent's/carer's psychological needs.
  - (ii) Inability to distinguish between the child's reality and the adult's beliefs and wishes.
  - (iii) The child is used by the carer as a partner, friend, confidant.
  - (iv) The child is expected to fulfill the parent/carer's ambitions.
  - (v) The parent/carer needs the child to be treated as ill; this includes Fabricated or Induced Illness (see FII Section 6:12).
- (e) Failing to promote the child's social adaptation:
- (i) Promoting mis-socialisation (including corrupting).
  - (ii) Psychological neglect (failure to provide adequate cognitive stimulation and/or opportunities for experiential learning).
  - (iii) The child is deprived of the opportunity to develop peer relationships, including the carer not facilitating school attendance.
  - (iv) The child is allowed or encouraged to misuse illegal drugs.
  - (v) The child is allowed or encouraged to be involved in criminal activities.
  - (vi) Failure to provide adequate cognitive stimulation, education and/or experiential learning; intellectual deprivation.

### 6.9.9 Thresholds

If the parent-child interaction satisfies the definitional criteria (see above), the threshold for emotional abuse or neglect is reached. Pervasiveness is assessed during observation and is evidenced by descriptions which include terms such as 'always', 'usually' or 'often', observed at different times, in different settings and by different people - for example, home, clinic, school, and nursery.

### 6.9.10 Severity

An assessment of severity must include the actual or likely effect on the child. Factors which should be considered include the age of the child at onset (bearing in mind that recognition in later childhood may indicate late recognition rather than late onset); duration of the abuse; the 'intensity' of the harmful interaction; protective factors such as the child's innate ability and the availability of a trusted adult; and attachment relationships.

### 6.9.11 Cultural issues

It would seem that the categories of ill-treatment are universally applicable, although there is some cultural variation in the parental interactions within the categories, for example that which is deemed developmentally appropriate. Such issues require sensitive and thoughtful practice, bearing in mind that all children are entitled to the same threshold of protection and that certain apparently cultural practices may not be benign or indeed culturally sanctioned.

### 6.9.12 Responding to the recognition of emotional abuse and neglect

- (a) All three tiers of concern should be explored. Thus, if the ill-treatment has been recognised, look for possible harmful parental attributes (such as substance misuse) and any child impairment; if a parental attribute has been recognised (such as parental mental ill-health), look for possible ill-treatment and child impairment. If significant child impairment is found, explanation needs to be sought which includes emotional abuse and parental attributes.
- (b) Assess the severity of the emotional abuse and neglect and the possible need for immediate protection. Discuss with the Named/Designated nurse/doctor.
- (c) Refer the child and family either to Children's Social Care, Child and Adolescent Mental Health Services or a tertiary centre specialist team, highlighting either the child's needs for immediate protection or a monitored, time-limited trial for change. [Glaser & Prior 2002]

#### **Case History 6**

*Craig, a 9 year old boy with a long history of soiling has poor attendance in school. He is unpredictably violent to staff and pupils. He has no friends and has already been suspended on two occasions because of his behaviour. His mother says he is evil.*

## 6.10 Neglect

All professionals caring for children and families have a responsibility to recognize and make a judgement when the standard of care the child is receiving falls below acceptable standards.

### 6.10.1 Definition (HM Government 2006):

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs likely to result in the serious impairment of the child's health or development.

Different forms of child abuse co-exist, but emotional abuse may exist independently. A neglected child may be emotionally abused or emotionally neglected.

### 6.10.2 Forms of neglect

These include:

- (a) Neglect of a child's physical needs, e.g. nutrition/hygiene/clothing.
- (b) Neglect of a child's medical needs.
- (c) Neglect of supervision and lack of awareness of safety issues.
- (d) Failure to ensure the child receives stimulation and education appropriate to their age and level of development.
- (e) Neglect of a child's social needs, e.g. child not given opportunities to mix with peers.
- (f) Failure to provide affection and appropriate nurturing.
- (g) Failure to pay attention to child's personal hygiene, clothing etc.

Although neglect is usually chronic, on occasion episodic neglect may occur. This is often associated with a crisis in the family such as divorce or mental illness such as parental depression. It is important to note that disabled children are particularly vulnerable to neglect. In addition, while neglect is commonly associated with poverty it can also occur in more affluent families (e.g children left at home after school unsupervised while the parents are at work).

### 6.10.3 Presentations

- (a) Frequent A&E attendance (e.g. for injuries). These are often associated with accidents through lack of supervision.
- (b) Poor uptake/casual attitude to immunisations.
- (c) Untreated medical conditions and not giving essential treatment regularly or consistently for serious illness and/or minor health problems.
- (d) Physical care and presentation of the child outside acceptable norms for

the population (e.g. inappropriate clothing for the weather).

- (e) Parent/carer does not have the ability and/or motivation to recognise and ensure the needs of the child are met.

#### 6.10.4 **Assessment** (DoH et al 2000)

- (a) Neglected children may present with:
  - (i) Failure to thrive through lack of understanding of dietary needs of a child or inability to provide an appropriate diet; or they may present with obesity through inadequate attention to the child's diet.
  - (ii) Craving attention or ambivalent towards adults, or may be very withdrawn.
  - (iii) Being too hot or too cold – check hands/feet for cold injury - red, swollen and cold hands and feet (Hobbs, Hanks and Wynne 1999) or they may be dressed in inappropriate clothing.
  - (iv) Consequences arising from situations of danger – accidents, assaults, poisoning, other hazards (lack of safeguarding).
  - (v) Delayed development and failing at school (poor stimulation and opportunity to learn).
  - (vi) Difficult or challenging behaviour (failure of parenting).
  - (vii) Unusually severe but preventable conditions owing to lack of awareness of preventive health care or failure to treat minor conditions.
  - (viii) Health problems associated with lack of basic facilities such as heating.
- (b) Additional risks of neglect may be present for children with disability and chronic illness. These may be associated with the child's environment, lack of service provision, family circumstances and society's attitude towards disability.
- (c) Parenting issues may impact on the parent/carer's ability and motivation to meet the needs of the child. These include:
  - (i) Learning disabilities.
  - (ii) Mental health problems.
  - (iii) Substance or alcohol abuse, including binge drinking.
  - (iv) Domestic violence.
  - (v) Disability.
  - (vi) Chronic illness.
  - (vii) Unemployment or poverty.

- (viii) Homelessness.
- (ix) Young lone parents.

#### 6.10.5 History

- (a) Assess parent's/carer's knowledge and understanding of child's health, development and needs.
- (b) Family and social history – assess the parents' personal, social, financial resources, health, support (both formal and informal networks) and their availability to the child both physically and emotionally.
- (c) Consider the relationships within the family and particularly in relation to the identified child. Consider whether the child was planned or welcome? Does the parent treat other children in the family any differently? Was the child the wrong sex, born at the wrong time, or born at a time of crisis within the family? Does the child have specific needs that make them vulnerable to neglect, for example, complex health needs or disability?
- (d) Assess the child's health, development, behaviour, past illness and accident history, schooling.
- (e) Specific vulnerabilities (e.g. parental substance abuse and family violence or racial harassment).
- (f) Consider whether the parent/carer has the ability, motivation and opportunity to meet the needs of the child.

#### 6.10.6 Examination

- (a) Use the whole consultation to observe the parent/carer and child and their interaction.
- (b) Parent/carer:
  - (i) How do they care for and control the child?
  - (ii) How do they interact with the child?
  - (iii) Do they focus on the child and the child's needs?
  - (iv) Do the parent/carer's own needs come first?
- (c) Child – play, attention, relationship with adults and siblings. Observe the child's general demeanour and behaviour pattern.
- (d) Child's growth, development (language, social, fine motor), general physical examination (smelly, unwashed, dirt under nails, nappy rash, unkempt, infestation, untreated skin, eye or other conditions, poor nutrition), hair loss, chronic cold injury.
- (e) Look for signs of anaemia (iron deficiency) and measure haemoglobin.

- (f) 'Is the parenting good enough?' – that is, is the parent/carer providing an environment in which the needs of the child are likely to be met?

#### 6.10.7 Next steps

- (a) Involve other agencies, such as primary health care, children's social care, etc., to obtain further information and address other/wider needs.
- (b) Request a multi-agency assessment using the *Framework for Assessment of Children in Need and Their Families*. It is possible for health personnel to request a strategy discussion, S47 enquiries or a child in need assessment (HMSO 1989; HMSO 2004).
- (c) Identify child's unmet needs – health, social, developmental, educational.
- (d) Participate with other agencies in assessment, and treatment plan including following up child.
- (e) Meet the needs that you are able to (e.g. speech and language therapy).

#### Case History 7

*Tommy, aged 9 months is referred because of pallor and delayed development. He is the youngest of 5 children of a mother unable to read and an alcoholic father. The 4 older children attend school sporadically, none fully immunised and all have language delay.*

### 6.11 Sexual abuse

Sexual abuse is often associated with other types of abuse

A doctor should never work alone in this field. Early advice should always be sought from someone with experience in the management of child sexual abuse. Interagency working is crucial.

#### 6.11.1 Introduction

- (a) *The Physical Signs of Sexual Abuse in Children* (RCP 1997) is currently being revised by the RCPCH. It is frequently used in court: be familiar with this document and know its limitations before writing reports or attending Court.
- (b) Children who have been sexually abused may present in many ways. Some children will be presented by social workers during S47 enquiries and a care assessment, others may present medically with concerning signs or symptoms and be referred by their GPs or health visitors. Others make clear disclosure and after a video interview the police may request a medical examination which may need to include taking forensic samples.
- (c) The abuser frequently grooms and threatens children so that a clear disclosure is not often made at an early stage in the process.
- (d) There are very few absolutely diagnostic signs. The aim should be to build

up a wider jigsaw picture of the child which should include the child's story, behaviour and presentation (see Appendix 9).

- (e) The following are ways in which children may present – this is by no means an exhaustive list, but a guide to the type of concerns, which should raise suspicions.

#### 6.11.2 Concerning signs/symptoms

- (a) Vaginal bleeding – possible causes include:

(i) Trauma.

- Sexual abuse.
- Accidental injury such as straddle injury where there is usually a clear history and may be witnessed.

(ii) Precocious puberty.

(iii) Skin disease – Lichen Schlerosus et Atrophicus (N.B. sexual abuse can co-exist).

(iv) Rare anatomical abnormalities – Haemangioma.

- (b) Rectal bleeding – possible causes include:

(i) Fissures, which can be caused by severe constipation, inflammatory bowel disease, or abuse.

(ii) Inflammatory bowel disease.

(iii) Infective diarrhoea.

(iv) Polyp (rare).

- (c) Vulvo vaginitis with or without dysuria – possible causes include:

(i) Poor hygiene.

(ii) Trauma – Intracural intercourse.

(iii) Skin disease – Lichen sclerosus, eczema.

(iv) Allergies – Bath chemicals, soaps.

(v) Infection/Infestation.

Should these signs of vulvo vaginitis be recurrent/resistant to treatment, they are more concerning.

- (d) Infection including anogenital warts.

(e) Masturbation:

It is normal for children to masturbate, however this may be considered worrying if 'excessive' – usually defined as excessive if in public/interfering with life. Masturbation does not usually cause physical signs or injury.

(f) Foreign body in anus/vagina:

Although uncommon they may be associated with sexual abuse. Child should be referred for paediatric forensic medical assessment.

(g) Soiling/bowel disturbance/enuresis:

(i) Constipation, soiling and enuresis are common paediatric problems. Uncommonly they may have a physical cause and more often have a behavioural/psychological cause. Sexual abuse should be considered within the differential diagnosis. There may or may not be physical signs, other symptoms or history.

(ii) Encopresis – (the passage of normal faeces in socially inappropriate places) is associated with emotional disturbance. Sexual abuse should be considered.

(h) Behavioural presentation:

(i) Children may present with various behaviours including self harm/mutilation, aggressive and sexualised behaviours as well as psychosomatic symptoms.

(ii) Children can express their distress following sexual abuse in a wide variety of ways (e.g. nightmares, poor school performance, regression, anxiety and increased attachment behaviour). Any major change in a child's behaviour should prompt a search for the cause and abuse should be considered if there is no obvious explanation.

(i) Definite diagnostic presentations:

(i) Pregnancy.

(ii) Some sexually transmitted infections (e.g. chlamydia and gonococcus) (see Appendix 10 for swabs and Thomas et al 2003).

(iii) Presence of semen/sperm.

6.11.3 **History** (see Chapter 8, 'The medical assessment')

As with any other paediatric diagnosis, a full history is needed. Include the following:

(a) Bowel and urinary history.

(b) History of genital/anal symptoms.

(c) Behaviour changes.



- (d) Check the menstrual and sexual history in adolescents.
- (e) If the child presents with a disclosure, then the medical assessment usually follows a formal Police/ Children's Social Care interview.
- (f) If the Police and Children's Social Care have already interviewed the child in detail, there is no need to repeat this, but check the history with Police/ social services. Only essential details need to be confirmed with the child.
- (g) If no interview has taken place then more history will be needed and this should be taken by allowing the child to speak freely, avoiding leading questions and keeping a careful verbatim account of both question and answer.
- (h) Anything disclosed by the child may form evidence in Court. It is possible by inappropriate questioning to introduce information or contaminate this evidence by direct and leading questions.

#### 6.11.4 When to examine a child's genitalia and anus

- (a) Examination of the anogenital area of a child may be included as part of the routine examination and would certainly be essential in many clinical situations (e.g urinary infection, soiling, abdominal pain, straddle injury).
- (b) It is wise to have clear consent for this part of the examination from the child and parent. The use of a phrase such as 'I normally carry out a full examination of children, this includes the bottom' may be helpful.
- (c) The paediatric examination for suspected abuse requires a doctor with specific expertise and training, and preferably with facilities for use of colposcope and photodocumentation, STI and forensic testing as appropriate (see RCPCH and APS 2004 and Thomas et al, 2003).

#### 6.11.5 Examination technique (see also Chapter 8, *The medical assessment*)

Specific aspects of examination for suspected sexual abuse:

- (a) Examination of the female genitalia is usually done in the supine, frog leg position.
- (b) The prone knee-chest position is useful to visualize the posterior hymen.
- (c) Labial separation and gentle labial traction are usually needed to display the hymenal opening.
- (d) Internal instrumental examination is not normally done in prepubertal girls. In post pubertal girls, assessment of the hymen usually requires other techniques in addition to inspection e.g. cotton tip swab to define the hymenal margin, flooding with sterile water, or use of foley catheter.
- (e) Pubertal children may require a more detailed examination using a speculum (a proctoscope can be kinder when there are acute injuries) for sampling (forensic and STI).
- (f) Anal inspection is usually performed in the left lateral position and if a

different position is used then it must be specified. Part the buttocks, observe for 30 seconds, as there may be a delay before the anus dilates. Anal dilation may be an indicator of sexual abuse and on its own raises suspicions but is not absolutely diagnostic.

- (g) Take the appropriate swabs for STIs (Thomas et al, 2003).
- (h) Where appropriate, take forensic swabs, paying attention to the chain of evidence (Appendices 17 and 18).

#### 6.11.6 Chain of evidence

- (a) This is a process which is intended to protect forensic specimens from any contamination. It consists of the person collecting the specimens completing a form with the details of the patient and their details with date and signature recorded.
- (b) Following this, any individual handling the sample needs to sign and date the same form, (e.g. the person conveying the sample from the examination area to the laboratory). Once at the laboratory, the recipient also needs to sign and date the form. Thereafter, anyone else handling the sample will need to sign and date the form. Examples of such forms are in Appendices 18a and 18b.

#### 6.11.7 Clinical management

- (a) Having taken all necessary forensic swabs and swabs for STIs, it is essential to prescribe emergency contraception and prophylactic antibiotics for STIs when indicated.
- (b) It is crucial that the child is looked at in terms of all their needs, e.g. neglect, not in school, poor relationships, failure to thrive, infections, immunisations (Hep B), drug/alcohol abuse, family planning.
- (c) The possibility of HIV infection will need to be considered, discussed with child/parent/carer, investigated and managed appropriately. Seek advice from your local virology or GUM Department.

#### **Case History 8**

*Sarah, aged 3, was brought to the Emergency department at night. The mother was extremely anxious as she had noticed blood in her knickers. The casualty SHO took a history and asked the paediatric registrar for advice. The mother agreed to a paediatrician's assessment including inspecting the genital and anal area where it was found that the hymenal opening appeared large and gaping. The child was referred to a consultant with CSA experience for further assessment with a detailed note of the earlier presentation and assessment accompanying the child. The mother was extremely anxious about possible abuse and the child had recently visited her father on a contact visit. The mother agreed to admission as abuse was suspected. Children's Social Care and child protection police units were contacted.*

## 6.12 Fabricated or Induced Illness (FII)

FII is a form of abuse, not a medical condition. Previously known as Munchausen Syndrome by Proxy, this label applies to the child, not the perpetrator. The label is used to describe a form of child abuse.

There is a spectrum of fabricated illness behaviour, and FII may co-exist with other types of child abuse. The range of symptoms and systems involved is very wide and it is usually the parent or care giver who is the perpetrator. FII includes some cases of suffocation, non-accidental poisoning and sudden infant death.

### 6.12.1 Features

- (a) A child is presented for medical assessment and care, usually persistently, often resulting in multiple medical procedures.
- (b) Mismatch or incongruity between symptoms described by parent/carer and those objectively observed by medical attendants.
- (c) The perpetrator denies knowledge of the aetiology of the child's illness.
- (d) Acute symptoms and signs cease when the child is separated from the perpetrator.
- (e) Intentional or non-accidental poisoning often presents with bizarre symptomatology – a range of substances are involved (e.g. methadone, salt).

### 6.12.2 Think of FII when:

- (a) Inconsistent or unexplained symptoms and signs.
- (b) Poor response to treatment.
- (c) Unexplained or prolonged illness.
- (d) Different symptoms on resolution of previous ones, or over time..
- (e) Child's activities inappropriately restricted.
- (f) Parents/carers unable to be assured.
- (g) Problems only in the presence of parent/carer.
- (h) Incongruity between story and actions of parents/carers.
- (i) Erroneous or misleading information.
- (j) Family history of unexplained illness or death.
- (k) Exaggerated catastrophes or fabricated deaths.

The paediatrician is usually the professional who suspects FII. This hinges on taking very detailed histories from all adults who may have information to give, careful checking

of aspects of history which can be corroborated, and if necessary a period of admission or specific tests, constantly weighing up the balance between needing to confirm the abuse and avoiding necessary harm to the child. The production of a detailed chronology is essential in the investigation of this form of abuse.

#### 6.12.3 Professional roles:

- (a) **Paediatrician** – the consultant responsible for the child’s clinical care should take lead responsibility to find out whether the child’s illness and individual symptoms and signs have an unequivocal explanation as a natural illness. If this is not clear, the possibility of fabrication or illness induction has to be considered as part of the differential diagnosis together with the effect on the child.
- (b) **General practitioners** should be encouraged to share information about the parents/carers, and avoid being an advocate for the parent/carer where there are serious concerns about possible harm to the child.
- (c) **Psychiatrists and psychologists** may be needed to look at the effects on the child, and establish whether there are underlying disorders in the carer.
- (d) **Police** must investigate a possible crime.
- (e) **Social workers** make an assessment of the child’s welfare including the risk of harm, parental capacity and family and environmental factors and provide services to parents during the assessment.

#### 6.12.4 Management (DoH et al. 2002; HM Government 2006; RCPCH 2002)

The first principle of management is to avoid any ongoing harm to the child.

- (a) Paediatricians must work with other professionals and not in isolation. Start with discussions with all the medical and nursing staff looking after the child.
- (b) The criterion for referral to Children’s Social Care and/or the Police is that the paediatrician has continuing concerns about the child’s welfare; NOT that fabrication or induction of illness has been proved.
- (c) Involvement of other agencies should be early and not wait for an absolute identification of FII. A multi-agency strategy discussion is indicated and should involve very careful consideration of how the concerns might be disclosed to the parents, as uncontrolled disclosure may cause a parent to behave in unpredictable ways, which may be harmful for the child.
- (d) It is not necessary to share your concerns with the parents if by doing so you may put the child at increased risk of harm. It is important to consider carefully the risk of disclosure of concern to the family before adequate discussions have taken place and protection achieved for the child.
- (d) Existing diagnosed chronic illness in a child does not exclude the possibility of induced illness.
- (e) The strategy discussion should identify an appropriate person to assemble a

It is not necessary to share your concerns with the parents if by doing so you may put the child at increased risk of harm. It is important to consider carefully the risk of disclosure of concern to the family before adequate discussions have taken place and protection achieved for the child.

health chronology. This is usually the paediatrician, who will have to obtain the following documents/talk to relevant professionals:

- (i) Child's general practitioner and health visitor records and/or community child health records.
- (ii) Child's records from any hospital the child has attended.
- (iii) Minutes of all social service meetings and child protection case conferences.
- (iv) Medical and social records of parents/carers and siblings, with consent by Court Order.

It is important that although the clinician has to rely on other people's documents, they should not rely on another professional's chronology. Chronologies prepared by Children's Social Care or lawyers often omit important medical facts, and only a paediatrician may have the insight to realize the significance of these. Wherever possible the paediatrician should indicate what aspects of the history were told to that paediatrician personally, and what parts of the history were copied from previous medical notes. Similarly the paediatrician should make clear what aspects of the examination of the child the author undertook, and to what extent the paediatrician is actually recording the examination findings of others.

- (f) Using these documents, and from the paediatrician's own experience of the case, a written report is produced to include:
  - (i) Detailed account of the child's medical problems:
    - Chronology.
    - History including therapy/interventions.
  - (ii) Examination:
    - Be graphic.
    - Include photos/charts.
    - The date of any examination.
  - (iii) Opinion:
    - Has Fabricated or Induced Illness occurred?
    - Mechanisms if known.
    - The future likelihood of suffering significant harm, and prognosis.
  - (iv) Conclusions.
  - (v) Signature and date.
  - (vi) Outcome of any covert video surveillance

## 6.13 Intentional or imposed upper airway obstruction

This is a difficult and controversial area. It may be impossible to distinguish intentional airway obstruction from other causes of SUDI (sudden and unexplained death in infancy). In children who survive the outcome can be serious (e.g. neurological handicaps). In many cases there are no signs of external injury (face/neck/upper chest/conjunctiva, injury to nose or mouth). There are clinical features although conclusive diagnosis may be very difficult to achieve. Remember child protection demands balance of probabilities.

### 6.13.1 Presentation

- (a) Sudden death
- (b) An infant or occasionally older child suffering an apparent acute life-threatening event (ALTE). Such a child may be floppy, pale or cyanosed, apnoeic with a low oxygen saturation when measured close to the event. It may occur in the family home or even on a hospital ward.
- (c) Well baby with the following history particularly if the events consistently began in the presence of one parent/carer.
  - (i) Apnoea/episodes of transient respiratory difficulty.
  - (ii) Cyanotic episodes.
  - (iii) Recurrent seizures.
  - (iv) Other unusual episodes of unexplained collapse/illness.
  - (v) Bleeding from the nose or mouth.
- (d) The following should raise consideration of imposed airway obstruction:
  - (i) Previous episodes of cyanosis, floppiness, apnoea particularly if the apnoea requires resuscitation and where the events have started in the presence of one carer.
  - (ii) Age of presentation over 6 months.
  - (iii) Previous unexplained sudden deaths in infants or children in the family.
  - (iv) Families where there are already major social concerns relating to abuse or neglect.
  - (v) Strong suspicion of fabricated illness in this child or siblings.
  - (vi) Parent presenting with somatisation or abnormal illness behaviour.
- (e) Examination findings:
  - (i) Blood around the nose or mouth in a child who has survived an apparent life threatening episode.

- (ii) Petechiae around the face, neck, upper chest and conjunctival haemorrhages.
- (iii) Signs of neglect/failure to thrive.
- (iv) Other signs of trauma, eg damage to the frenulum in an infant.
- (v) It is important to evaluate the history of resuscitation if it has occurred and how it was done.

### 6.13.2 Investigations

There are no biochemical or haematological tests that can distinguish between acute life threatening episode due to natural or imposed airway obstruction.

- (a) In either event there may be signs of an hypoxic ischaemic injury with the following findings:
  - (i) Metabolic acidosis.
  - (ii) Electrolyte disturbance, e.g. hypocalcaemia.
  - (iii) Transient clotting disturbance.
  - (iv) Raised white cell count with a predominant relative lymphocytosis.
  - (v) Changes on EEG with encephalopathic features.
- (b) Respiratory complications may arise after an episode of imposed airway obstruction and chest x-ray may show changes that can be due to:
  - (i) Aspiration.
  - (ii) Pneumonia.
  - (iii) Pulmonary haemorrhage.
  - (iv) Air leak.
- (c) The chest X-ray may show rib fractures (acute/fresh rib fractures may not show up on first x-ray. It is good practice to repeat after 11-14 days when healing may reveal callous formation at the point of fracture. A bone scan or a repeat skeletal survey plus oblique views of the ribs will increase recognition.
- (d) Acute life threatening episodes can be confused with gastro-oesophageal reflux. It is important to note the latter must be severe to cause similar symptoms.

### 6.13.3 Action in children with suspected imposed airway obstruction

If there is any suspicion that this has occurred:

- (a) Take a careful and detailed history not only from the carer but from others involved in care who may provide important information. Include those present immediately before, during and after the event.

Where there is a presentation of sudden unexpected infant death, local protocols should be followed. (RCPATH & RCPCH 2004).

- (b) Take careful details of the resuscitation, who did it and how it was done.
- (c) Admit the child and consider appropriate supervision and monitoring as further incidents may well occur in hospital.
- (d) Contact the appropriate consultant paediatrician according to local guidelines. This may be the on-call paediatrician, designated doctor or named doctor for child protection depending on local agreement.
- (e) contact Children's Social Care, who should organise a strategy meeting promptly.
- (f) involve the Police early, preferably the Child Protection Team/Unit.
- (g) Where there is a presentation of sudden unexpected infant death local protocols should be followed. (RCPATH & RCPCH 2004).

### 6.14 Covert video surveillance (CVS)

This form of investigation is rarely used. All other means of assessment should be explored before this is considered. If considered the decision to implement must be made by senior management (Chief Executive of Trust) and the ultimate decision rests with the Chief Constable of the local police force. (DoH et al. 2002; RCPCH 2002)

### 6.15 Domestic violence/abuse

#### 6.15.1 Role of Paediatrician

- (a) All professionals working with women and children should be alert to the inter-relationship between domestic violence and the abuse and neglect of children.
- (b) The paediatrician needs to be aware of available support in their area for victims of domestic violence. It is important to ask carers about domestic violence but the paediatrician needs to be aware of immediate support for the family. There needs to be a low threshold for referral of these families to Children's Social Care as children living with domestic violence are children in need and are likely to be 'at risk' of harm.
- (c) Ensure that there is a child health representative on your local Domestic Violence Forum.

#### 6.15.2 Definition

- (a) Domestic violence is a term which describes a continuum of violent behaviour between current or former partners in an intimate relationship, wherever and whenever the violence occurs. The violence may include physical, sexual, emotional or financial abuse. In 40-60% of families where either domestic violence or child abuse was occurring, the other form of violence was also occurring. Domestic violence and child abuse co-exist. (Hughes 1989)
- (b) The majority of domestic violence is perpetrated by men against women and their children. 75% of mothers in homes where domestic abuse is occurring said their children had witnessed violent incidents and 33% had seen their



mothers beaten (NCH, 1994). 90% of children were present in the same or the next room at the time of the assault (Hughes 1992).

- (c) Of 127 women in refuges in Northern Ireland, 60% had been abused in pregnancy – 13% had lost their babies as a result and 22% had threatened miscarriages (McWilliams et al 1993).

### 6.15.3 Presentation

- (a) Effects on victim: social isolation, physical injuries, mental health problems.
- (b) Parenting problems: undermining of parenting ability and ability to protect children.
- (c) Effects on child: fearful, withdrawn, anxious, lacking in self confidence and social skills, difficulties in forming relationships, sleep disturbance, non-attendance at school, aggression, bullying, post traumatic stress disorder, behaviour suggestive of ADHD.
- (d) Children in refuges have unmet health needs – low immunisation levels, poor dental health and non-attendance at clinic appointments.

Children in refuges have unmet health needs - low immunisation levels, poor dental health and non-attendance at clinic appointments.

### 6.15.4 Next steps:

- (a) Explore the risks with the victim unless the partner is present.
- (b) The welfare of the child(ren) is paramount.
- (c) Offer support to the victim. This usually helps to promote the welfare of the child(ren) (DoH 2000). Supports include: helping to make safe choices for him/herself and the child(ren), practical information such as Women's Aid services and refuges, social services, legal services, police or health service referral for health related problems.
- (d) Document carefully and consider confidentiality. Any letters to outside agencies, such as lawyers, should be written in the knowledge that they may be made available to both sides in a legal case.
- (e) Recognise your responsibility to contribute to inter-agency processes e.g. child protection case conferences.
- (f) Cases are complex, time consuming and emotionally demanding.

## 6.16 Adult mental health and child protection

- 6.16.1 It is well recognised that parental mental health problems have a significant effect on the well being of children and may lead to concerns about harm. There is a high incidence of parental mental illness in children referred to children's social care: parental mental illness was recorded in 31% of children registered on the child protection register for emotional abuse. In a report of 100 cases of fatal child abuse, there was parental psychiatric morbidity in 32% of cases including depression, drug abuse, postnatal depression and personality disorder. Parental mental illness is an important cause of children entering the

care system and to some children remaining in care for long periods. (Falkov 1996, Reader and Duncan 1997).

- 6.16.2 Adult mental health problems are common in the general population: all adults have a one in four chance of experiencing a period of mental illness during their lifetime. 30% of mentally ill adults have dependent children. However, not all children whose parents are mentally ill will suffer adversely as a result.
- 6.16.3 It is important that both Adult and Children's Services recognize the overlap between child protection and parental mental illness. The best way forward is collaborative working between these services. Good examples include joint assessment of a family by the community mental health and children's teams, and health visitors being informed of a family with a parent with mental illness by the adult mental health team. Paediatricians have a responsibility to develop an understanding of mental health issues and their influence on parenting abilities. Adult psychiatrists need to be aware of the family and think about child protection. Paediatricians have an important role in training and communication with adult mental health teams.
- 6.16.4 A useful training resource is *Crossing bridges* (DoH 1998), which promotes collaborative working.

## 6.17 Substance misuse

- 6.17.1 Parental problem alcohol and drug use can, and often does, compromise children's health, development and welfare at every stage from conception onwards.
- 6.17.2 'Problem substance use' is so defined when the use of alcohol or drugs has a harmful effect on a person's life. The substance use becomes the person's central preoccupation to the exclusion of significant personal relationships and to the detriment of their health and social functioning. Problem substance users who are parents may find that their substance use affects their ability to look after their children and maintain positive relationships with their families.
- 6.17.3 Problem substance use is usually a chronic, relapsing condition, which requires continuous review and long term flexible support in order to respond to the individual's ongoing needs.
- 6.17.4 Concerns about the care and welfare of children living with families with problem substance use may come from a variety of sources/services focused on the adults/or the child. They include:
  - (a) Children's Social Care.
  - (b) Health services.
  - (c) Drug and Alcohol services.
  - (d) Education (and Community Education) services.
  - (e) Police.

- (f) Housing agencies.
- (g) Leisure services.
- (h) Voluntary agency services.

6.17.5 When parents are suspected to have a problem with substance abuse, the paediatrician should consider the following questions:

(a) General:

- (i) Are there any factors which make the child(ren) particularly vulnerable, for example a very young child, or other social needs such as physical illness, behavioural and emotional problems, psychological illness or learning disability? Are there any protective factors that may reduce the risks of harm to the child?
- (ii) How does the child's health and development compare to that of other children of the same age in similar situations?
- (iii) Are children usually present at home visits, clinic or office appointments during normal school or nursery hours? If so, does the parent/carer need help getting children to school?
- (iv) How much money does the family spend on alcohol/drug use? Is the income from all sources presently sufficient to feed, clothe, and provide for children, in addition to obtaining alcohol/drugs?
- (v) What kind of help do you think the child needs?
- (vi) Is there evidence of neglect, injury or abuse, now or in the past? What happened? What effect did/does that have on the child? Is it likely to recur?
- (vii) Is the concern the result of a single incident, a series of events, or accumulation of concerns over a period of time?
- (viii) Do the parents/carers perceive any difficulties and how willing are they to accept help and work with professionals?

(b) Drugs Specific:

- (i) What arrangements are made for the child(ren) when the parent/carer goes to get illegal drugs or attends for supervised dispensing of prescription drug(s)?
- (ii) What do you think might happen to the child? What would make this likely or less likely?
- (iii) Do parent/carer(s) think that their child knows about their problem alcohol or drug use? How do they know?
- (iv) What does the child think? What do other family members think?

How do you know?

- (v) Is there a failure on the parent/carer(s) part to maintain contact with helping agencies?
  - (vi) Who will look after the child(ren) if the parent/carer is arrested or is in custody?
- (c) Alcohol Specific ( HMSO 2003; Scottish Executive 2003):
- (i) What is the current pattern and level of use? Type and amount of alcohol consumed/where/when/alone or with others? If with others, with whom? When and where does this occur?
  - (ii) Is this typical of the last three months?
  - (iii) Tendency to binge drink or drink every day?
  - (iv) How is alcohol financed?
- (d) The paediatrician should consider the information received and with Children's Social Care and the Police, decide whether to directly implement Safeguarding Children Procedures and/or commission an interagency assessment to understand further the issues involved.
- (e) The aim of an assessment should be to establish the extent to which substance use is affecting parenting capacity, not solely to determine whether the parent is dependent on alcohol and/or drugs.
- (f) Assessment, planning, intervention and decision making should be based on effective, open and honest communication and collaboration between practitioners in different agencies, particularly in relation to the sharing of relevant information to determine the degree of risk of harm to a child and what action to take.
- (g) Professionals in services for children and alcohol/drug services should work in partnership with each other as well as with parents to achieve the best possible outcome for children and their families.

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### Useful websites

- Association of Forensic Physicians. [www.afpweb.org.uk](http://www.afpweb.org.uk)
- British Association of Forensic Odontology. [www.bafo.org.uk](http://www.bafo.org.uk)
- British Society of Paediatric Radiology. [www.bspr.org.uk](http://www.bspr.org.uk)
- Child Accident Prevention Trust [www.capt.org.uk](http://www.capt.org.uk)
- General Medical Council [www.gmc-uk.org](http://www.gmc-uk.org)
- Northern Ireland Women's Aid Federation. [www.niwaf.org/Domesticviolencefactsfigures.htm](http://www.niwaf.org/Domesticviolencefactsfigures.htm)
- Royal College of Paediatricians and Child Health. [www.rcpch.ac.uk](http://www.rcpch.ac.uk)
- Welsh Child Protection Systematic Review Group [www.core-info.cf.ac.uk](http://www.core-info.cf.ac.uk)

# 7

## What to do if you are concerned that a child may be abused

(DOH et al 2003)

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It is not the responsibility of professionals to prove that abuse has occurred.

### 7.1 What to do if you have a concern (see Appendices 1, 11 & 12)

Doctors working with children in hospital or community settings may become concerned that a child is being neglected or abused.

- 7.1.1 Child discloses abuse.
- 7.1.2 Parent alleges/discloses abuse.
- 7.1.3 Parent complains of medical symptoms, signs or behaviour to GP or other health professional.
- 7.1.4 Child presents as emergency with an injury (e.g. to A&E).
- 7.1.5 Children's Social Care or police request assessment of a child about whom concerns have been reported or identified.
- 7.1.6 Other professional e.g. nurse, physiotherapist, surgeon has concerns about a child.

### 7.2 The golden rules

- 7.2.1 Consult widely – talk to other team members, the consultant concerned and nursing staff.
- 7.2.2 Gather information from other professionals who know the child eg Health Visitor, School Nurse, GP, and information from other hospital admissions.

- 7.2.3 Check with Children's Social Care whether the child is on the child protection register.
- 7.2.4 Make a referral by phone to Children's Social Care and send your concerns in writing within 48 hours.
- 7.2.5 Document your concerns and write a medical report for Children's Social Care (see Chapter 10).
- 7.2.6 Record all concerns, discussions, decisions made and the reason for these decisions. Record all telephone conversations.
- 7.2.7 If your concerns have not been addressed you have a responsibility to talk to Named/Designated professionals.
- 7.2.8 If you still have concerns you could also, without necessarily identifying the child concerned, discuss your concerns with peers or colleagues in other agencies.

### 7.3 Points to remember

- 7.3.1 Child's safety comes first.
- 7.3.2 Do not accuse anybody of harming the child.
- 7.3.3 Remain objective, "seems a nice family" can be unhelpful.
- 7.3.4 "Concern" is not the same as "diagnosis", it is a starting point to look and think further.
- 7.3.5 Share information openly and honestly with those who need to know.
- 7.3.6 Diagnosis is like a jigsaw – information has to be collected widely (you may only have one piece of the jigsaw).
- 7.3.7 Remember to discuss your concerns with the child as appropriate for their age and also their parents, unless you consider such a discussion would place the child at risk of significant harm.
- 7.3.8 If the child has recently moved into the country, information may need to be sought from equivalent agencies in countries abroad.
- 7.3.9 A child about whom child protection concerns have been raised whilst in the hospital setting must only be discharged on the decision of a consultant paediatrician (DoH 2003b).

A child about whom child protection concerns have been raised whilst in the hospital setting must only be discharged on the decision of a consultant paediatrician (DoH 2003b).

### 7.4 Referral pathway (see Appendices 1, 11 & 12)

- 7.4.1 Where a health professional has concerns that abuse or neglect is suspected in a child, they have a responsibility to refer to Children's Social Care.
- 7.4.2 **Making a referral to Children's Social Care**
  - (a) It is probably better to tell parents before referring to Children's Social

Care. Exceptions to this are suspected FII or sexual abuse

- (b) When you make your referral to Children's Social Care discuss and agree with them what will be told to the child and parents, by whom and when.
- (c) If you make a referral to Children's Social Care by telephone, confirm it in writing within 48 hours. The written referral should be acknowledged within one working day, so the person making the referral should contact Children's Social Care again if nothing has been heard within 3 working days. If the decision is that no further action be taken, the reason should be made clear by Children's Social Care.

#### 7.4.3 Situations that require immediate referral to:

(a) Police:

- (i) Allegations of recent rape or sexual assault (forensic sampling may be necessary).
- (ii) Dead or severely injured children where abuse is thought likely (preservation of crime scene).
- (iii) Threatened removal from hospital where the child is thought to be in danger.

(b) Children's Social Care and/or Police:

- (iv) Suspected abuse or neglect where the circumstances indicate that the child or siblings are unprotected.
- (v) Serious abuse that has been witnessed, for example attempted smothering of a child.

Police have extra powers of protection that may be used in serious situations.

## 7.5 Admission to hospital

### 7.5.1 Most abused and neglected children do not require admission to hospital but consider admission for:

- (a) Injured children requiring treatment.
- (b) Any infant or child where medical investigation is facilitated by admission.
- (c) Where the family or social situation indicate an immediate need for a temporary safe and supportive space while the investigations take place.

## References

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DoH et al. (2003) *Getting the Right Start: National Service Framework for Children, Young People and Maternity Services: Standard for Hospital Services*. Department of Health.

# 8

## The medical assessment

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Any doctor examining a child may become aware of the possibility that the child is being abused. It is important therefore to keep good records and document findings in detail. The child will need a full medical assessment by the appropriate paediatrician.

The central medical task in child protection is a comprehensive paediatric assessment.

Always assess with the same degree of thoroughness and attention to detail as you would any potentially life-threatening medical condition (HMSO 2003).

### 8.1 Key messages

- 8.1.1 The child should have an appropriate understanding of the examination.
- 8.1.2 The assessment should be sensitive to the child's needs.
- 8.1.3 Siblings should be assessed for risk of harm and needs.
- 8.1.4 Be clear of the indications for assessment and ask if you are the appropriate doctor in terms of training and supervision.
- 8.1.5 In sexual abuse, an examination under general anaesthetic is rarely needed.
- 8.1.6 Always record conversations, history, examination findings, investigation findings immediately (Appendix 13).
- 8.1.7 Be culturally sensitive and use an interpreter when English is not the preferred language or the child / adult has a communication impairment.

### 8.2 The examining doctor

- 8.2.1 The assessment of the child should be carried out by a paediatrician, either

consultant, associate specialist, staff grade or specialist registrar working under consultant supervision.

Avoid examining child alone (even if the carer is present). Always ensure an appropriate chaperone is present.

- 8.2.2 Where forensic information is sought, as in acute sexual assault, if the paediatrician does not have the forensic skills, he/she may request from the police that a Forensic Medical Physician (FMP), formerly known as a Police Surgeon, be in attendance for the collection of forensic specimens (see *Protocol for forensic testing* in Chapter 12, and Appendices 17 & 18).
- 8.2.3 Older children may express a preference for a male or female doctor and if at all possible this should be respected.
- 8.2.4 Avoid examining child alone (even if the carer is present). Always ensure an appropriate chaperone is present.

### 8.3 Degree of urgency

- 8.3.1 **The doctor to whom the request for an examination is made must judge the timing of the examination:**
- (a) Physical injury should be seen, if at all possible, on the same day.
  - (b) Acute sexual assault. Examination should be completed as soon as possible to optimise assessment of clinical signs and forensic evidence. It may still be possible to gather forensic evidence up to a week after the event. Out-of-hours examination in side wards during the night should be discouraged. Properly set up examinations with appropriately trained staff and access to appropriate equipment is likely to yield better information / evidence and be more reassuring to the child and family.
  - (c) Non-acute sexual abuse should be seen at the first available appointment and usually within a week. Some sexual abuse is allegedly historical i.e. occurred months or years previously. Medical examination is advised although signs may have healed. The child is at risk from sexually transmitted infections. A medical examination can be reassuring and contribute to the child's recovery.

### 8.4 Where to examine

The environment should be child friendly, with access to appropriate support, including nursing/medical support, laboratory (haematology, microbiology), radiology and medical photography. Access to a colposcope for genital and anal examination is recommended (RCPCH/AFP 2004): a bright light source is the minimum.

### 8.5 Follow-up examinations

- 8.5.1 It is good practice to follow-up children in whom there are concerns about abuse or neglect. Physical signs may change over time and this can contribute to the diagnosis. Secondly, the child may have ongoing needs, not all of which were addressed at the initial assessment.
- 8.5.2 With sexually abused children, it is necessary to work together with colleagues

from other disciplines (e.g. genito-urinary medicine). Repeated examination without specific medical indication and which is not part of the child protection plan is discouraged.

## 8.6 Process

- 8.6.1 In planned assessments, the child should be accompanied by either a social worker or police officer, to provide information on the abuse or neglect.
- 8.6.2 Establish consent for examination (a separate consent for genital/anal examination and photo-documentation is required. See Chapter 5).
- 8.6.3 Do not use physical restraint (pre-verbal infants may need to be held by carer or nurse).
- 8.6.4 Talk to the child before and during the examination.
- 8.6.5 Explain the process, respect privacy and build up child's confidence.
- 8.6.6 The child may choose who is to be with him / her during the examination (carer, nurse, social worker, friend).
- 8.6.7 Notes should be contemporaneous, legible, dated, detailed and signed.
- 8.6.8 A medical proforma is useful as an aide-memoir (see Appendix 13)
- 8.6.9 Reports and police statements are ideally written on the day of the assessment.
- 8.6.10 However, avoid giving opinions under pressure (take time to think / consult). If necessary, indicate that it is a provisional opinion.

## 8.7 Components of paediatric assessment

### 8.7.1 History (see relevant sections for 'injury-specific' questions)

To avoid interfering with police investigation, do not ask leading questions unless agreed after discussion with the police, or introduce issues which have not previously been raised.

Avoid taking a detailed history from the child if it is likely to cause distress. In acute sexual abuse ask about:

- (i) History of pain.
- (ii) Bleeding.
- (iii) Urinary / bowel history.
- (iv) Last menstrual period.
- (v) Type of sanitary protection.



- (vi) Use of contraception.
- (a) Enquire re: time and place, witnesses, precise details of the events surrounding any injury/episode, for example washing, action taken following the injury/episode and child and parent's response. Always consider consistency/inconsistency of injury with history provided.
- (b) Systematic enquiry, focusing on relevant systems e.g.:
  - (i) Bleeding tendencies.
  - (ii) Bowel and urinary problems.
  - (iii) Genital symptoms.
- (c) Behaviour changes.
- (d) Birth and developmental history.
- (e) Past medical history.
- (f) Family history including genogram (family tree), domestic violence, mental health, drug/alcohol problems in parents.
- (g) Social history – employment, housing, relationships, family support.
- (h) Previous involvement with Children's Social Care/ child protection concerns.
- (i) In adolescents, ask for full menstrual and sexual history; consider asking about smoking, drug and alcohol use.
- (j) Brief assessment of the child's development.
- (k) Description of the child's emotional wellbeing.
- (l) Demeanour, response to carer, play, attention, behaviour during the examination.

#### 8.7.2 Full physical examination

- (a) Physical presentation, state of clothing.
- (b) Assessment of growth (height and weight centiles).
- (c) Assessment of maltreatment – neglect, physical injury, malicious injuries (e.g. nails pulled out, needle marks, incised wounds).
- (d) Top to toe examination including scalp (fontanelle if appropriate), fundi, inside of mouth, frenum, behind ears, genitalia, anus and soles of feet.
- (e) Detailed drawing of any injuries including measurements, site, pattern (consider the position the child was in at the time of injury), depth of injury. Consider effects of clothes on injuries. Document on body chart. Relate site of injury to anatomical landmarks.

- (f) Systems examination.
- (g) Stage of sexual development.
- (h) Examine genitalia and anus as part of the whole examination (naked eye).
- (i) Genital / anal examination: position (supine-frog legged, knee-chest, left lateral) examination technique (labial separation or traction to demonstrate hymenal edge), length of time of buttock separation should all be recorded.
- (j) If using colposcope take photographs or video during the genital and anal examination, with consent.
- (k) Was the child able to co-operate? If examination incomplete, record the limitations and reasons.
- (l) Further history, medical records (school, hospital and GP) may become available later.

#### 8.7.3 Further actions

- (a) Forensic specimens should be taken. Remember chain of evidence (Appendix 17 and 18).
- (b) Photographs of injuries – (Appendix 18). If possible, arrange for medical illustration or a police photographer.
- (c) Laboratory and radiological investigations should be carried out as indicated. (Remember chain of evidence - Appendix 18).

8.7.5 Record verbatim any comments made by the child during the examination.

## References

RCPCH & AFP (2004). *Guidance on paediatric forensic examinations in relation to possible child sexual abuse*. Royal College of Paediatrics and Child Health and Association of Forensic Physicians September 2004.

HMSO (2003) *The Victoria Climbié Inquiry. Report of an Inquiry by Lord Laming*. London: The Stationery Office.

## 9

# Documentation and recording

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## 9.1 Records

It is imperative that all facts and findings are recorded with considerable accuracy and detail (preferably using a proforma) because all the potential legal ramifications are not always apparent at the outset.

- 9.1.1 It is imperative that all facts and findings are recorded with accuracy and considerable detail (preferably using a proforma) because all the potential legal ramifications are not always apparent at the outset.
- 9.1.2 Your hand-written notes and drawings may be seen by the Court. Clear, well-written notes are important documents on which your formal typewritten report must be based.
- 9.1.3 Medical notes, including all diagrams, must always be dated and signed, with a time when the interview/observations are made.
- 9.1.4 Name and job title should be clearly printed beside your signature.
- 9.1.5 Include:
- (a) Why examination requested.
  - (b) Who made the request.
  - (c) Where examination took place.
  - (d) Who was present.

A medical proforma may be helpful, and an example is shown in Appendix 13. This includes a structure to cover all the important components of the assessment, including history, examination and investigations. Body plans facilitate drawings of visible lesions and injuries, including genital and anal findings. Diagrams should be included with the report as appendices and should be referred to in the text. Appropriate photography should also be performed, and reference to it made in the report.

## 9.2 Record keeping

- 9.2.1 The name of the consultant responsible for child protection aspects of the case should be clearly documented in the case notes.
- 9.2.2 Within a given location, health professionals should attempt to work from a single set of records for each child.
- 9.2.3 Make comprehensive, contemporaneous notes. It is best to make your own notes. However, if someone else is writing in the notes for you, be clear about what you want them to record.
- 9.2.4 Document all discussions regarding a child, whether they be face to face or telephone. If you do not have the notes at the time of the discussion, ensure that a note is written as soon as possible.
- 9.2.5 In cases where harm to the child is suspected, a history should be taken from the child if the doctor feels that this is in the best interests of that child (In such cases, permission from parents is not required).
- 9.2.6 Record verbatim important information given to you by adult and child, including any disclosures. With sensitive questions, record your question as well as the answer (e.g. Q: "What do you think made you sore?" A: "Uncle Tommy touches my tinkle" ). Courts will need to make sure that you have not asked questions which lead or direct the child towards a particular answer, so the question is as important as the answer.
- 9.2.7 It is particularly important to distinguish carefully between what a child says in your presence and what a parent tells you a child has said in some other setting.
- 9.2.8 It is useful to indicate any obvious emotional accompaniment to statements made (e.g. "Donna was obviously upset when she told me this – she avoided eye contact and was visibly shaking").
- 9.2.9 Record difficulties in either history taking or examination, indicating the limitations of the information you obtained. Thus it is important to say if you did not complete an adequate genital examination and only obtained a brief look (e.g. "genital examination, owing to lack of co-operation, was incomplete, and information may have been missed. However, I detected no obvious abnormality")
- 9.2.10 It is imperative to include all negative, as well as positive findings (HMSO 2003).

## 9.3 Growth charts

- 9.3.1 Be familiar with type of growth chart you regularly use and recognise that there are different charts in use. A single measure may fall on different centiles, especially between parent held record charts and hospital charts.
- 9.3.2 Inaccuracies can arise with measurement. You may be asked to comment how a measurement was obtained and its reliability.
- 9.3.3 Plot measurements carefully and check the accuracy of plotting of other measurements plotted by others.

## 9.4 Developmental assessment

- 9.4.1 Describe method of assessment, for example Griffiths, Denver schedule of growing skills.

## 9.5 Hospital admission & discharge summary

- 9.5.1 Any child in whom there are child protection concerns should have a full physical examination, fully documented in the case notes, within 24 hours of admission.
- 9.5.2 There should be a clearly documented care plan for the future before discharge. This may require multidisciplinary discussion or meetings.
- 9.5.3 **When a child is to be discharged**
- (a) A consultant or senior SpR should agree to this and the agreed care plan.
  - (b) This must be discussed with Children's Social Care as needed.
  - (c) Primary healthcare team must be informed.
  - (d) Education / school may be informed where appropriate.
  - (e) Ensure appropriate medical, social work, voluntary agency, education follow-up as appropriate.

## References

HMSO (2003) *The Victoria Climbié Enquiry. Report of an Inquiry by Lord Laming*. London: The Stationery Office

# 10

## Medical reports and Police statements

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### 10.1 Medical reports

Where there is any concern raised about the possibility of abuse or neglect, the doctor must provide an initial medical report. Great care must be taken over construction of the report as it may well be used as medical evidence in court even if it was originally prepared for a professionals' meeting or child protection conference. It is important that the opinion given is clear and deals with all potential concerns or findings within the body of the report. It is also important for a doctor to produce a medical report whether he/she has concluded there has been abuse or not (negative findings are also important). (See Appendix 14, *Medical report example*.)

#### Writing reports

Reports written for different purposes will be different. A medical note for the general practitioner, a referral letter to a child psychiatrist, a report for the Criminal Injuries Compensation Board, and a formal statement for the Police serve very different purposes. However, it is important to be aware that all these documents will be subject to meticulous scrutiny if the case ever goes to Court. In addition, lawyers for the defence may well use even the smallest inconsistency between the reports and notes to try and undermine any testimony you are called on to give months or even years later. Indeed, many lawyers will exploit any such inconsistency to the full even if it is more imagined than real. Anything put into a formal witness statement that is not also recorded in the notes you wrote immediately after seeing the child may also be challenged as unreliable unless you completed both the notes and the formal statement immediately after the child was seen. However, such reports (unlike the original case notes) do not normally need to be burdened by the inclusion of all the negative findings. The qualifications and experiences of the writer needs to be recorded.

- (a) The report should start with the name of the person who is writing it along with their qualifications and experience.
- (b) The report should contain a detailed history and examination.
- (c) Consider differential diagnosis and give reasoning for preferred opinion.
- (d) Make it clear that the opinion is your professional opinion.

10.1.1 **Practical points for report writing** (See Appendix 14, 15 and 16 for report examples)

- (a) Use non-medical language where possible (or explain in brackets).
- (b) Separate sections for history, examination, summary, opinion and conclusions.
- (c) Include times and dates in chronology – a good chronology can have significant impact.
- (d) Record results of investigations or indicate if investigations ordered or results pending.
- (e) Indicate origin of any third party information given.
- (f) Use child's own words where possible.
- (g) Always separate fact from opinion.

10.1.2 **Other points to remember**

- (a) Remember a normal examination does not mean “no abuse” – you may need to say so if you have concerns (e.g. clear disclosure by child and a considerable time interval between event and examination would allow healing to occur).
- (b) Restrict suggestions about management to areas of responsibility (e.g. request for child protection conference, need to see siblings, need for further investigation, need for follow up).
- (c) Discuss finding with the parent(s) unless he or she is involved in criminal proceedings. The parent(s) are not shown and do not usually receive a copy of your report directly. (Their solicitor may provide them with the report if they are involved in proceedings under the Children Act 1989.)
- (d) Always stick to your own area of expertise. Never stray into other professionals' roles (e.g. Police investigations).
- (e) Remember – the interests of the child are paramount when there are difficulties over confidentiality.

10.1.3 The report should ideally be dictated within 24 hours. It must be typed and signed as soon as possible and circulated. Less experienced doctors may wish to have their reports checked by a consultant. Discussion with a peer is also often very helpful.

**Send the medical report to:**

- (a) General Practitioner.
- (b) Community Child Health Service.
- (c) Children's Social Services if a child protection conference is planned.
- (d) Police if a criminal hearing is possible.
- (e) Appropriate personnel for the reasons of supervision and audit.
- (f) Copy should be kept in the notes.

10.1.4 All reports should be marked Private and Confidential, not to be distributed without the author's permission.

10.1.5 Do not copy or show the report to another party without the author's consent.

10.1.6 Medical reports are likely to be used in civil proceedings, particularly family care cases.

10.1.7 Additional reports may be requested prior to Court appearances or for other purposes (e.g. claims for criminal injury compensation). Always make reference to the original report when writing additional reports. Do not exaggerate or make the condition more serious than it is. Do not change the significance of the findings from one report to another.

## **10.2 Opinion**

If less experienced, always check with senior colleague before the report goes out – this is a legal document. It is important you are as accurate as possible and neither too hesitant nor too dogmatic.

## **10.3 Police statements**

In some cases of child abuse or neglect the Police will require a report in the form of a witness statement. The Police prefer this type of report which is more appropriate for criminal cases. This may need to be done on special witness statement paper obtainable from the Police (See Appendix 15) or some Police forces accept a word processed version provided that the wording conforms to that on official statement forms.

## **10.4 Self audit**

If what is said or found later triggers legal action, every word in the case notes is likely to be subjected to legal scrutiny. Even minor flaws are sometimes used to try and undermine subsequent medical testimony, so it is wise to subject the paper record to critical self-audit. Submitting a few case records to others for scrutiny and constructive criticism on a regular basis can also be a useful discipline and it is easy to check, during any such audit, that the notes are not just signed and dated but also clear, comprehensive and unambiguous. It is not too difficult to judge how well the child's and the family's needs were assessed and recognized. It is much less easy, but just as important, to try and assess how well the interview was managed and how well the child's trust was first won and then sustained. Reports that have been scrutinised by colleagues are less likely to be found wanting when scrutinized by the Court.



# 11

## Photography

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### 11.1 Practice

It is good practice to photograph any visible finding in suspected child abuse or neglect. This can be undertaken by:

- (a) Medical photographer.
- (b) Police photographer.
- (c) Doctor who is seeing the child.
- (d) Other designated professional working as part of investigative team.

(a) and (b) are the preferred options.

### 11.2 Photography may be used to record:

- (a) Injuries e.g. bruises, burns, lacerations.
- (b) Genital and anal signs (usually injury or infection) - when a colposcope is recommended (RCPCH and AFP 2004).
- (c) Growth.
- (d) Appearance, demeanour, emotional signs and signs of neglect.

### 11.3 Uses of photographs

11.3.1 Document any visible findings.

11.3.2 Share findings with others who may need to know e.g. second opinions.

11.3.3 Evidence for Court (bruises, burns but not usually genital/anal signs).

11.3.4 Peer review (cases should be anonymised).

#### 11.4 Good medico-legal practice

11.4.1 Consent required - from parent and child where appropriate (Appendix 3).

11.4.2 Photographs not copied without consent of doctor responsible for child's care.

11.4.3 Photographs made available for second opinions on doctor-to-doctor basis.

#### 11.5 Showing photographs in Court

It is the doctor's responsibility to confirm the identity of photographs. These photographs are usually only disclosed from one doctor to another (examining doctor to defence expert) or under the direction of the judge.

11.5.1 Should be prior warning. Check that projection facilities are available.

11.5.2 Prints - copies to each party, images can be projected for all parties to see.

11.5.3 Images are returned after use (property of NHS Trusts).

11.5.4 Highly sensitive medical images (e.g. of genitalia) should be treated with respect for the child's feelings.

11.5.5. It is the doctor's responsibility to confirm the identity of photographs. These photographs are usually only disclosed from one doctor to another (examining doctor to defence expert) or under the direction of the judge.

#### 11.6 Digital photography

##### 11.6.1 Advantages

- (a) The new cameras are producing images of comparable quality to conventional photography.
- (b) There is no processing of films required and hence no delay. The image is available when the report is written and immediate viewing of image is available so that the doctor can ensure the desired image has been captured.
- (c) Doctors including trainees may be able to obtain opinions from colleagues with greater ease and rapidity.
- (d) Storage of images may be facilitated on computers but data protection issues will need to be addressed.
- (e) There may be a saving in cost.
- (f) It is possible to send images for second opinions via the Internet without time consuming scanning (security will, however, be a consideration), on CD Rom or by producing prints.

### 11.6.2 Disadvantages

- (a) The possibility of someone manipulating the image is greater with digital photography. However problems in the legal arena have not arisen.
- (b) Software modification of any image should in general be avoided but if necessary (e.g. if underexposed) recorded.

### 11.6.3 General points

- (a) The doctor is responsible to the court for identifying the image and for accuracy of representation.
- (b) The original image should never be destroyed.
- (c) It is likely with the passage of time and developments in technology that digital photography will replace conventional photography.

## 11.7 Patient identification

For each patient, there should be a means of clearly identifying the clinical pictures as belonging to the patient.

## 11.8 Common pitfalls and problems

- 11.8.1 No film, camera not switched on, film not properly loaded/ wound on.
- 11.8.2 Too light / dark exposure: check exposure compensation and film speed settings.
- 11.8.3 Film dark / orange cast: flash failed to fire – not switched on, dead batteries.
- 11.8.4 Blurred Image – child / photographer moved, out of focus, too close.

## 11.9 Tips for photographing children

- 11.9.1 Explain what is going to happen.
- 11.9.2 Provide comfort for the child.
- 11.9.3 Do what you can to gain the trust of the child.
- 11.9.4 Use automated techniques / film advancer to avoid delays.
- 11.9.5 Use photographs sensitively.
- 11.9.6 Use landmarks on photographs.
- 11.9.7 Use dark / green background.
- 11.9.8 Doctor must show police or medical photographer what to photograph.
- 11.9.9 It is very important to include a measure on the surface of the skin when taking photographs. This is particularly important with bites.

### **11.10 Video recordings**

These can be made to record whole examinations e.g. of genitalia / anus using a colposcope or to record interviews, a child's behaviour or interaction with parent. Written consent is again obviously required having given an indication of what the material will be used for.

### **11.11 Publication of photographs**

GMC current advice is that express consent must be sought from patients (in the case of children who cannot give consent, those with parental responsibility) before publishing personal information about them (includes case histories or photographs) whether or not you believe the patient can be identified.

### **References**

RCPCH & AFP (2004). *Guidance on paediatric forensic examinations in relation to possible child sexual abuse*. Royal College of Paediatrics and Child Health and Association of Forensic Physicians September 2004.

# 12

## Forensic samples

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If a child has suffered or is alleging 'acute' sexual abuse, forensic testing should be considered. This should be done in liaison with the police so that any samples taken can be handed to the police using the chain of evidence procedure for forensic testing. A joint examination with a forensic medical examiner can be arranged if complimentary forensic skills are required. (RCPCH and AFP 2004)

### 12.1 Definition of 'acute'

- 12.1.1 Evidence is best obtained as quickly as possible - preferably within 24 hours of the assault.
- 12.1.2 Evidence may still be present up to 72 hours and even up to 1 week.
- 12.1.3 **Although there is a need to arrange for forensic testing, an out-of-hours medical is rarely indicated because of the following:**
  - (a) It is rarely in a young child's interest to be brought to hospital after their bedtime.
  - (b) Older children may occasionally need to be seen out-of-hours following an acute assault. A better overall paediatric assessment and picture will be obtained when appropriate trained staff and paediatric environment are available and the individual child/teenager is rested.
  - (c) An examination with the colposcope will give a better view and allow for photographic evidence to be obtained.
  - (d) Full infection screening is important and may be difficult out-of-hours.

12.1.4 **Forensic Samples fall into two categories** ( see Appendix 17).

- (a) Evidential samples:
  - (i) Loose debris/particles.
  - (ii) Stains.
  - (iii) Analysis of preserved blood or urine for alcohol, drugs and solvents.
  - (iv) Unwashed clothing, bedding, carpets, sofa covers and items used in the assault.
  - (v) Anogenital swabs for semen and DNA.
- (b) Control samples for comparison purposes.

Sampling materials and instructions are usually supplied in individual modular kits by police forces. It is important that the recommended sampling materials and containers are used and the precise storage instructions are followed.

12.1.5 All forensic samples must comply with a chain of evidence and be accompanied with an appropriate form (Appendix18).

12.1.6 It is important to appreciate that a prepubescent child is unlikely to require all forensic samples to be taken. It is beholden on the paediatrician to discuss what is needed and appropriate according to the child's age and disclosure.

It is important to appreciate that a prepubescent child is unlikely to require all forensic samples to be taken. It is beholden on the paediatrician to discuss what is needed and appropriate according to the child's age and disclosure.

**Time limits for detection of spermatozoa and seminal fluid are:**

Site	Spermatozoa	Seminal Fluid
Vagina	6 days	12–18 hours
Anus	3 days	3 hours
Mouth	12–14 hours	–
Clothing/Bedding	Until washed	Until washed

**References**

RCPCH & AFP (2004). *Guidance on paediatric forensic examinations in relation to possible child sexual abuse*. Royal College of Paediatrics and Child Health and Association of Forensic Physicians. September 2004.

# 13

## Court proceedings: giving evidence

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British justice is based on an adversarial system. One 'side' (i.e. local authority or English and Welsh Crown Prosecution Service (CPS) ) usually calls the doctor who examined the child. The medical witness is there to advise the Court. He/she should remain impartial.

It is likely that if you diagnose abuse or neglect you will be required to give evidence in Court. Legal proceedings are divided into Family (Civil) and Criminal Cases.

### 13.1 Family/Civil Court

- 13.1.1 Proceedings to protect the child from harm— a range of powers are available to the Court to safeguard and promote the child's welfare.
- 13.1.2 Heard by Judge or Magistrate. (In Scotland, Children's Reporter).
- 13.1.3 Hearsay evidence is allowed.
- 13.1.4 Burden of proof – 'balance of probability' but the more serious the allegation the stronger the evidence needs to be.

### 13.2 Criminal Court

- 13.2.1 Proceedings to prosecute an alleged offender.
- 13.2.2 Brought by the Crown Prosecution Service. In Scotland, Crown Office Procurator Fiscal Service.
- 13.2.3 No hearsay evidence allowed.
- 13.2.4 Usually heard by Judge and Jury.
- 13.2.5 Burden of Proof – 'beyond reasonable doubt'.

### 13.3 Role of the doctor

A Doctor may be called as:

- 13.3.1 Witness to fact.
- 13.3.2 Professional witness.
- 13.3.3 Expert witness.

The treating doctor will be expected to give a factual account of the history of any examination findings. Paediatricians should only give an opinion appropriate to their training, experience and specialist knowledge. Other parties or the Court may engage other expert witnesses who will have been asked to perform specific functions and to write an expert report and gather appropriate evidence based on the published literature.

### 13.4 Appearing in Court

You are there to assist the Court. You are not there to be the advocate for the child or the adult.

- 13.4.1 Giving evidence can be stressful and doctors may need support from colleagues including designated/named professionals/lead clinicians. The adversarial system of justice in this country encourages vigorous cross-examination of testimony but the doctor is best protected if adequately prepared.
- 13.4.2 Courses on Court skills are available.
- 13.4.3 Giving evidence is never easy and requires practice and an expectation of frustration that you may not always feel you have had a fair hearing. Nevertheless, what a doctor says is important information and you are there to inform and sometimes educate.
- 13.4.4 You are there to assist the Court. You are not there to be the advocate for the child or the adult.

### 13.5 Guidelines for attending Court

- 13.5.1 You must attend if asked. Witness summonses are not usually served on doctors but if you receive one you must attend or you will be under threat of contempt (carries a prison sentence). Witnesses must be treated reasonably in court. You may complain if you feel you have been treated badly.
- 13.5.2 Schedule with the Court – In care proceedings, the solicitor acting for the local authority should contact you for convenient dates and times. Agree in writing and ask for written confirmation of when and where. In criminal proceedings reasonable notice should be given and if you cannot attend for good reason, contact whoever has summoned you and explain your difficulty. A more convenient time should be arranged. Ask for written confirmation.
- 13.5.4 Pre-Court conferences between doctors and experts or with solicitors or barristers are there to reduce court time and resolve as many issues as possible beforehand. Attend if possible. Your comments will be used in evidence after you have agreed and signed a written record of the meeting.
- 13.5.5 Attend on time, take copies of reports/notes as required, look presentable and



prepare the case in advance, anticipating any difficult questions, checking details and references.

- 13.5.6 Stick to your knowledge and expertise area and avoid straying into other areas or speculation.
- 13.5.7 Be willing to admit it if you do not know the answer to a question.
- 13.5.8 Answer the questions but also say what you feel the Court needs to know. In care proceedings, there is much more freedom to talk generally about the child and to give hearsay evidence not allowed in criminal proceedings.
- 13.5.9 Photographs of bruises, burns etc. may be used (give notice) but avoid showing genital and anal images unless ordered to do so by the Court. The Courts can obtain notes by an order of the Judge, but they are not yours to show or hand over to a solicitor who asks you for them.
- 13.5.10 Avoid appearing dogmatic in your evidence – a fair and balanced witness impresses the Court most.
- 13.5.11 Your testimony should be the same in substance, whether you are testifying at the request of the prosecution or the defence.
- 13.5.12 At the end of your evidence the Court should release you to return to your duties. In care proceedings, a formal judgement with reasons has to be made by the judge or magistrate and you should receive feedback on the case. This is not available in the same way in criminal proceedings.

# 14

## Abuse of disabled children

---

### 14.1 Important points

- (a) May be more common than abuse of non-disabled children but evidence for this is poor.
- (b) Under reported.
- (c) Children may have difficulty communicating their abuse.
- (d) Abuse may compound pre-existing disability, or be the cause of the disability.
- (e) All forms of abuse are seen including neglect and sexual abuse.
- (f) It is easy to fail to recognise abuse in disabled children by making too many allowances for the disability as a cause of problems.
- (g) Remember that professionals can be drawn into collusion with families.

### 14.2 Recognition

- (a) Children with disability may exhibit the types of behaviour and signs seen in children without disability. An abnormal behavioural sign must be considered as carefully as in any other child. Manifestations include:
  - (i) Abnormal or sexualised behaviour which may indicate sexual abuse in the same way as any other child.
  - (ii) Bruises and other physical injury.
  - (iii) Anxiety and distress.

- (iv) Self harm.
  - (v) Vaginal or rectal bleeding.
  - (vi) Sexually transmitted infection, pregnancy.
  - (vii) Signs of neglect including non-organic failure to thrive.
- (b) Abuse may be difficult to separate from symptoms of disability eg increase in seizures in a child with epilepsy if anti-convulsants are withheld. Induced and fabricated illness may be even more difficult to recognise because the child may have co-existent diagnoses.

### 14.3 Communication

- (a) It is important to obtain specialist skills when communicating with disabled children (e.g. where a child has difficulty in communication, the skills of a person with expertise in augmented and alternative communication is invaluable).
- (b) It may be useful to involve the child's key worker during the investigative process (e.g. interview of child). A child's teacher can often be of considerable help.

# 15

## Abuse in special circumstances

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There are children living in circumstances at risk of achieving poor outcomes. Health professionals need to be aware of the role they can play in recognition of these children, identifying their particular needs and preventing significant harm (DoH 2003a).

In the current multicultural society of the United Kingdom, it is important to recognise that there may be children and families in need of skilled interpreters. You should also recognise the differences that may exist in child-rearing practises in minority groups.

### 15.1 Children and young people living away from home

15.1.1 This group may include children looked after by local authorities, in private foster care and young people living independently (DfES 2005, DoH 2003b).

15.1.2 It has been estimated that 4% of foster carers/placements are abusive to children. Many children looked after and young people living independently have been abused or neglected prior to going into care. This is a particular group where assessment may be made more difficult, because of pre-existing symptoms and behaviour. There should be a low threshold in seeking advice from experienced professionals in these circumstances (e.g. Designated / Named professional).

15.1.3 There are many children in private foster care not known to Children's Social Care and hidden from sight. It is important to be aware of these children and refer them to Children's Social Care.

15.1.4 Points to remember:

- (a) Local Authority gives consent for medical examination / treatment if the child is in their care.

- (b) Always notify the Social Worker of the child if you have any concerns.
- (c) Abuse can be perpetrated by the foster or residential carers, by other children in the household or on contact with parents/relatives.
- (d) Safeguarding children procedures are the same as with any other child.

## **15.2 Asylum-seeking children or refugees, both with families and unaccompanied**

15.2.1 The importance of having skilled interpreters in assessment of these children cannot be over-emphasised. The children's behaviour on entering the country may already have been influenced by previous experience. It is important to remember their general health needs and the families will need help in accessing services (Kings Fund and RCPCH, 1999).

## **15.3 Children with troubled parent/s** (see also Chapter 6 Sections 6.15, 6.16, 6.17)

15.3.1 These include children of substance misusing parents, children living with domestic violence, children whose parents have chronic mental or physical health problems, children whose parents have a learning disability, children with a parent in prison.

15.3.2 Parental unavailability for whatever reason increases the risk to the child of all forms of abuse, especially neglect and emotional abuse. Specific consideration of the effects of the parent's problem on the children must be made, whatever the circumstances of presentation.

## **15.4 Children in the Armed Forces**

15.4.1 Children in the Armed Forces have a tendency to move frequently. There are extra strains upon the families engendered by:

- (a) Frequent moves.
- (b) Frequent changes of school.
- (c) Separation of parents by the nature of the job.
- (d) Separation from immediate support from family and friends.

15.4.2 Where a child in the Armed Forces presents with evidence of abuse or neglect, it is important to ascertain or gain information from other areas of the country/ other countries where they may have lived.

## **15.5 Children of travelling families**

15.5.1 Children in Travelling Families have particular needs because of

- (a) Frequent moves.
- (b) Frequent changes of school.

- (c) Poor health care.
- (d) poor environment

15.5.2 Refer to relevant agencies and support groups for these children.

## 15.6 Runaway children and prostitution

- 15.6.1 Remember that runaway children may already have been the subject of abuse and are at risk of exploitation and prostitution.
- 15.6.2 Children of troubled families are more likely to be involved in prostitution than other groups.

## 15.7 Children as young carers

- 15.7.1 Neglect and emotional abuse may be part and parcel of the difficulties of being a carer at a young age. Young carers lose out on normal childhood experiences (e.g. school attendance, peer groups).
- 15.7.2 Young carers may not welcome interventions from agencies, for fear of being removed from home and therefore their caring responsibilities.
- 15.7.3 If possible, enlist the help of local "Young Carers" projects.

## 15.8 Children in hospital

- 15.8.1 Children can be abused by other patients in hospital, by staff, parents, visitors or strangers. Any suspicions which you may have must be reported to the consultant in charge of the child, senior nurse manager for the unit on which the child was abused and the Named/Designated professional without delay.
- 15.8.2 The procedures for investigation are the same for abuse as in other circumstances. The Named and/or Designated professionals must be involved from the outset.

## References

- DoH (2003a). *Getting the Right Start: National Service Framework for Children, Young People and Maternity Services :Standard for Hospitals Services*. Department of Health
- DoH (2003b). *What to Do If You Are Worried A Child Is Being Abused*. London
- Fostering Guidance (2005). The Children (Private Arrangements for Fostering) Regulations. Section 44, *Children Act 2004*.
- HO and DoH (2000). *Guidance of Children Involved In Prostitution*. Department of Health and the Home Office.
- Kings Fund and RCPCH (1999) *The Health of Refugee Children: A Guide for Paediatricians*.

# 16

## Training and support for doctors

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### 16.1 The need for training

- 16.1.1 All doctors who work with children and families require training in aspects of the abuse and neglect of children. The breadth and depth will depend on their roles and responsibilities. All paediatricians will need to recognise and know the signs and symptoms of abuse and neglect in some detail so as to be able to make a diagnosis. General and community paediatricians will have frequent exposure to abuse and neglect and will develop a high level of expertise. Guidelines are being developed for child protection competencies by the RCPCH.
- 16.1.2 Training grade doctors require training, support and clinical experience. They work under supervision of a consultant paediatrician, performing examinations, writing reports, participating in multi-agency work and in some cases commensurate with their experience, attend court to give evidence. RCPCH is developing guidelines for child protection training in the framework of competences for the different stages of training: Basic Specialist Training (RCPCH 2004), Core Higher Specialist Training (RCPCH 2005) and Higher Specialist Training.

### 16.2 Peer review and clinical supervision

- 16.2.1 Peer review meetings in local hospital and community settings provide clinical supervision and training opportunities for paediatricians.
- 16.2.2 All health organisations should provide child protection training to their staff. Child protection training should be mandatory for all doctors who work with children and families. Child protection training should be reviewed in the appraisal process for paediatricians.
- 16.2.3 Further child protection training is offered by the Child Protection Special Interest Group and RCPCH: specific child protection training modules are being developed by RCPCH and will be introduced from 2006. Other courses are available throughout the country and advertised in paediatric newsletters.

- 16.2.4 Opportunities for doctors to discuss clinical cases with child protection issues including diagnosis and management should be available locally. The Named Doctor and Designated Doctor will be aware of these opportunities and should be contacted for information.
- 16.2.5 Voluntary organisations offer multidisciplinary conferences e.g. NSPCC and the British Association for the Study and Prevention of Child Abuse and Neglect (BASPCAN).

### 16.3 Training that will be available

16.3.1 Basic training:

RCPCH/NSPCC/ALSG programme which includes a reader and companion, full-day taught programme, digital video disc case scenarios and other material.

16.3.2 More advanced training:

A more in-depth course is in the early stages of development. for those who already have some experience and feel they need a more advanced course. This course may be taken further by those with a particular interest in this area. There are other courses available round the country.

16.3.3 Training with the Judiciary:

Links are being made between the RCPCH and the Family Justice Council (Judiciary). This should lead to the development of:

- (a) training opportunities at a local and regional level between judiciary and paediatricians.
- (b) a local mini-pupillage scheme whereby a paediatrician or specialist registrar could take advantage of sitting with the barristers and judge throughout the court case. Thus hearing the legal arguments, the evidence, the Judge's reasoning and conclusions. This should provide a better understanding of the court process and help the individual be better prepared for future court hearings.

### References

RCPCH (2004) *Framework of Competencies for Basic Specialist Training in Paediatrics*.  
London

RCPCH (2005) *Framework of Competencies for Core Higher Specialist Training in Paediatrics*.  
London



# 17

## Aftercare following abuse

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### 17.1 Responsibilities

The Paediatrician's responsibilities following the recognition of abuse or neglect include:

- (a) Examination of siblings or other children as appropriate (arrange with social worker).
- (b) Follow-up of medical or developmental problems.
- (c) Multi-agency working – attend strategy meeting, initial and review child protection conferences and any other relevant meeting.
- (d) Writing reports to relevant agencies including the police.
- (e) Giving evidence in civil or criminal proceedings, as required.
- (f) Providing a report to the Criminal Injuries Compensation Authority, if requested.
- (g) Providing advice, where appropriate, to adoption and fostering agencies.

### 17.2 Paediatric follow up

It is important that children in whom abuse or neglect has been identified are offered appropriate paediatric follow up, to:

- (a) Monitor child's overall progress.
- (b) Attend to areas of developmental need (e.g. failure to thrive, language delay, behavioural disturbance).
- (c) Ensure that as far as possible the child will return to a safe environment.
- (d) Perform a further medical examination as appropriate (e.g. to check for signs of healing).

- (e) Make appropriate referrals for therapeutic support (e.g. to mental health services).
- (f) In some cases, follow up by a social worker or other health care professional may be appropriate.

### 17.3 Therapeutic support for children

Protection and good care in themselves may be insufficient to meet a child's needs following abuse. Consideration should be given, along with others involved in the care of the child, for the need for specialist support and help to the child and carer where the child is exhibiting continuing signs of emotional or behavioural disturbance.

Resources vary from area to area and include CAMHS teams, therapeutic social work teams, clinical psychologists and child psychiatrists. You should make a note in the spaces below of the contact information of therapeutic services to which referral may be made in your area.

#### 17.4 Locally based therapeutic resources for children following abuse:


# Appendices

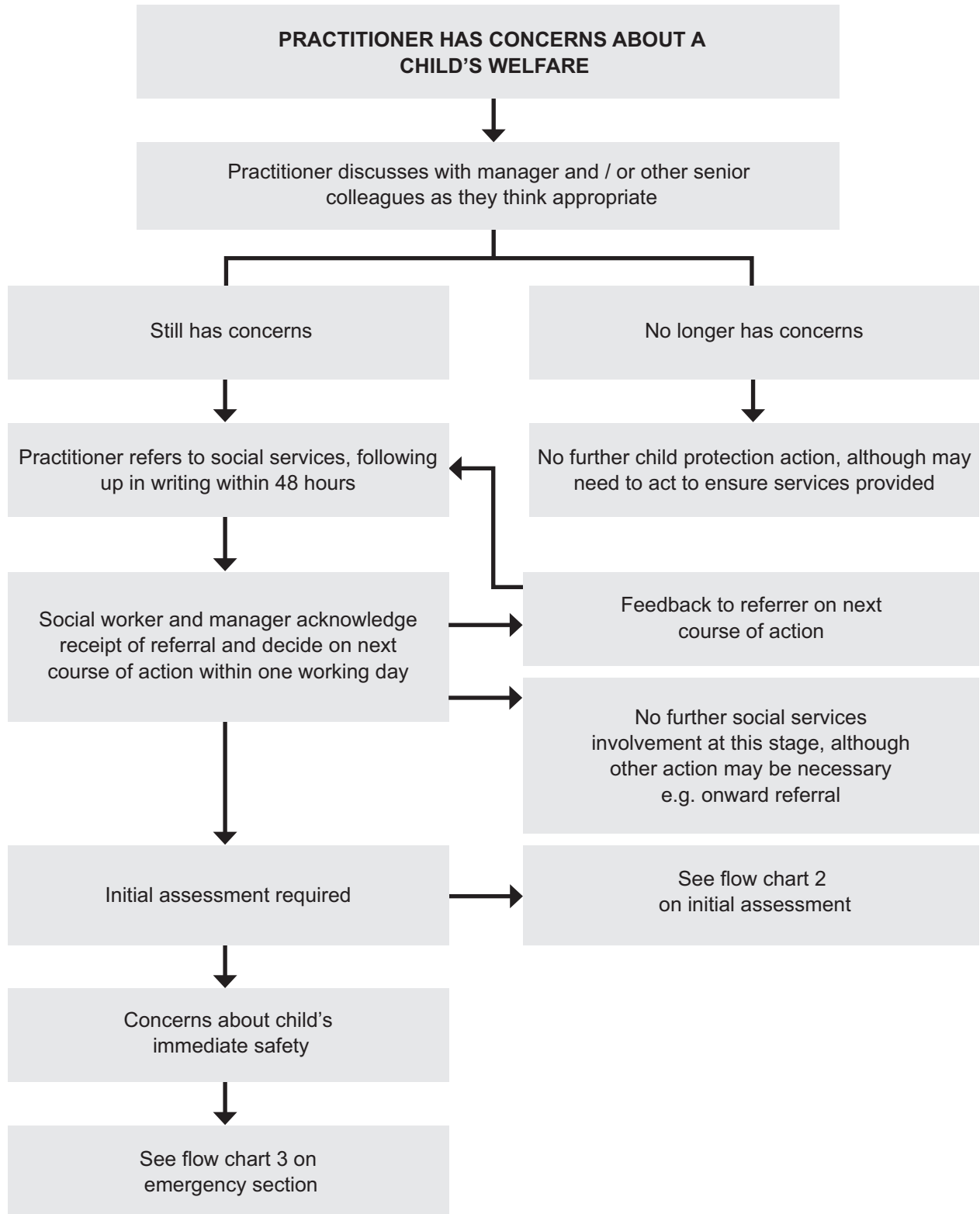
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## APPENDIX 1

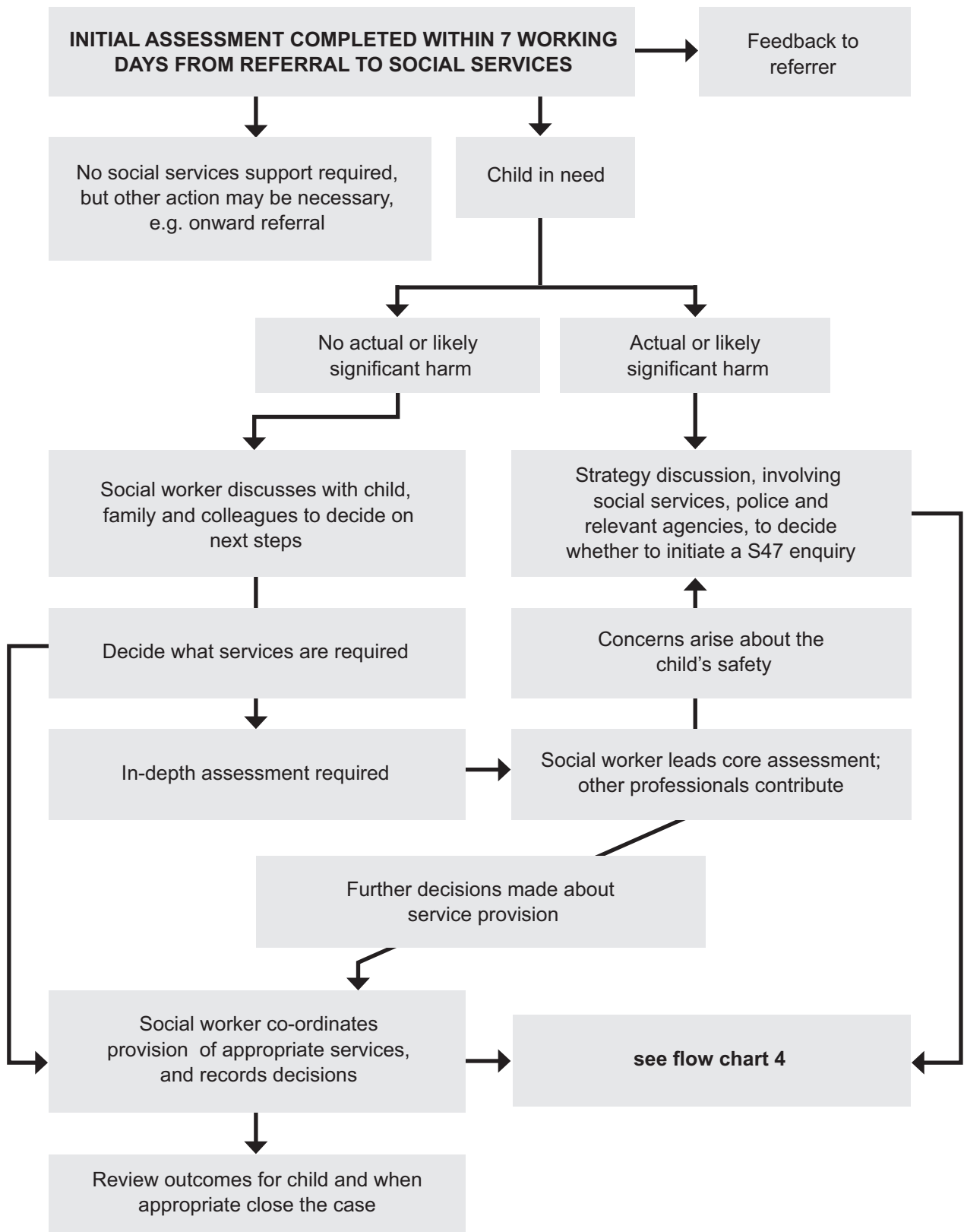
### What to do if you are worried a child is being abused

**FLOW CHART 1 Referral**



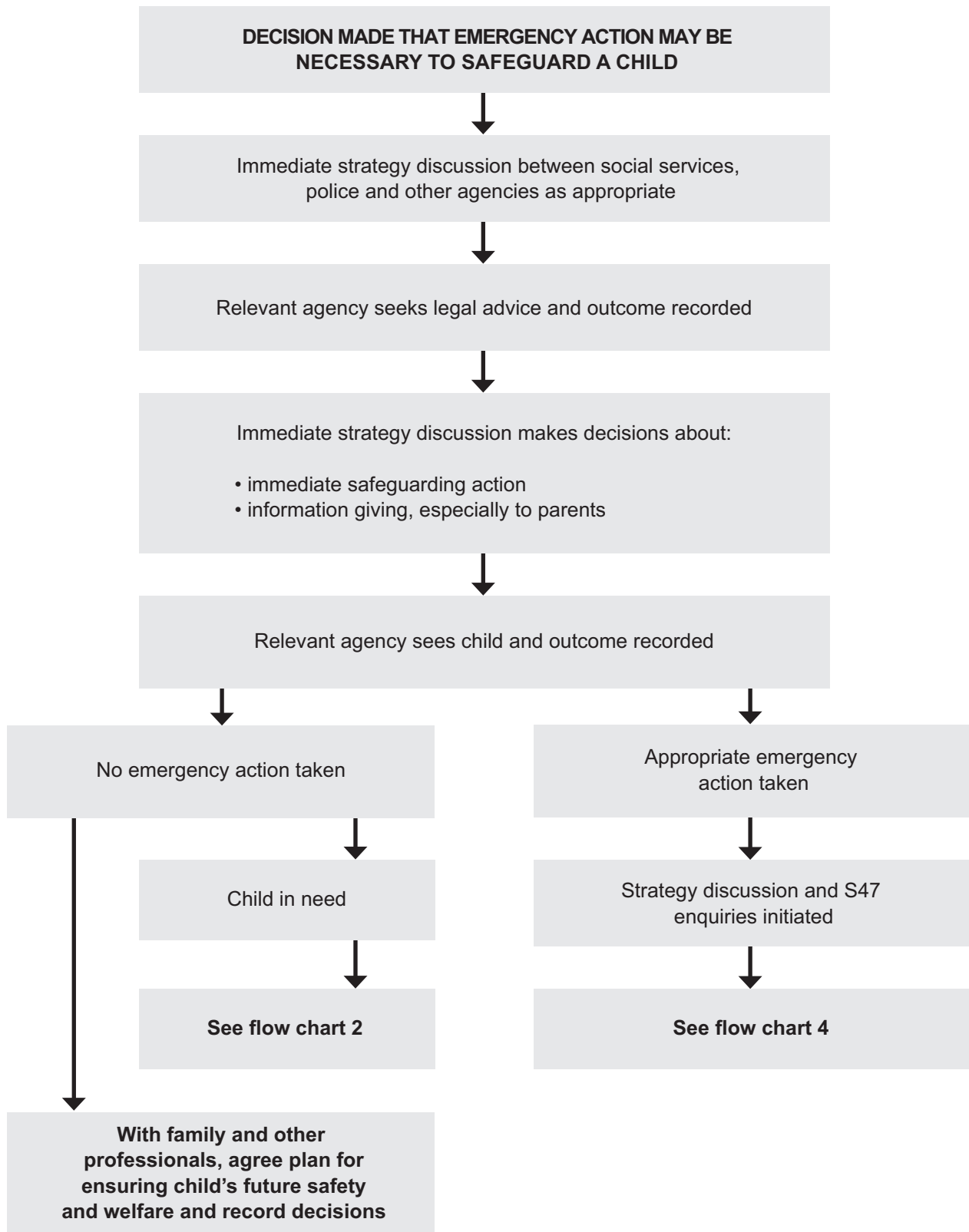
Adapted from: *What to Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).

**FLOW CHART 2 What happens following initial assessment?**



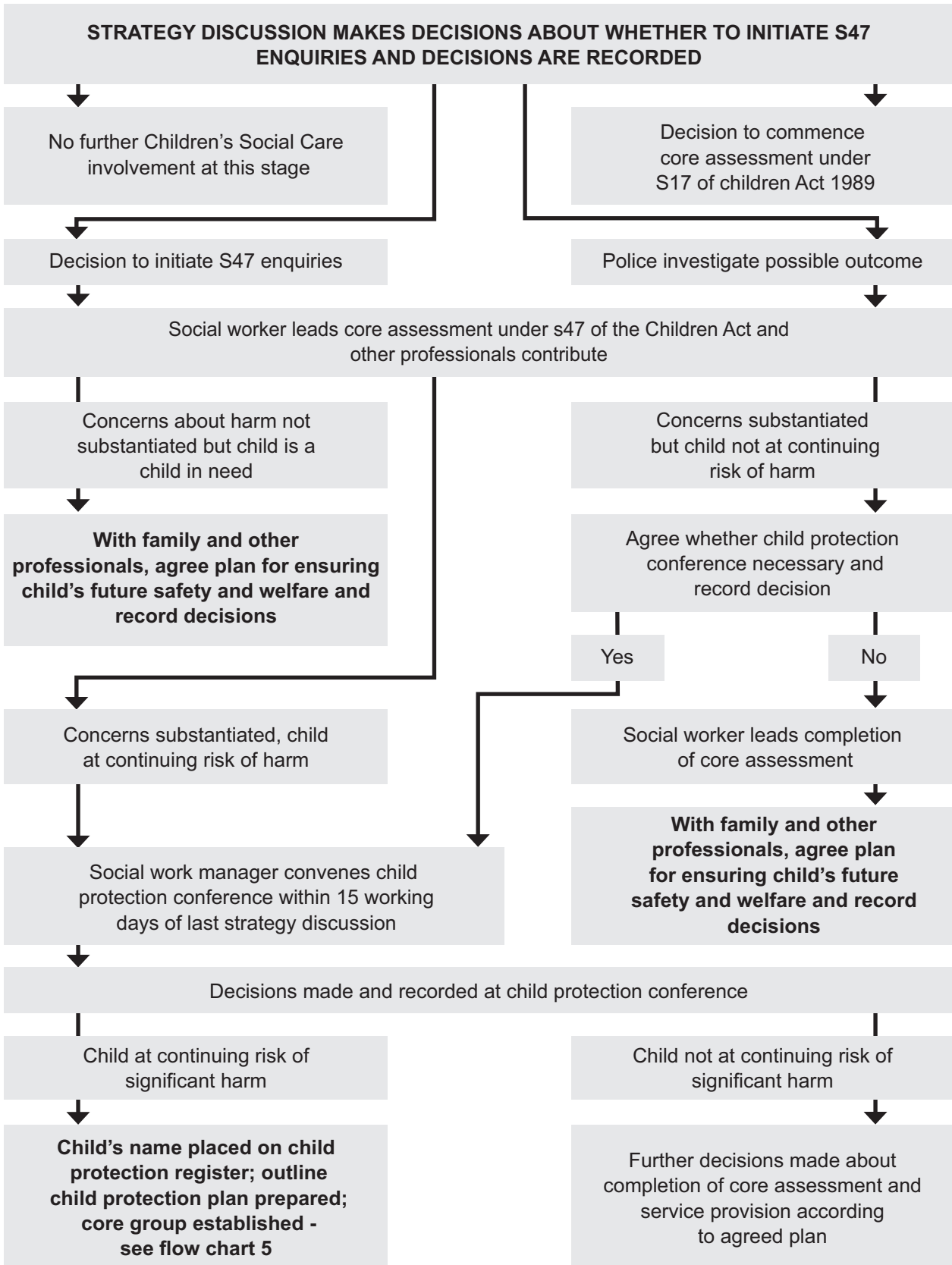
Adapted from: *What to Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).

**FLOW CHART 3 Urgent action to safeguard children**



Adapted from: *What to Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).

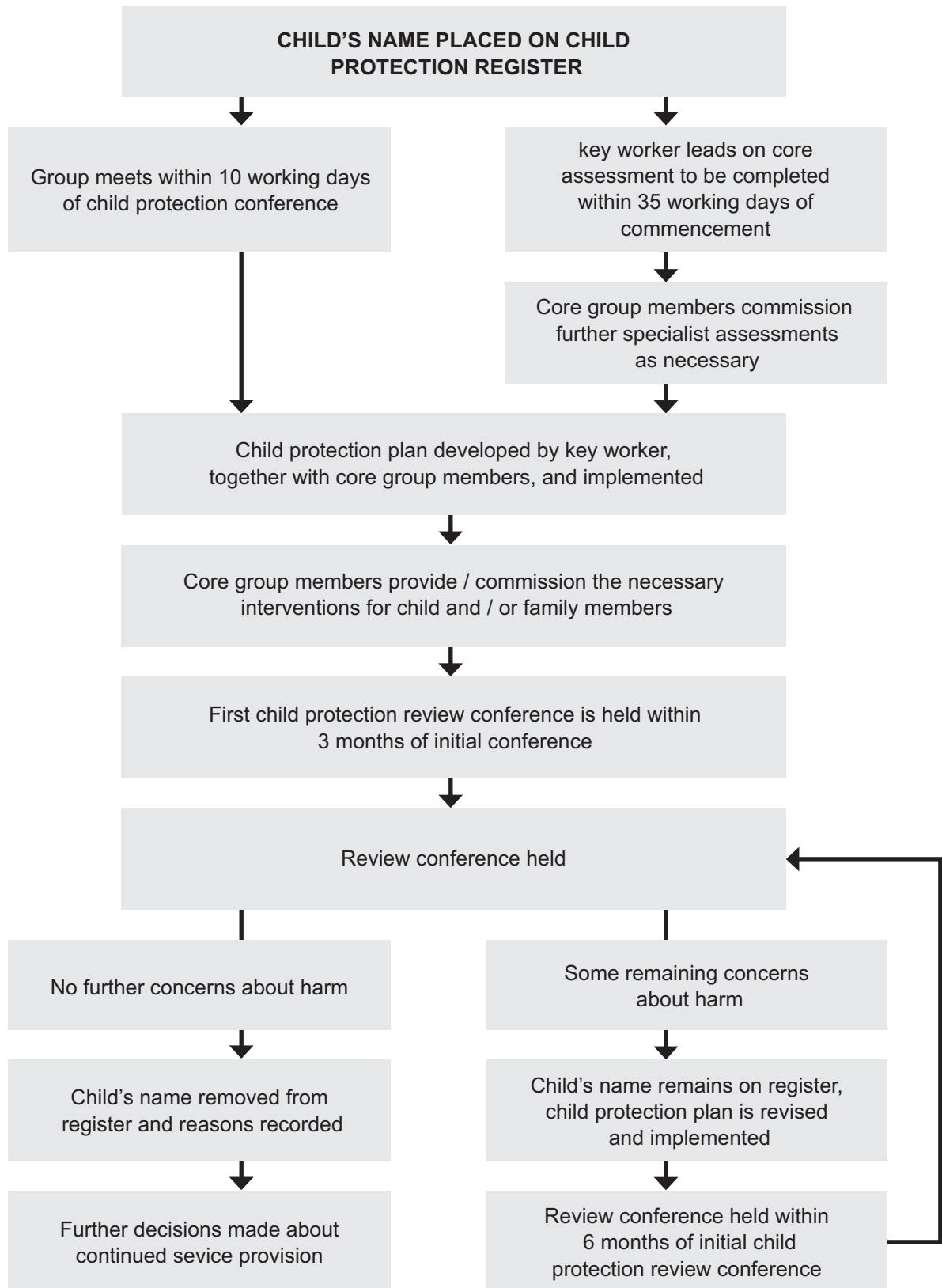
**FLOW CHART 4 What happens after the strategy discussion?**



Adapted from: *What to Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).



**FLOW CHART 5** What happens after the child protection conference, including the review process?

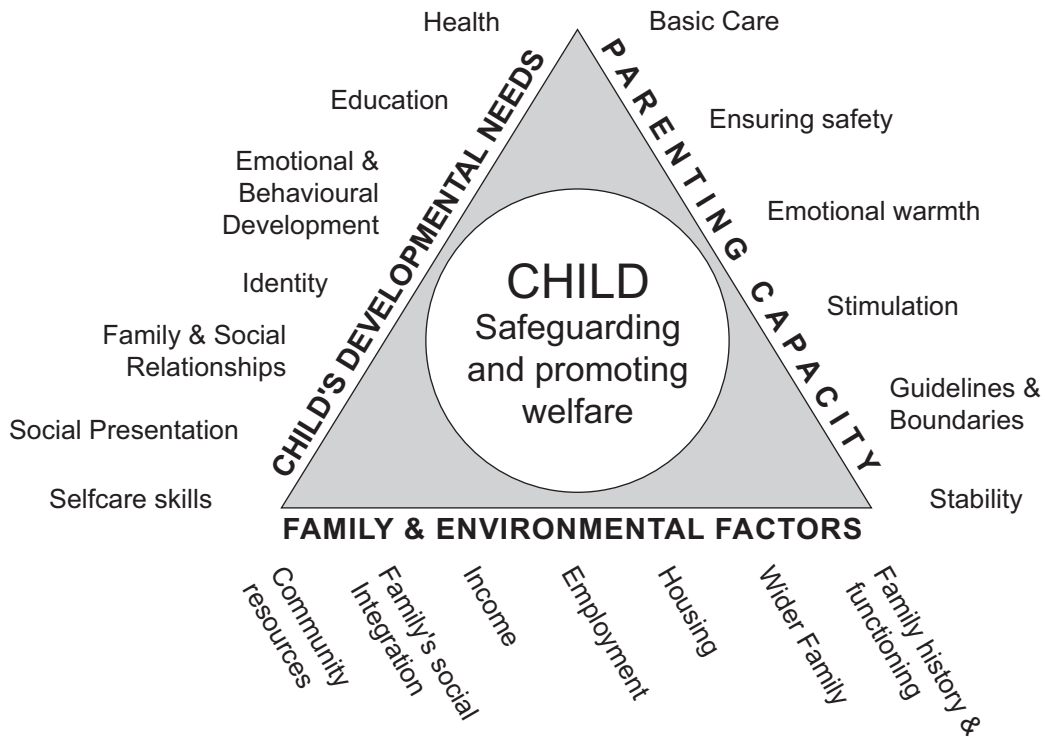


Adapted from: *What to Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).

## APPENDIX 2

### The assessment framework

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Reproduced from Department of Health/Department of Education and Employment / Home Office(2000) *Framework for the Assessment of Children in Need and Their Families*, London: The Stationery Office

## APPENDIX 3

### Confidential medical record consent form

Name..... DOB .....

Computer ID N°..... Hospital / Community Child Health no.....

Permission must be obtained from parent(s) or other(s) with responsibility for the child, and from the child where appropriate.

I give permission for:

1	Medical Examination	Yes	No	N/A
2	Photography of Clinical Findings	Yes	No	N/A
3	Photography of Genital Findings	Yes	No	N/A

Photographs may be used to support clinical evidence of injury and may need to be shared with another Doctor involved in any court proceedings, or may be used for teaching and training other professionals.

I give permission for photographs to be used:

1	To support clinical evidence in court proceedings	Yes	No
2	For teaching / training purposes	Yes	No
3	For peer review	Yes	No

I give permission for a report or letter / summary on the medical of my child to be shared with:

	Report	Letter
Social Services	Yes / No	Yes / No
Police	Yes / No	Yes / No
GP	Yes / No	Yes / No
Health Visitor / School Nurse	Yes / No	Yes / No

Other (specify) .....

I understand that at any stage of the examination, I may withdraw my consent.

Signed..... Date.....

Name..... Parent / Carer / Professional with parental responsibility

Doctor(s).....

Signature..... Date.....

Data Protection Act 1998: You are advised that info and treatment. Everyone working for the NHS has a legal duty to keep information confidential.

Reproduced with permission from Southampton City Primary Care Trust

## APPENDIX 4A

### Factors which may put a child at increased risk of harm

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#### **Child**

1. Prematurity
2. Difficulty with feeding
3. Disability (including learning difficulties)
4. Chronic illness
5. Children Looked After

#### **Parent**

1. Learning difficulties
2. Mental health problems
3. Substance abuse
4. Domestic violence
5. Disability
6. Chronic illness
7. Unemployment or poverty
8. Homelessness
9. Young, unsupported parents
10. Parents with poor role models of their own

## APPENDIX 4B

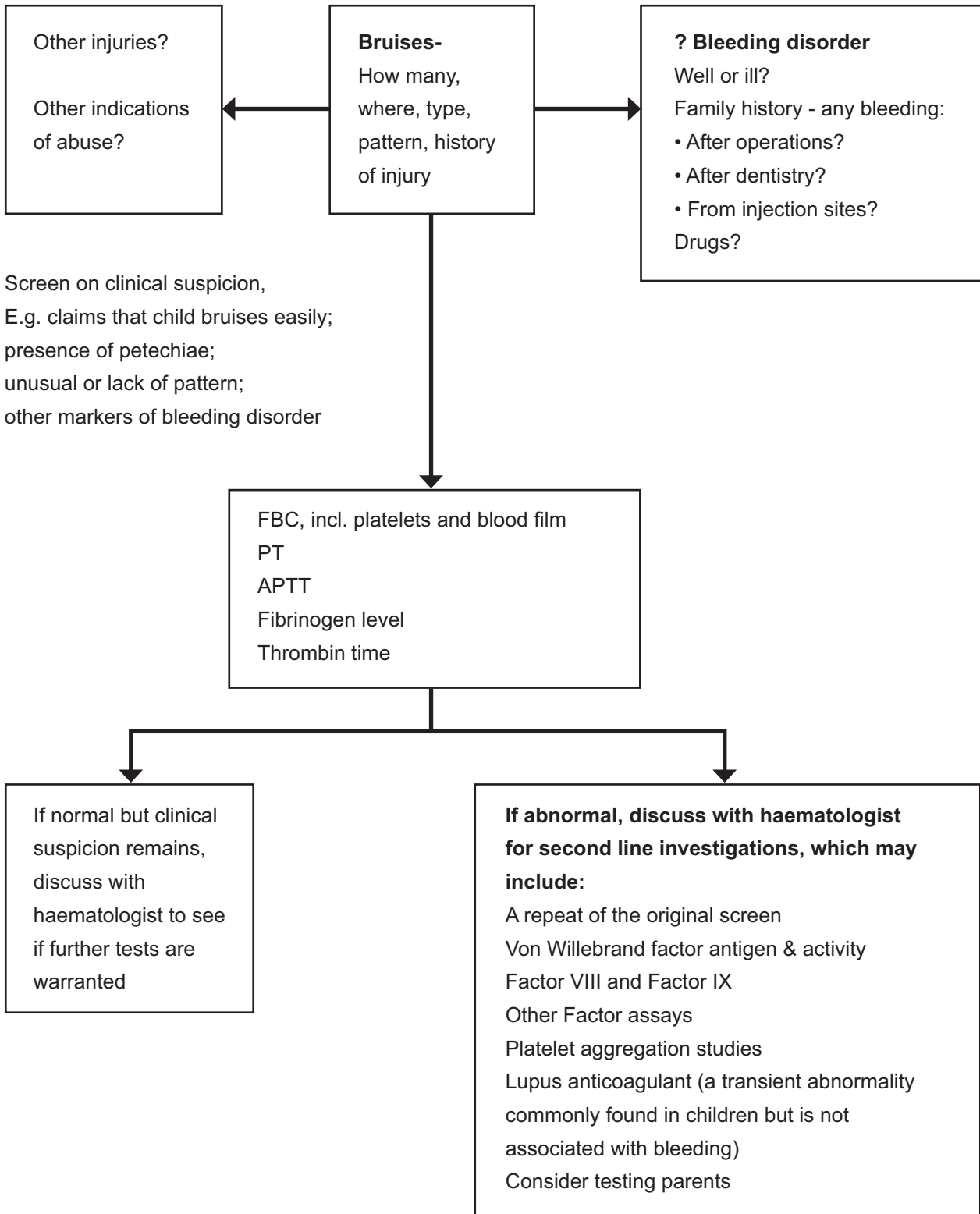
### Checklist for paediatric injury

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- Is there any unreasonable delay in presenting the injury? .....
- Is there one or several versions of the history for the injury? .....
- Have there been any changes in the history? .....
- Is the injury reasonably explained by the history? .....
- Do you clearly understand what is being said? .....
- Is there anything unusual about this injury? .....
- Bearing in mind the child's development is it possible for him to have done what is suggested? .....
- How does the child and any adult relate to one another? .....
- Are there any other additional injuries? .....
- Are there any injuries that should be looked for e.g. with x-rays or special examinations e.g. ophthalmoscopy? .....
- Have there been any previous injuries, accidents, ingestions or admissions to hospital? .....
- Are there any risk factors in the family such as drug and alcohol abuse, domestic violence, or mental health problems in either parent? .....
- Is the child and family known to Children's social care? .....

## APPENDIX 5

### Flow chart for investigation of possible bleeding disorder



Reproduced with permission from Angela Thomas, Consultant Paediatric Haematologist, Edinburgh

## APPENDIX 6

### Dealing with injuries caused by teeth

---

Many injuries do not have an immediately obvious cause and any such should be considered potentially suspicious. Be alert to possible dental cause if the history or appearance is suggestive – i.e. any injury which is curved, oval, or shows what could be individual tooth marks.

In such cases it is undoubtedly wise to contact an odontologist as soon as possible.

If an odontologist cannot attend immediately, it is vital that, in addition to your normal examination and history, and prior to any treatment, if possible, the following steps are taken:

- swabbing for saliva, ABO status in secretions and DNA
- recording and measuring – a full description, drawing and overall dimensions should be noted

Do not attribute the injury to an adult/child perpetrator on the basis of size. This can easily be quite wrong.

Arrange photography as soon as possible even if an expert photographer is not available. Most cases hinge on the quality of the photography and it is not easy to get it right. Ideally, an odontologist should supervise, but, if not available, the following points are essential:

#### **Essentials of good bite mark photography**

- take an overall locating view – no scale
- take close ups of each injury with and without scales
- an L-shaped rigid scale is ideal but it must not obscure any possible part of the injury. A date written on the scale can be useful
- the scale *must* be level with and parallel to the plane of injury
- the camera must be directly over the injury and at right angles to it (our analysis is dependent on distortion-free photographs)
- it will often be necessary to take several views when dealing with a curved surface (e.g. opposing tooth marks on an arm)
- some injury patterns become clearer with time so repeat photography should be considered. The odontologist can advise the photographer

## APPENDIX 7

### Assessment of an infant or young child with SDH (subdural haemorrhage)

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Multi-agency team members	General paediatrician, collaborating with paediatrician with expertise in Child Protection Paediatric neurologist and / or neurosurgeon Neuroradiologist Ophthalmologist Local Safeguarding Childrens Board Social Worker and Police
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Clinical history	Full paediatric case history Full documentation of all possible explanations for injury
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Social and police history	Identify any previous child protection concerns, relevant criminal record of carers
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Examination	Thorough general examination Documentation and photographs of injuries Monitor head circumference
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Laboratory	Full blood count repeated over first 24-48 hours Coagulation screen Urea and electrolytes, liver function tests, serum amylase Septic screen Urine for toxicology and metabolic screen
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Ophthalmology	Examination of both eyes using indirect ophthalmoscopy by ophthalmologist
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Radiology	Initial cranial CT scan Repeat neuroimaging at 7 and 14 days (MRI scan preferable) Discuss neuroimaging with neuroradiologist Full skeletal survey: repeat imaging at 11-14 days
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Ref: Dr A. Kemp (February 2002) Investigating Subdural Haemorrhage in Infants. *Archives of Disease and Childhood* 88(2);98-102

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## APPENDIX 8

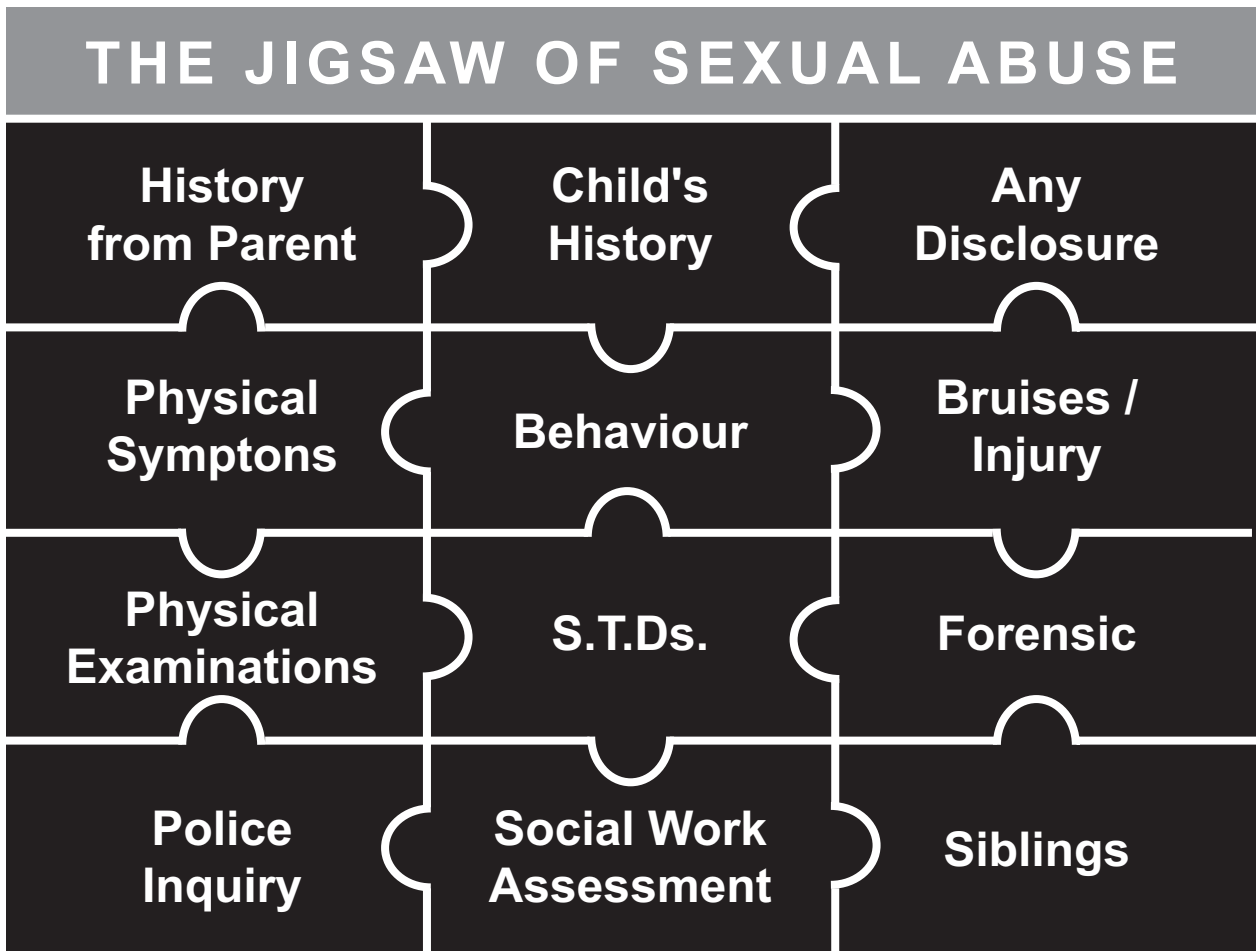
### Proforma for immersion scalds

Case No:				Present Date:			
Possible Perpetrators Name:				Child's Name:			
Place where injury occurred							
Bath or sink measurements:		Width:				Inches/cms	
		Top length:				Inches/cms	
		Bottom length:				Inches/cms	
		Inside depth:				Inches/cms	
Running Water Temperature - HOT		Running Water Temperature - COLD		Running Water Temperature - Full HOT AND COLD			
Seconds	Degrees	Seconds	Degrees	Seconds	Degrees		
0		0		0			
5		5		5			
10		10		10			
20		20		20			
Peak Temperature:		Peak Temperature:		Peak Temperature:			
Full hot water standing 5 inches deep (temperature measured in middle of bath / sink at mid-depth):							
Fill Time				Temperature in Degrees			
Inches/cms	Minutes	Seconds					
1							
2							
3							
4							
5							
Parent ran a tub of water on my request. (Measurement was mid-bath / mid-depth)							
Depth 5 inches		Temperature (1 minute after water off)				Degrees	
Investigator Name:			ID No.		Division		
Investigator Name:			ID No.		Division		

Reproduced with permission from P.J.Peltier. Office of District Attorney San Diego

## APPENDIX 9

### The clinical jigsaw in child sexual abuse



Hobbs CJ, Wynne JM (1990). The Sexually Abused Battered Child. *Archives of Disease in Childhood* 65:423-427.

**APPENDIX 10****Swabs for STIs****STI screening protocol for Prepubertal Children and Pubertal girls intolerant of speculum examinations**

<b>Minimum screen for sexually transmitted infections</b>	
<b>Sample</b>	<b>Condition or organism to be detected</b>
Females: sample can be either from vagina, vestibule or discharge (if present)* 1 Swab: - Slide for Gram stain/clue cells/spores/pseudohyphae + - Amies transport media 1 Swab rubbed on posterior vaginal wall or vestibule: CT culture if available (NAAT/EIA/DIF not evaluated. If positive with these tests recommend confirmation with CT culture where available or with different NAAT test)	Abnormal flora, BV, Candida, GC  CT
Males: 2 urethral swabs (if tolerated) 1 swab - Slide for Gram stain + Amies transport media 1 swab - CT culture (EIA/DIF/NAAT as for females)	Urethritis, GC, TV CT
Male & Female: FVU (20ml) NAAT yet to be evaluated in young people. Consider using urine as screening test and confirm with cultures or different NAAT if positive (EIA/DIF can be used in males)	CT, GC

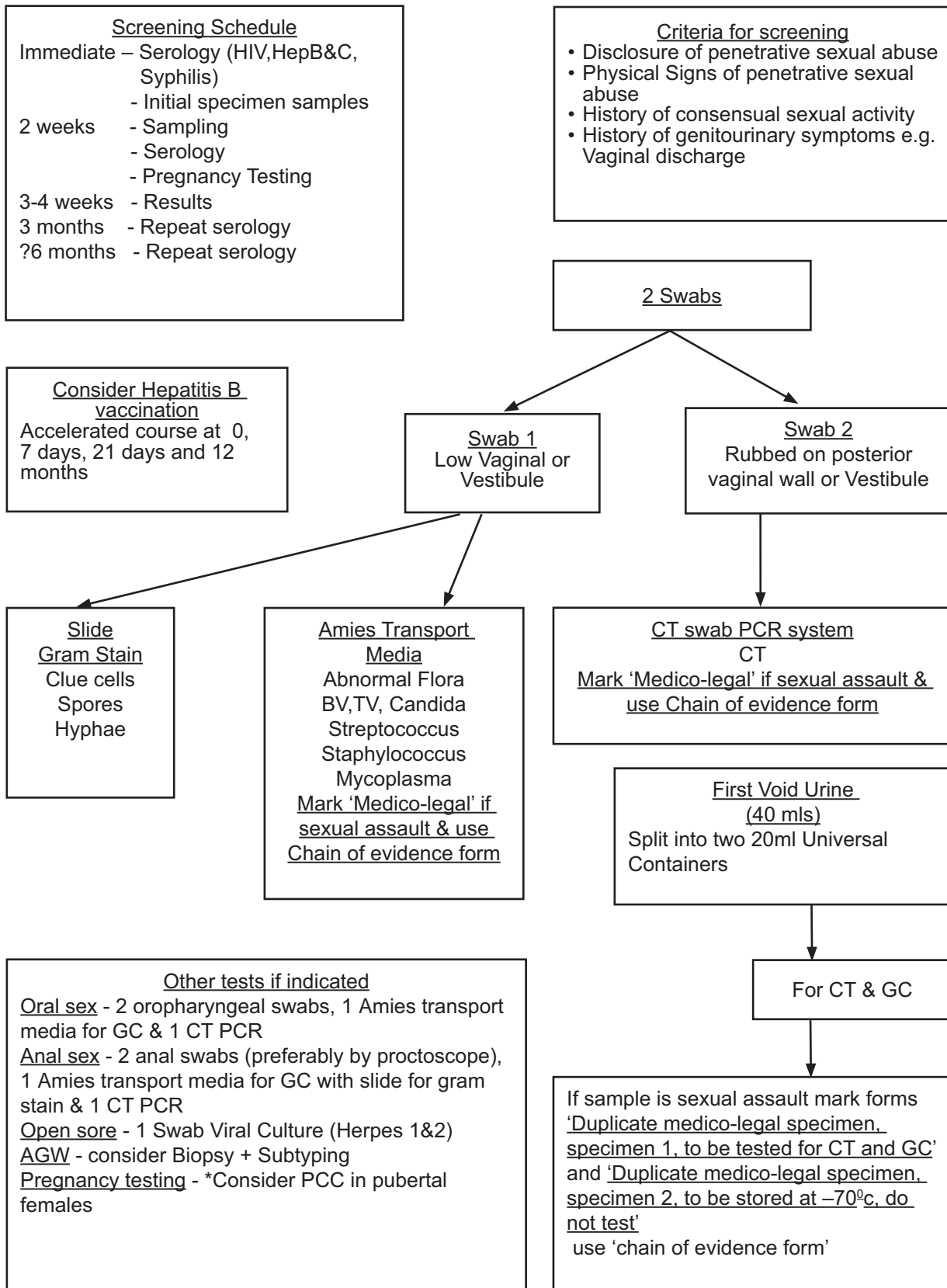
\* If discharge present or swabs well tolerated, consider inoculation directly onto TV culture and gonococcal medium.

<b>Other tests as indicated</b>	<b>Condition or organism to be detected</b>
1 Swab from open sore: - Virus culture, NAAT or Antigen detection	HSV type 1 and 2
2 Swabs from oropharynx (if indicated) - 1 swab Amies transport media - 1 swab for CT by NAAT	GC CT
2 Anal/Rectal Swabs (if indicated, preferably by proctoscope) - 1 swab Amies transport media - 1 swab for CT by NAAT	GC CT
Consider biopsy of AGW, DNA probe techniques for subtyping have not been fully evaluated.	AGW
Serology Tests	Offer; Syphilis, HIV, HBV, HBC. HSV-1 or 2 type specific serology (if indicated following rape or abuse). Repeat at 3 and 6 months.

AGW– Anogenital warts, BV-Bacterial Vaginosis, CT- Chlamydia trachomatis, DIF-Direct Fluorescent Antibody, EIA- Enzyme Immunoassay, FVU-First Void Urine, GC- Neisseria gonorrhoeae, HIV-Human Immunodeficiency Virus, HPV-Human Papilloma virus, HSV-herpes simplex, NAAT-Nucleic Acid Amplification Techniques, TV- Trichomonas vaginalis.

Adapted with permission from Amanda Thomas, Consultant in Community Paediatrics, Leeds

## STI Screen for Prepubertal and Pubertal Females Intolerant of a Speculum



Adapted with permission from Amanda Thomas, Consultant in Community Paediatrics, Leeds

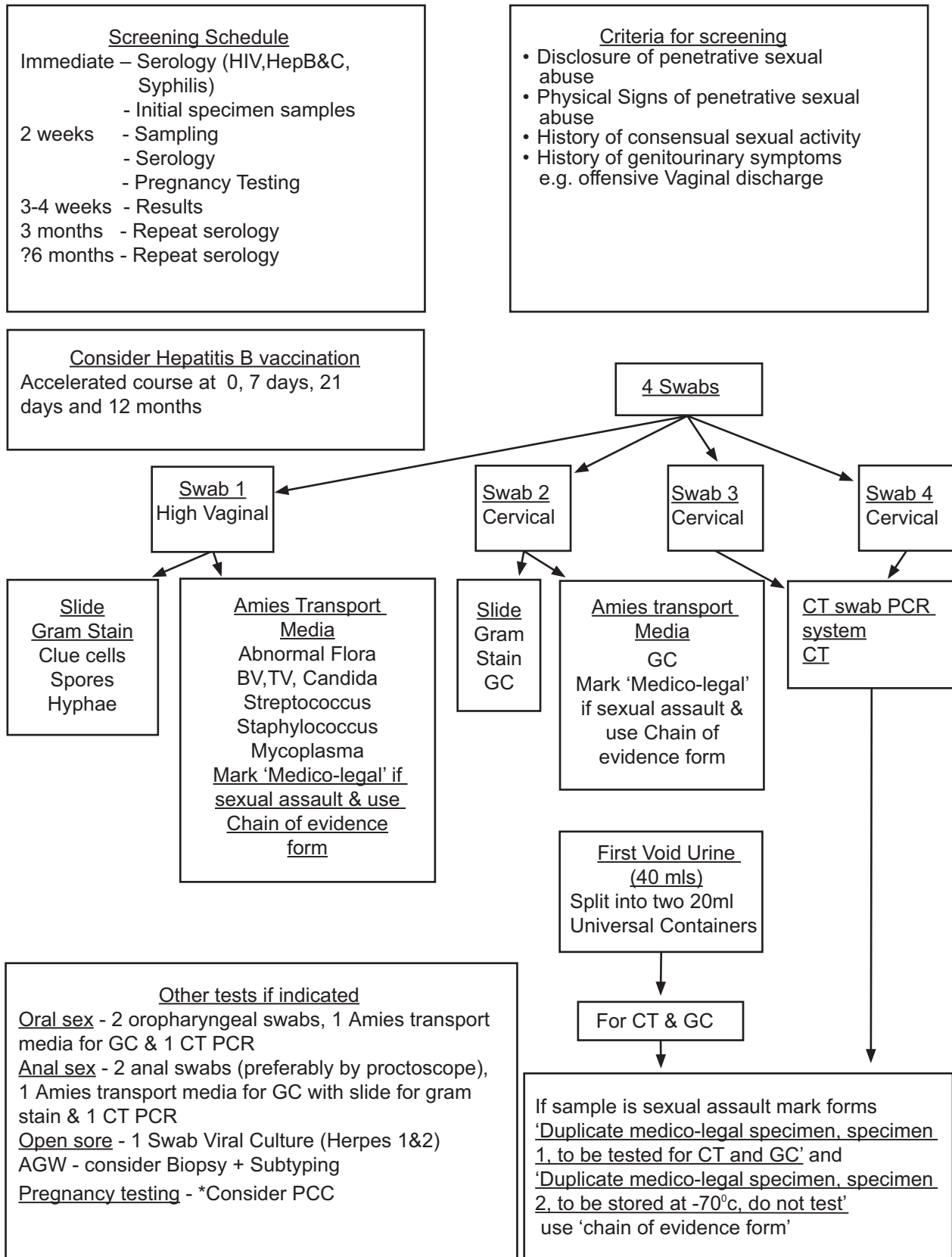
## STI screening protocol for Pubertal Young People and Females tolerant of a speculum

Sample	Condition or organism to be detected
Males: 2 Urethral swabs (if tolerated) <ul style="list-style-type: none"> <li>- Slide for Gram stain + Amies transport media</li> <li>- GC &amp; TV culture medium (if available)</li> <li>- CT for NAAT/EIA/DIF. If positive recommend confirmation with CT culture or with different NAAT test)</li> </ul>	Urethritis, GC, TV GC, TV CT
Females: 2 Urethral swabs (if tolerated, alternatively FVU): <ul style="list-style-type: none"> <li>- Slide for Gram stain</li> <li>- Gonococcal medium</li> <li>- CT for NAAT/EIA/DIF. If positive recommend confirmation with CT culture or with different NAAT test)</li> </ul>	GC, TV CT
1 High Vaginal Swab & pH test (females): <ul style="list-style-type: none"> <li>- Slide for Gram stain/clue cells/spores/pseudohyphae</li> <li>- Amies transport medium</li> <li>Sabouraud's medium (if available)</li> </ul>	Abnormal flora, BV, Candida
Loop collection High Vaginal secretions (females): <ul style="list-style-type: none"> <li>- Wet slide direct microscopy</li> <li>- TV culture medium</li> </ul>	TV
2 Cervical Swabs (females): <ul style="list-style-type: none"> <li>- Slide for Gram stain + Amies transport medium</li> <li>- GC culture medium (if available)</li> <li>- CT for EIA/DIF/NAAT (can add to FVU if testing by NAAT). If positive recommend confirmation with CT culture or with different NAAT test</li> </ul>	Cervicitis , GC CT
Male & Female: FVU (20ml) NAAT. If positive recommend confirmation with CT culture or with different NAAT test	CT, GC

Other tests as indicated	Condition or organism to be detected
1 Swab from open sore: <ul style="list-style-type: none"> <li>- Virus culture, PCR or Antigen detection</li> </ul>	HSV type 1 and 2
2 Swabs from oropharynx (if indicated) <ul style="list-style-type: none"> <li>- 1 swab Amies transport media</li> <li>- 1 swab for CT by NAAT</li> </ul>	GC CT
2 Anal/Rectal Swabs (if indicated, preferably by proctoscope) <ul style="list-style-type: none"> <li>- 1 swab Amies transport media</li> <li>- 1 swab for CT by NAAT</li> </ul>	GC CT
Consider biopsy of AGW + DNA probe techniques for subtyping	AGW
Serology Tests	Offer; Syphilis, HIV, HBV, HBC. HSV-1 or 2 (if indicated following rape or abuse). Repeat at 3 and 6 months.

Adapted with permission from Amanda Thomas, Consultant in Community Paediatrics, Leeds

## STI Screen for Pubertal Females Tolerant of a Speculum



Adapted with permission from Amanda Thomas, Consultant in Community Paediatrics, Leeds

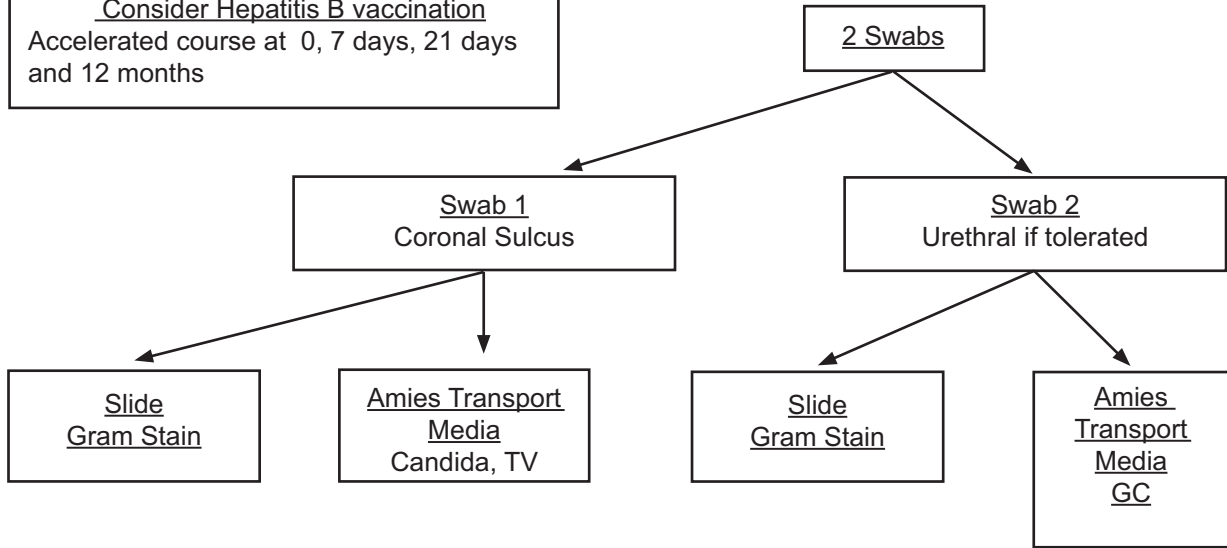
### STI Screen for Prepubertal and Pubertal Males

Screening Schedule  
 Immediate – Serology (HIV, HepB&C, Syphilis)  
 - Initial specimen samples  
 2 weeks - Sampling  
 - Serology  
 3-4 weeks - Results  
 3 months - Repeat serology  
 ?6 months - Repeat serology

Criteria for screening

- Disclosure of penetrative sexual abuse
- Physical Signs of penetrative sexual abuse
- History of consensual sexual activity
- History of genitourinary symptoms e.g. Penile discharge

Consider Hepatitis B vaccination  
 Accelerated course at 0, 7 days, 21 days and 12 months



Other tests if indicated

- Oral sex - 2 oropharyngeal swabs, 1 Amies transport media for GC & 1 CT by PCR
- Anal sex - 2 anal swabs (preferably by proctoscope), 1 Amies transport media for GC with slide for gram stain & 1 CT by PCR
- 1 Swab open sore - Viral Culture (Herpes 1&2)
- AGW - consider Biopsy + Subtyping

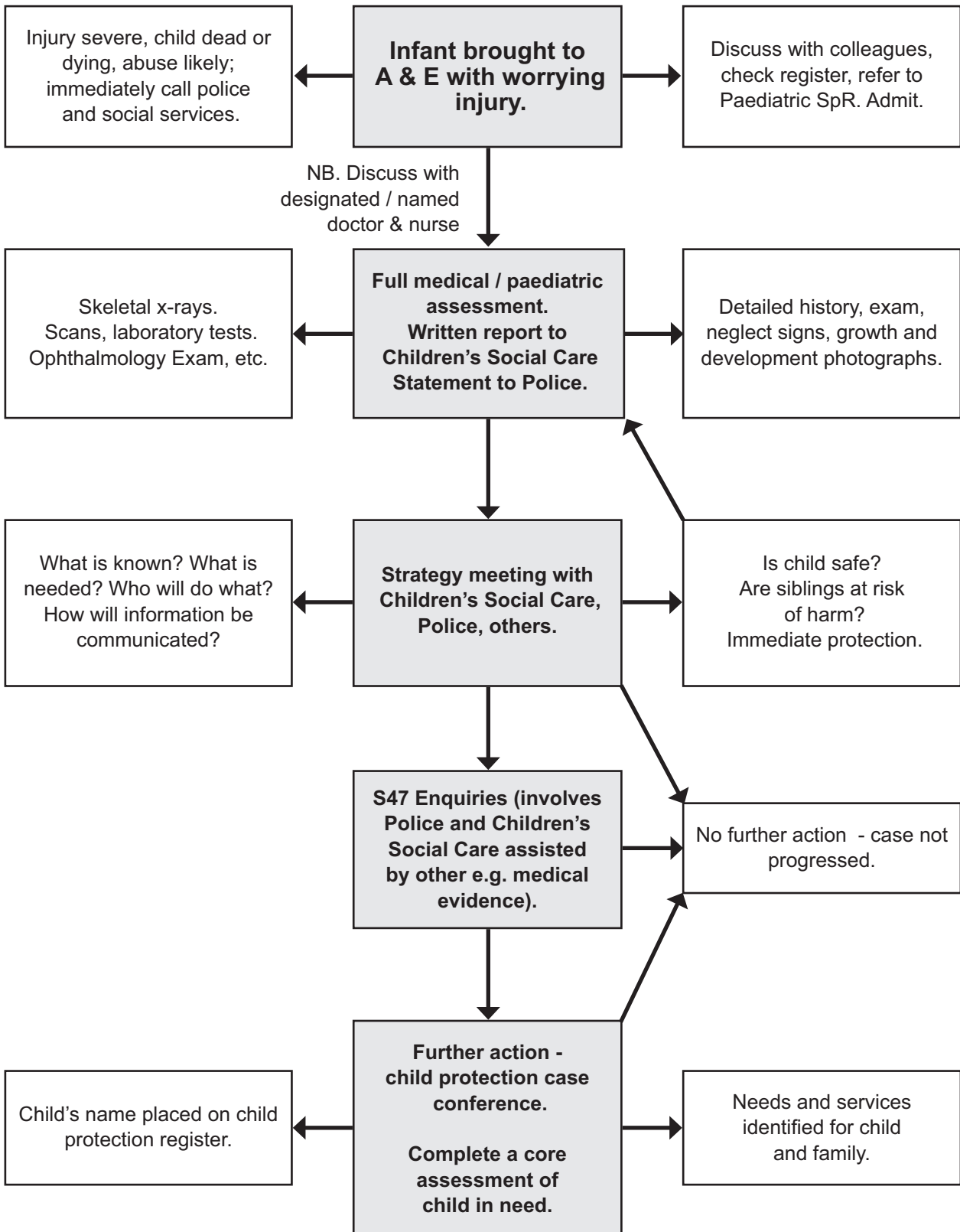
First Void Urine  
 (40 mls)  
 Split into two 20ml Universal Containers

CT & GC  
 If sample is sexual assault mark forms  
 'Duplicate medico-legal specimen, specimen 1, to be tested for CT and GC' and  
 'Duplicate medico-legal specimen, specimen 2, to be stored at -70°C, do not test'  
 use 'chain of evidence form'

Adapted with permission from Amanda Thomas, Consultant in Community Paediatrics, Leeds

## APPENDIX 11

### Case Management – high immediate risk

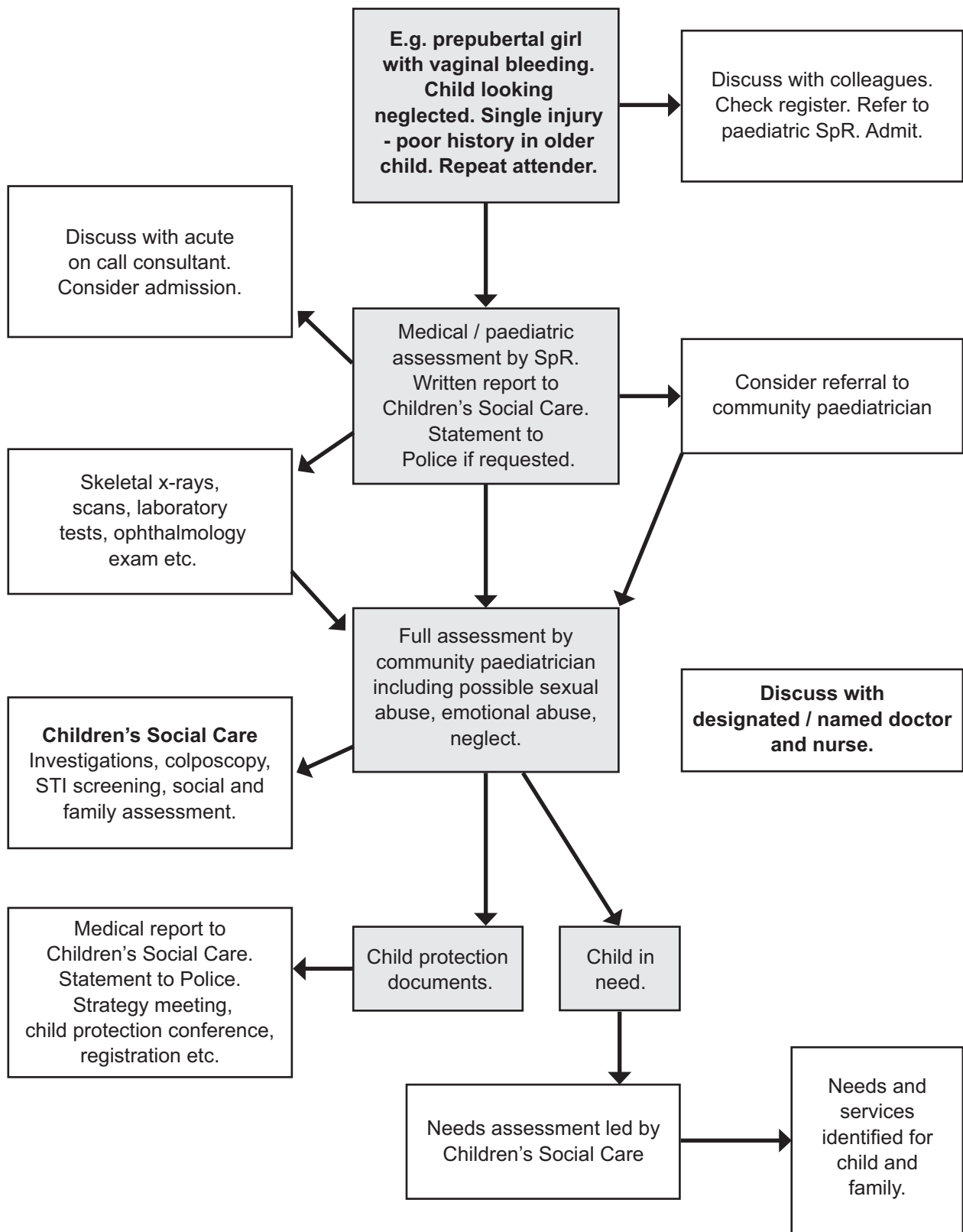


Adapted from: *What To Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).



## APPENDIX 12

### Case Management – less clear or possible child protection concerns



Adapted from: *What To Do if You're Worried a Child Is Being Abused* (London: Department of Health, 2003).

## **APPENDIX 13**

### **Example of a Medical Proforma**

---

#### **PLEASE REMEMBER**

- 1 Child Protection Data Collection form is the first part of this record.
- 2 Plot weight and height while child is still on site (so can be checked if needed).
- 3 Plot injuries as found - the child may like to help with tape measure/crayons.
- 4 If in doubt, record, photograph and take Forensic Specimens, so you can get further advice later if necessary.
- 5 Be as open and honest as possible about your limitations/findings/the future.
- 6 Be open about the need to share information with other agencies.

TELEPHONE CALLS

	Caller	Date	Time	Time Taken
1				
2				
3				
4				

Seen at Hospital / Clinic / other .....

Clinic Date..... Time.....

Child's Name..... DoB..... Sex: M / F

Current Address ..... Age .....

.....

.....Postcode .....

Tel No .....

Previous Address .....

.....

..... Postcode .....

ETHNIC GROUPS - CIRCLE	
0 not identified	6 Pakistani
1 White	7 Bangladeshi
2 Black - Caribbean	8 Chinese
3 Black - African	9 Mixed Race
4 Black - Other	10 Other
5 Indian	Specify

School / Nursery.....Tel No .....

Examination Requested By (Name).....Agency .....

.....

Is child or sibling on the Child Protection Register? Yes / No / N/A

If yes, give details .....

.....

Any Court Orders PPO / EPO / ICO / CO .....

Has the Court granted leave for this examination? Yes / No / N/A

Examining Doctor..... Consultant .....

Others Present Name..... Designation.....

Parent / Carer .....

Who has parental responsibility? .....

Police.....

Children's Social Care .....

Nurse .....

Others.....

.....

Interview / Exam Start Time .....
Interview / Exam Finish Time .....
Report Preparation - Time Taken.....
Report Correction - Time Taken.....







**Family**

Family Composition (draw family tree / include date of birth where possible).

Employment .....

Housing (type, who lives where) .....

Pets .....

Any residence / contact issues?      Yes / No

Details .....

Any other relevant family / social information (*include any medical conditions*)

Details .....



**Detailed Medical History**

Pregnancy Planned? Unplanned?.....

Problems .....

Birth Weight ..... kg/lb Gestation.....Place of birth .....

Delivery..... Neonatal health.....

Feeding .....

Immunisations:

<b>Up to date:</b>	<b>According to carer</b>	<b>According to computer record</b>
Triple (dip/tet/pertussis)		
Polio		
HIB		
MMR		
Meningitis C		
BCG		
Other		

Past History (A & E visits, admissions, fractures, illness, abuse, social service involvement, with dates)

From: Parent? Hospital Notes? Other?

.....

.....

.....

.....

.....

.....

.....

Developmental History/School Progress

.....

.....

.....

.....

Any relevant family medical history

.....

.....

.....

**Relevant Enquiries - Acute CSA / Sexual Assault**

Eating/Drinking since event.....  
Bowels Opened .....  
Passed Urine .....  
Washing/Bathing .....  
History of straddle injury? .....  
.....  
Previous sexual experiences/boyfriends or girlfriends .....  
.....  
Menses: Commenced ..... Frequency.....  
Duration..... Date of LMP.....  
Uses: Tampons Towels

**Symptomatology**

Sleeping .....  
.....  
Eating/Appetite .....  
.....  
Micturition .....  
.....  
Bowels .....  
.....  
Headaches .....  
.....  
Behaviour (e.g. withdrawn, disruptive, hyperactive, sexualised).....  
.....  
.....  
.....

**For CSA access only:**

Symptoms (eg soreness, pain, discharge, bleeding) .....  
.....  
.....  
.....

**Summary of Development (for under 5 years, or as appropriate)**

0 = Normal 1 = mild 2 = moderate 3 = severe delay 4 = profound delay 9 = unknown

Gross Motor/Locomotor skills ( ).....

.....

Fine Motor/Manipulation skills ( ).....

.....

Visual Skills ( ).....

.....

Hearing & Language skills ( ).....

.....

Speech & Language skills ( ).....

.....

Social Interactive skills ( ).....

.....

Social self help skills ( ).....

.....

Cognitive skills ( ).....

.....

Other information.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....



**Genital Examination (Girls)**

(Use clock face to describe findings - pubis = 12 o'clock, anus = 6 o'clock)

Examination position used            Supine ( )    Knee Chest ( )    Lateral ( )

Colposcope: Yes/No                    Method of Examination: Separation ( )    Traction ( )

**Findings**

External Genitalia:

	Yes	No	Describe (where, shape, etc)
Reddening			
Local Abrasion			
Bruising			
Laceration			
Labial fusion			

Vestibule/Hymen

Hymeneal opening            Visualised/not visualised

Diameter:                    Horizontal (Trans).....mm    Vertical (AP).....mm

	Normal	Abnormal	Describe:
Vestibule			
Posterior fourchette			
Hymen			
Vagina			
Discharge	Yes	No	
Bleeding	Yes	No	

**Genital Examination (Boys)**

Findings - genitalia. Describe (eg abnormality) .....

.....

Penis .....Circumcised? Yes / No

Testes ( ) 2 present ( ) 1 present : L / R ( ) Absent

Bruises/Trauma .....

.....

.....

**Anus (Boys & Girls)**

Examination position used: Left lateral ( ) Knee Chest ( ) Other ( )

	Yes	No	Describe
Skin Change			
Bruises			
Venous Congestion			
Tyre Sign			
Gaping/Dilatation			
Laxity			
Reddening/Inflammation			
Fissures (number, position, superficial/deep)			
Lacerations			
Scars			
Mucosa/prolapse			
Other, eg warts, twitchy			

**Genital/Anal**

Examination complete	Yes / No	Anaesthetic/Sedation	Yes / No
Instruments	Yes / No	Digital insertion	Yes / No
Colposcope	Yes / No	Still photos taken	Yes / No
Joint Examination	Yes / No	Still photos - No. taken:	.....
.....		Video	Yes / No

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**Acts Described by child and / or other historian (CSA only) N/A**

	Child			Other historian		
	Yes	No	Unknown	Yes	No	Unknown
<b>Vaginal Contact</b>						
Penis						
Finger						
Foreign object						
Describe object:						
<b>Anal Contact</b>						
Penis						
Finger						
Foreign object						
Describe object:						
<b>Oral Copulation</b>						
Of victim by assailant						
Of assailant by victim						
<b>Masturbation</b>						
Of victim by assailant						
Of assailant by victim						
<b>Other:</b>						
Did ejaculation occur	Outside body? Yes / No		Inside body? Yes / No			
If yes, describe:						
Condom used?						
Foam jelly used?						
Lubricant used?						
What.....						
Fondling?						
Kissing?						
Licking?						
If yes, describe						
Other sexual acts						
Was force used upon victim?						
Describe:						
Implements/animals used						

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**Investigations**

	Yes	No	Date	Result
X-ray				
Skeletal survey				
CT / MRI				
Hb, WBC, platelets				
Clothing studies				
HIV				
Others (specify), eg hep B, Hep C				
(specify)				

	Genital	Anal	Other	Date	Result
Gram film					
GC					
Trichomonas					
Chlamydia PCR					
Chlamydia culture					
Rectal swab					
Oral swab					
Other					

	Yes	No	Date	Result
Pregnancy Test				
Treatment, eg morning after pill / antibiotics				

**Notes**

**Summary of Medical Problems, Recommendations and Management**

**Child.....Date of Birth.....**

Date	Problem	Action	Date Completed	Signed

**Action**

	Yes	No	Date
Child Protection conference recommended / requested			
Admission to hospital			
Admission to other safe place			
Follow up			
Appointment made			
Referral elsewhere			
To whom?			
Siblings to be examined			
Any previous reports			
Child Protection Conference held			

**Conclusions**

Child Protection Register      Yes / No

Category .....

Key Worker..... Tel No.....

Other recommendations (eg care proceedings).....

.....  
 .....  
 .....  
 .....

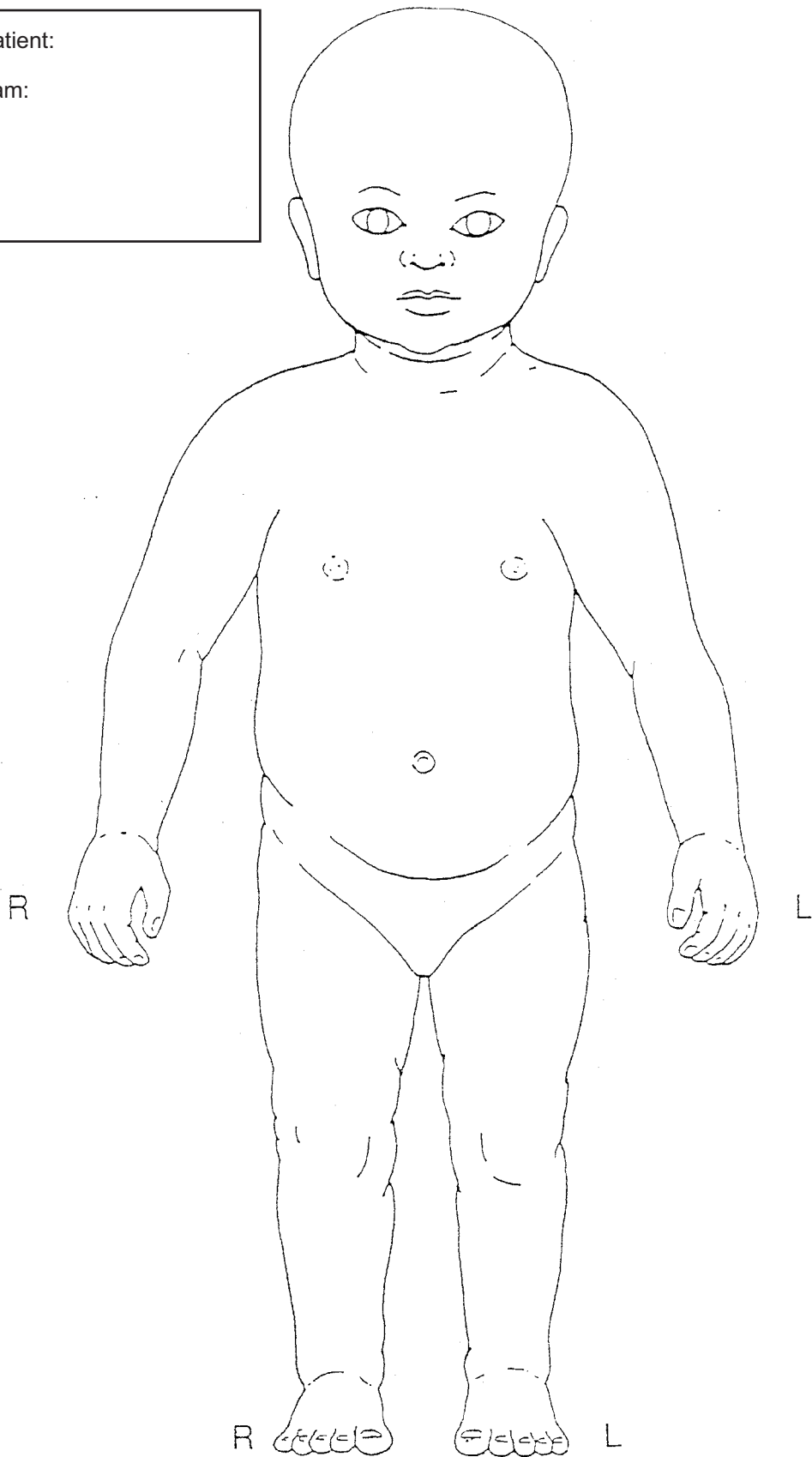
**ETHNIC GROUPS – CIRCLE**

- 0 not identified      6 Pakistani
- 1 White                7 Bangladeshi
- 2 Black – Caribbean    8 Chinese
- 3 Black – African      9 Mixed Race
- 4 Black – Other        10 Other
- 5 Indian                (specify)

**Data Protection Act 1998:** You are advised that information on children seen by the paediatrician is routinely registered on the Child Health computer system as part of their care and treatment. Everyone working for the NHS has a legal duty to keep information confidential.

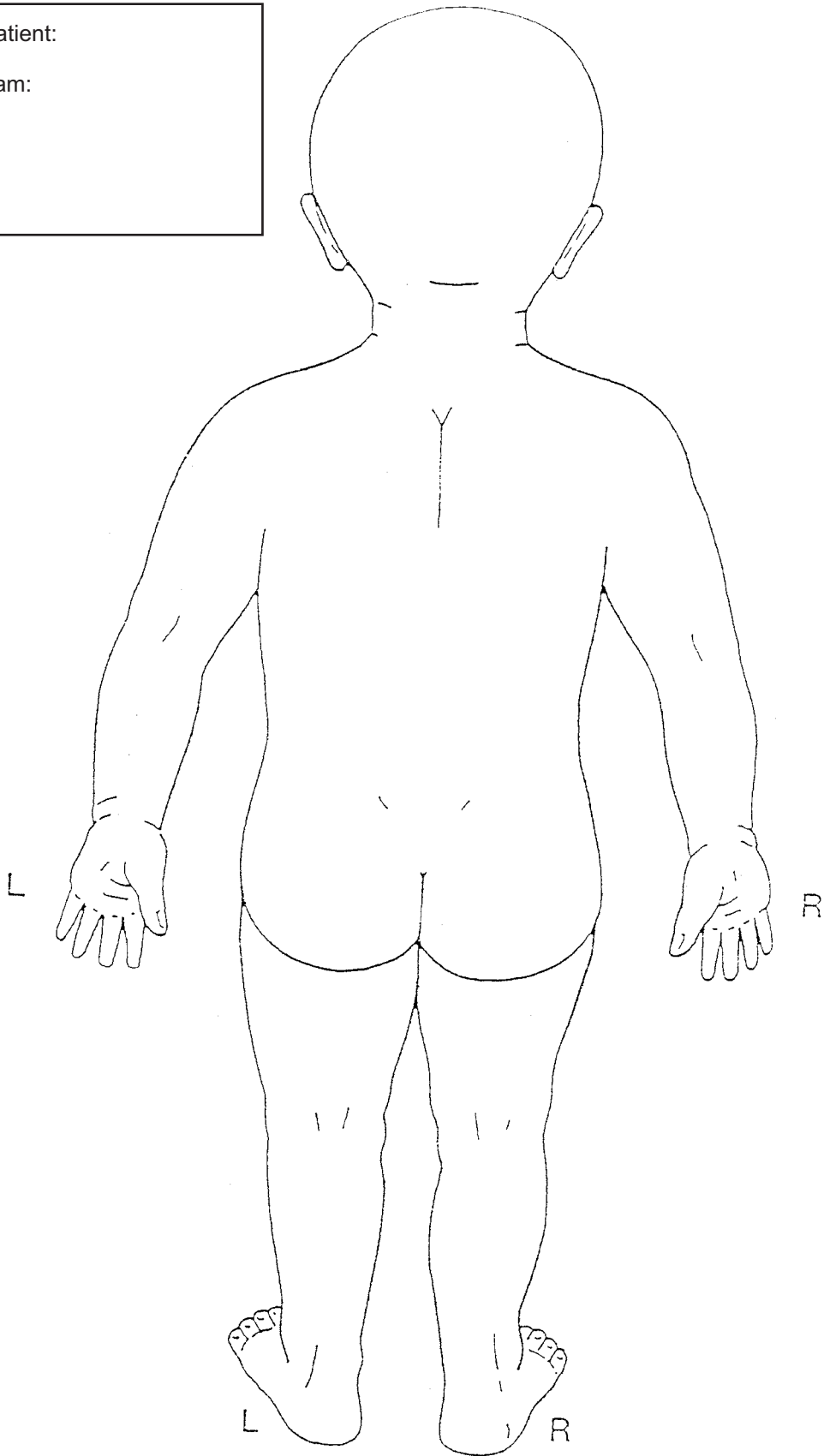
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Name of Patient:  
Date of Exam:  
Examiner Name:  
Signature:

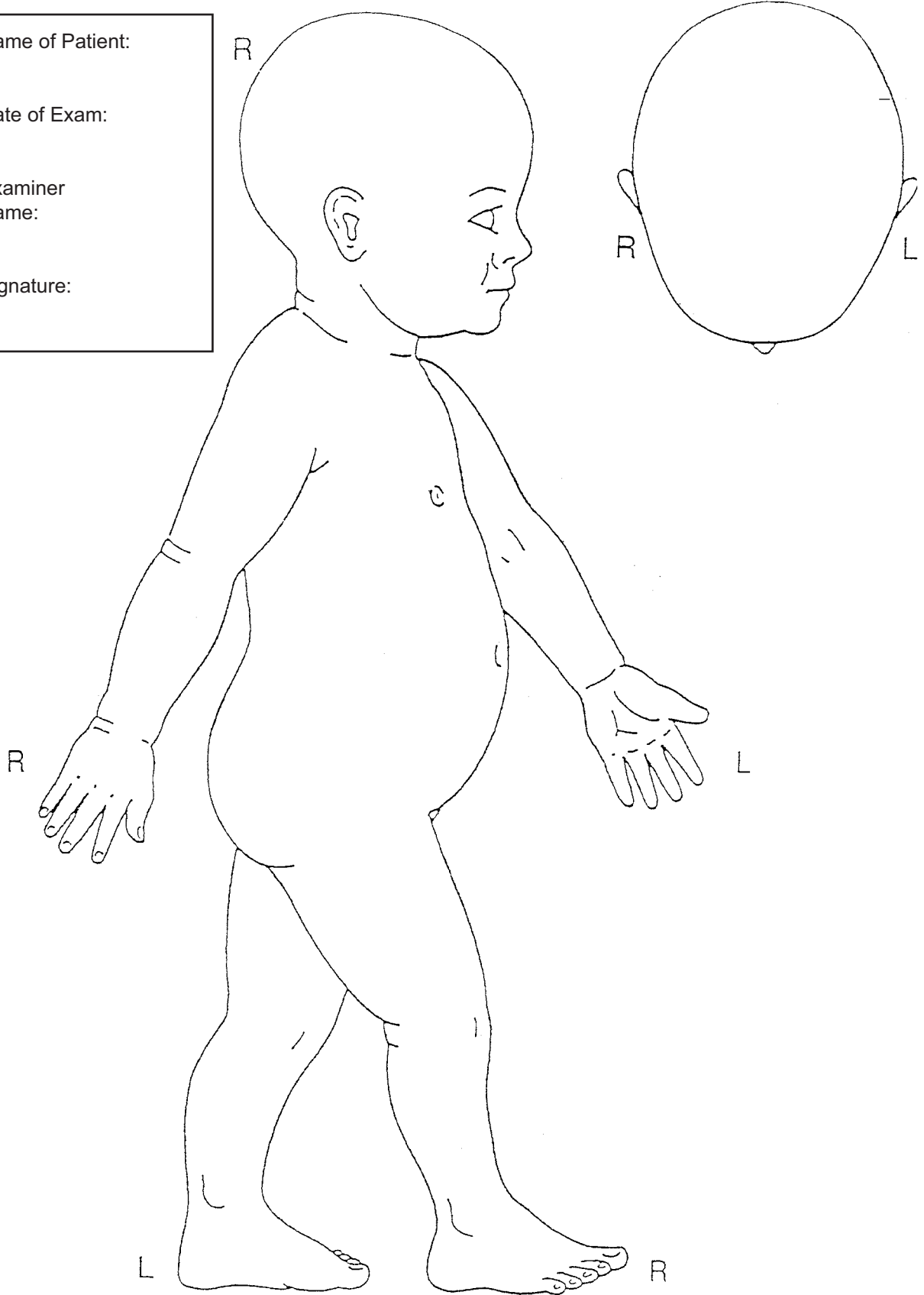


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Date of Exam:
Examiner Name:
Signature:

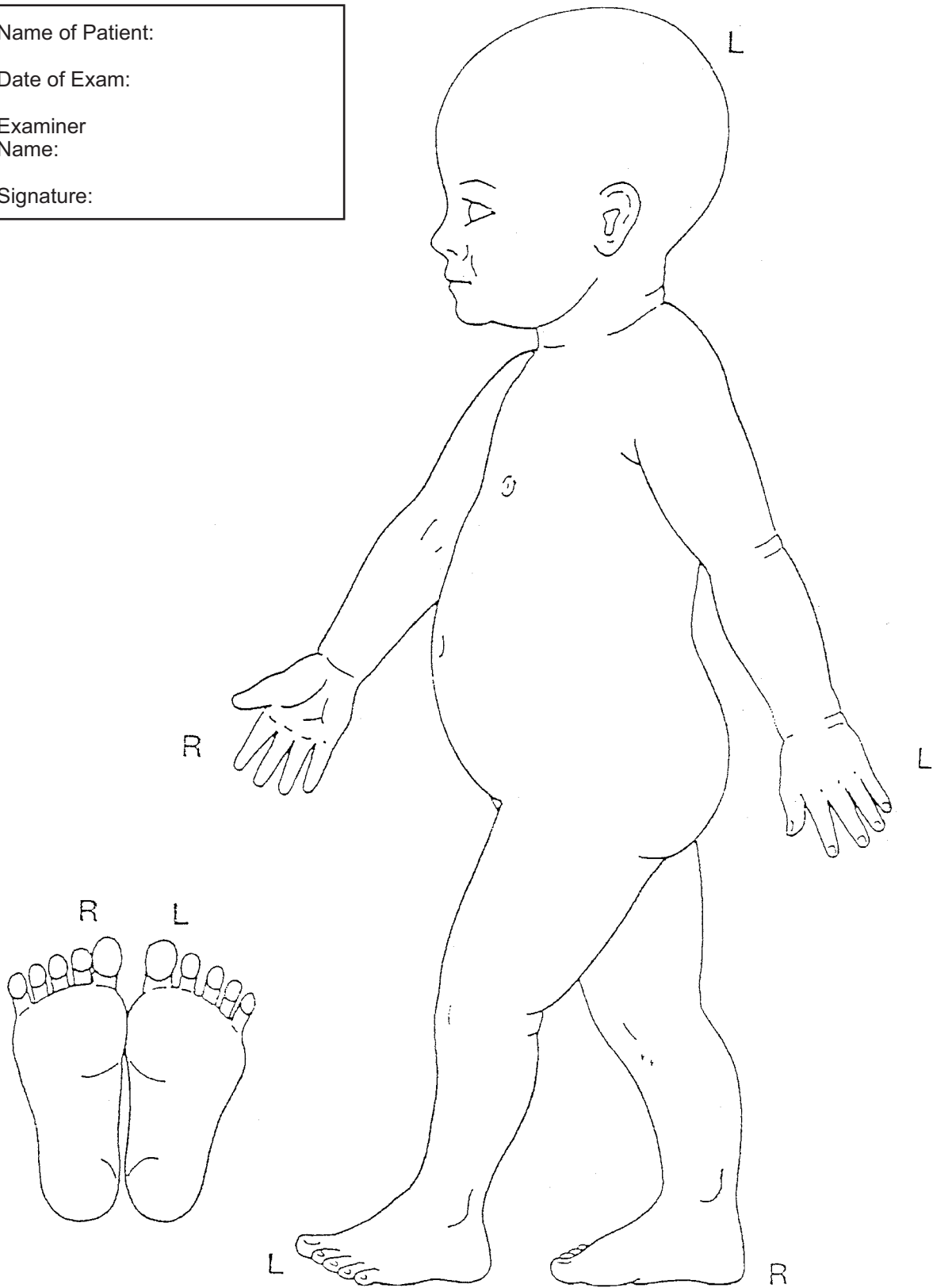


Name of Patient:
Date of Exam:
Examiner Name:
Signature:



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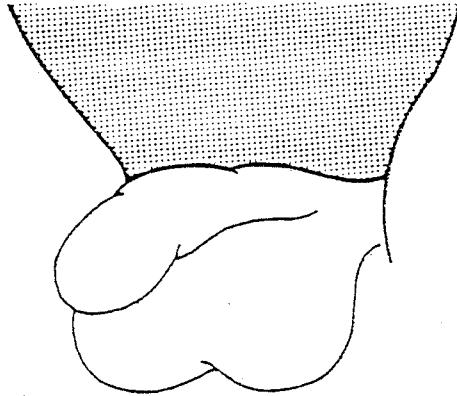
Name of Patient:
Date of Exam:
Examiner Name:
Signature:



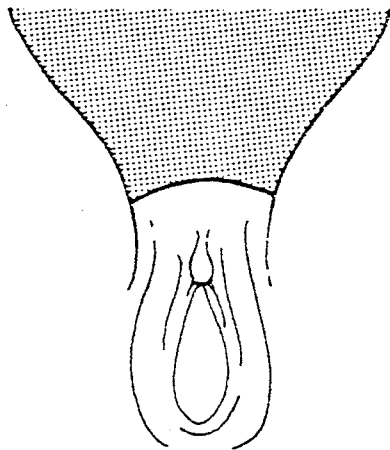
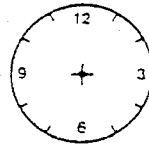


NAME

NO.



DRAW SHAPE OF ANUS AND ANY LESIONS ON GENITALIA, PERINEUM AND BUTTOCKS.



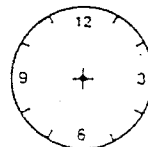
DRAW SHAPE OF HYNEN AND ANUS AND ANY LESIONS GENITALIA, PERINEUM AND BUTTOCKS.

Name of Patient:

Date of Exam:

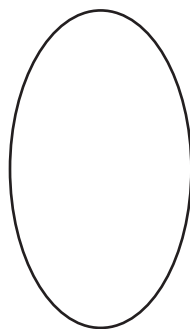
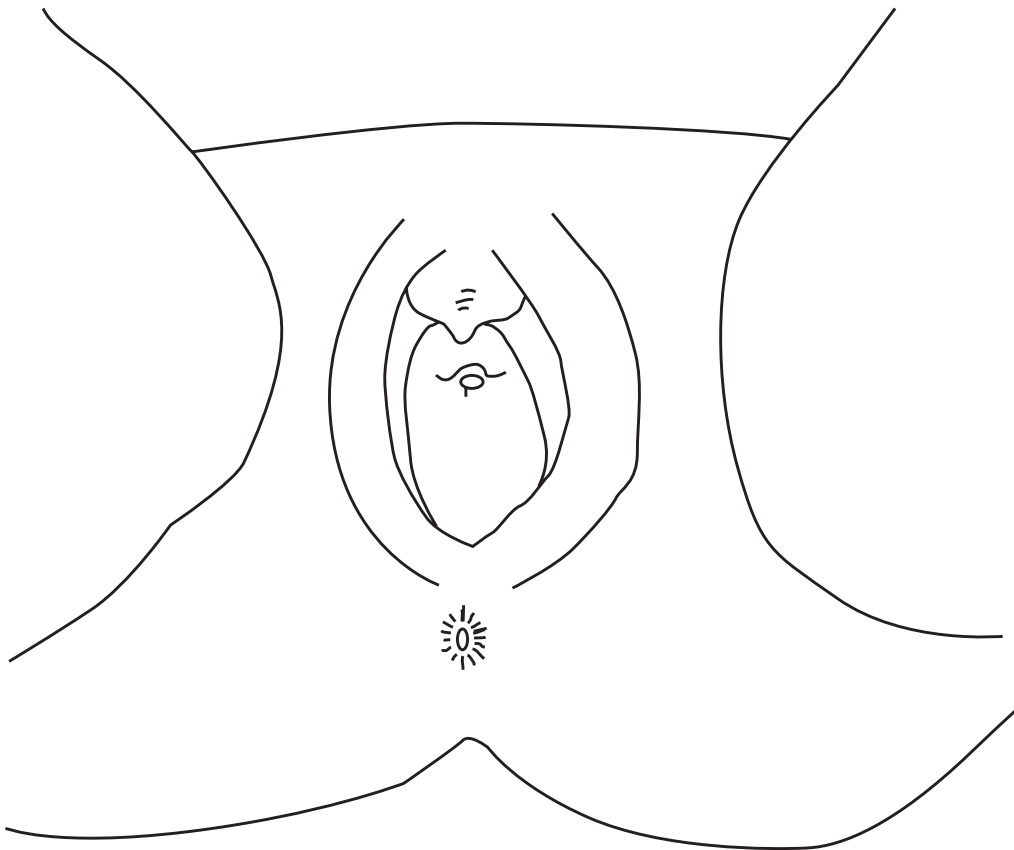
Examiner  
Name:

Signature:



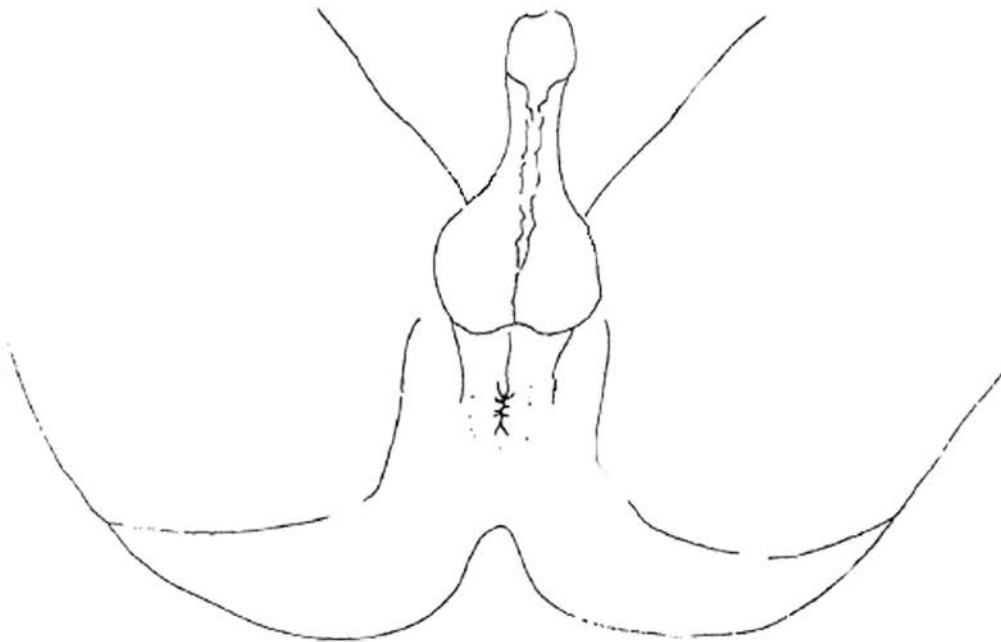
Name of Patient:
Date of Exam:
Examiner Name:
Signature:

Mark position of injuries.



Introitus of vagina.  
Draw in shape of hymen and orifice and  
position of tears / concavities / bumps.

Name of Patient:
Date of Exam:
Examiner Name:
Signature:



## APPENDIX 14

### Medical Report example

---

#### History

Place of examination

Time and date

Who requested the examination

Reason for referral

Persons present (include chaperone)

“ I saw AB on ward X at 3pm on 2.2.02 at the request of ...with...present”

Current concerns / complaints / allegations

    In child's / parent's own words

    If information from others - whom e.g. – “social worker told me.....”

Previous medical history

General systems inquiry

Relevant family history

Social history

Developmental milestones/School progress

Behaviour

#### Examination

General – quiet & withdrawn / uncontrollable; cleanliness, any signs of neglect; cooperation/behaviour with anogenital examination

Growth including height and weight and centiles

List injuries / bruises – size, site, shape, colour, depth. Attach diagram with explanations by the side of the lesions.

General examination

Tanner Staging

Ano-genital examination

Developmental findings

Investigations

Photographs taken or not

Colposcope used / not

## Interpretation

Interpretation of all clinical findings, both positive and negative, For example:

- i) the group of bruises (nos 6, 7, 8) on the shins would be in keeping with normal day to day activity
- ii) The bruises 1 and 2 on the front of the right upper arm together with bruise 3 on the back of the right upper arm could be indicative of a firm grip.

## Summary and Opinion **(NB. Children's Social Care ONLY receive this page)**

"I saw AB a 5 year old boy, on ward X at 3pm on 2.2.02 at the request of ..... in the presence of ....."

Summarise history and examination (you do not need to include the full details)

E.g. 'The bruising on the inner arms were consistent with finger tip bruises such as a forceful grip'

## Opinion – as clear as possible

Include – Opinion as to whether this may be abuse

Any recommendations

Any follow up arrangements

## APPENDIX 15

### Example of a Police statement

---

I am Dr ..... My qualifications are.....I have 10 years paediatric experience. My experience in child protection is.....

#### History

Who requested medical and why

Date, time and place where medical held

Who was present (include chaperone)

“ I saw ..... on ward ..... at 3pm on 2.2.02 at the request of ...with ...present”

Current complaint

In child's / parent's own words

Include the questions you asked and the victim's replies

If information from others - whom e.g. – “social worker told me.....”

Keep to the facts and try to avoid hearsay information

Previous medical history and Social history only if important and relevant

#### Examination

General – quiet and withdrawn / uncontrollable; Cleanliness; Co-operativeness – passivity on anogenital examination

Growth – summarise – ‘His growth was satisfactory’

Number in a list injuries / bruises denoting site, size, shape and colour.

Summarise the general examination

Anogenital examination

Developmental findings

Investigations

Photographs taken or not

Colposcope used or not

#### Interpretation of findings

Both positive and negative

As clear as possible

Include - whether this may be abuse; dating of injuries if possible

‘It is my opinion that the injuries numbered 2–5 are consistent with a forceful hand slap’

**NB.** Report must be signed and dated - check carefully for errors before signing and arranging distribution.

#### Conclusion

The clinical findings (list) are supportive of / unsupportive of the allegation made *or* consistent / not consistent

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## APPENDIX 16

### Practical points for report writing

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1. Reports should begin with your qualifications and experience. Do not undersell yourself.
2. Reports should be double-spaced and in a minimum font size 12.
3. Remember that most of the people reading your report will not be medically qualified. Avoid the use of medical terminology or ensure terms are defined.
4. Remember, your duty as a medical expert is to the Court, not to either party, nor even to the child. The Court relies on the objectivity, professional competence and integrity of expert witnesses. Try to avoid being manipulated into a partisan position by lawyers or others; express only opinions you genuinely hold and which are not biased in favour of one party.
5. State clearly what is fact and what is opinion.
6. Be balanced and accurate. Do not exaggerate. Stick to the facts you know and be clear about the source of your knowledge. You should stick to your own area of expertise and make it clear if a question falls outside of this. Be willing to admit if you do not know the answer to a question and be prepared to admit uncertainty.
7. Do not just quote aspects of literature or parts of an article that would advance the cause of the party that called you. Give both (or several) points of view. If you quote from any literature, ensure you have a full copy which can be provided should the Court request it.
8. Do not mislead by omission; consider all material facts in reaching your conclusions. Do not omit consideration of material facts which could detract from your concluded opinion.
9. Include positives and negatives in your report. Avoid selective extraction of negative information.
10. Avoid making generalisations or sweeping recommendations which are outside a medical expert's remit and would more properly come from another expert, such as a social worker or psychologist.
11. Point out any limitations in your report, such as certain information not being available at the time you make the report. If need be, you can provide an addendum report at a later date.

## APPENDIX 17

### Guidelines for the collection of forensic specimens in an adolescent girl.

(In a younger child, consideration needs to be given to what is absolutely necessary. Discuss with someone with expertise and the attending police).

Sample Type	Reason for Analysis	Method of Sampling	Packaging and Storage
Saliva	Detection of semen if oral penetration within 2 days. First sample.	Take 10 ml (if possible) of saliva.	Plastic bottle placed in tamper evident bag
Mouth swab	Detection of semen if oral penetration within 2 days	Take 2 sequential samples by rubbing swab around inside of mouth, under tongue and gum margins or over dentures or dental fixtures.	Plain sterile swab returned immediately to appropriate swab sleeve/tube and placed in a tamper evident bag. Freeze.
Mouth washings	Detection of semen if oral penetration within 2 days. Third sample	Rinse mouth with 10ml of sterile water and retain washings in bottle.	Plastic bottle placed in tamper evident bag. Freeze (place empty water vial with exhibit).
Skin swabs	Detection of body fluids and lubricants.	If stain is moist, recover on a dry swab. If stain is dry, dampen swab with sterile distilled water. Recover on more than one swab if staining remains visible after initial sampling.	Plain sterile swab returned immediately to appropriate swab sleeve / tube and placed in a tamper evident bag. Freeze.
Control skin swab	Recovery of background DNA for mitochondrial analysis.	Dampen swab with sterile distilled water and swab adjacent unstained area or skin.	Submit residual water and container in pot with swab in tamper evident bag. Freeze.
Unused swab	Control for low copy number DNA analysis.	Submit unopened swab from appropriate module in every case where swabs have been taken.	Place unused swab in tamper evident bag and store with other swabs taken.
Head hair	A: Detection of body fluids, eg semen. B: Identification of foreign particles or fibres (only where something is visible or an item has been placed over the head).	A: Cut or swab relevant area. B: Remove visible foreign particles with disposable forceps and collect in plain paper; tape head using low adhesive tape or comb hair with a primed comb if an item has been placed over the head. C: Cut representative sample of 10-20 hairs close to the skin.	Place in tamper evident bag. (Submit scissors in bag if used to cut hair.) Freeze.



Sample Type	Reason for Analysis	Method of Sampling	Packaging and Storage
Pubic hair	A: Detection of body fluids, eg. semen. B: Identification of foreign hairs or fibres.	A: Cut or swab relevant area. B: Comb hair and collect debris on paper.	As for swabs or place in tamper evident bag. Freeze.
Vulval swab	A: Detection of body fluids, if vaginal intercourse within 7 days or if anal intercourse within 3 days, or ejaculation onto perineum. First sample. B: Detection of lubricant, if used, or if condom used within 30 hours.	Rub 2 sequential swabs over whole of vulval area. Number the swabs in the order taken. (Moisten swabs with distilled water if required).	Plain sterile swab returned immediately to appropriate swab sleeve/tube and placed in a tamper evident bag. (Submit distilled water vial if used). Freeze.
Vaginal swab – low	A: Detection of body fluids, if vaginal intercourse within 7 days or if anal intercourse within 3 days.  Second sample: B: Detection of lubricant, if used, or if condom used within 30 hours.	Take 2 sequential swabs over whole of vulval area. Number the swabs in the order taken. (Moisten swabs with distilled water if required).	As above.
Vaginal swab – high	A: Detection of body fluids, if vaginal intercourse within 7 days or if anal intercourse within 3 days.  Third sample: B: Detection of lubricant, if used, or if condom used within 30 hours.	Take 2 sequential swabs using unlubricated speculum. (Moisten swabs with distilled water if required). Number the swabs in the order taken.	As above.
Endocervical swab	Only necessary if vaginal intercourse more than 48 hours previously.	Take 1 swab via the speculum.	As above.
Penile swab – Coronal	A: Detection of body fluids if intercourse within 2 days. B: Detection of lubricant, if used, or if condom used within 30 hours.	Take 2 sequential from coronal sulcus and 2 sequential swabs from shaft and glans. (Moisten with sterile distilled water). Number the swabs in the order taken.	Plain sterile swab returned immediately to appropriate swab sleeve/tube and placed in a tamper evident bag. (Submit distilled water vial if used).

Sample Type	Reason for Analysis	Method of Sampling	Packaging and Storage
Perianal swab	A: Detection of body fluids, if intercourse within 3 days. First sample. B: Detection of lubricant, if used, or if condom used within 30 hours.	Take 2 sequential swabs from the perianal area using swabs moistened with sterile distilled water. Number the swabs in the order taken.	As above.
Rectal swab	A: Detection of body fluids, if intercourse within 3 days. First sample. B: Detection of lubricant, if used, or if condom used within 30 hours.	Take swab from the lower rectum after passing proctoscope 2-3cm into the anal canal. (Moisten proctoscope with sterile water if necessary).	As above.
Anal canal swab	A: Detection of body fluids, if intercourse within 3 days. B: Detection of lubricant, if used, or if condom used within 30 hours.	Take swab as proctoscope withdrawn.	As above.
Fingernails	Recovery of trace evidence (eg. body fluid, possible fibres) or connection with fingernail broken at the scene (if the circumstances suggest this is a possibility).	Preferably cut nails. If the nails are too short or cutting is unacceptable, take scrapings from debris using fingernail quills into a paper wrapping.	Place in tamper evident bag. Freeze.
Buccal scrapes	Reference sample for DNA proofing.	Take 2 buccal scrapes from inside each side of the mouth (in cases involving oral sex between persons of the same gender, take an additional sample at least 2 days after the incident).	Place in tamper evident bag. Freeze.
Condoms	Detection of bodily fluids and seminal fluid, if used during intercourse.	Secure the open end with a freezer clip or knot.	Place in a plastic container/pot in tamper evident bag. Freeze.

Sample Type	Reason for Analysis	Method of Sampling	Packaging and Storage
Ground sheet/ couch cover	To identify foreign particles which may fall from clothing or body during examination.	Stand examinee on ground sheet.	Place in tamper evident bag. Store dry.
Sanitary towels/ tampons	Detection of bodily fluids, eg. semen, if in situ, or after vaginal intercourse.	Retain intact.	Place in tamper evident bag or in a plastic container in a tamper evident bag. Freeze.
Blood preserved (sodium fluoride & potassium oxalate)	Analysis for alcohol, drugs (drugs of abuse & medicinal) and volatiles.  NB: Take blood and urine in every case, unless the incident was more than 4 days prior to the examination when a urine specimen only is required. If in doubt, consult the Laboratory for advice.		Take 10ml of venous blood into blood container. Insert septum securely and screw cap on firmly. Invert several times to mix with preservative. NB: If volatiles are suspected (ie. solvent abuse) then a portion of the blood sample must be taken into a RTA vial with septum and aluminium cap (this vial is not supplied in the kit). The RTA vial must be filled approximately half full and the remaining blood placed in the container supplied.
Urine preserved (sodium fluoride)	Analysis for alcohol, drugs (drugs of abuse & medicinal).  NB: Take blood and urine in every case, unless the incident was more than 4 days prior to the examination when a urine specimen only is required.		Urine is passed into a collection vessel and approximately 20ml decanted into the urine container (fill to the line; do not exceed). Screw cap on firmly. Invert several times. (Do not remove preservative tablet). NB: Take a urine specimen as practicably possible; urine can be taken prior to full medical examination.
Body fluids = Blood, saliva, seminal fluid, vaginal secretions, (faeces and urine).			

Reference: Forensic Science Website: <http://forensic.gov.uk>

(nb. The information given in Appendix 17 is subject to change. Please refer to Forensic website for the latest guidelines.)

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# APPENDIX 18 A

## Example of a Chain of Evidence Form

**FORM 1: SPECIMEN COLLECTION WITH POTENTIAL MEDICO-LEGAL IMPLICATIONS**

Department/ward .....

Hospital .....

**PLEASE: USE BLOCK CAPITALS**

**ENTER ALL PATIENT AND SPECIMEN DETAILS**

**USE SEPARATE FORM FOR EACH SPECIMEN TAKEN**

Attach Patients Sticker Here

Person taking the specimen
Patient's name (may be omitted if sample is to be anonymous but <b>MUST</b> include Patient's hospital or clinic number)
Patient's date of birth
Patient's hospital or clinic number
Ward or clinic name or number
Specimen site
Date and time specimen taken
Name of person taking specimen -please print name
Position title and grade of person taking specimen ie Doctor grade or Nurse grade
Signature of person taking specimen
Bleep number or contact number
Clinical details
Specimen Transport
If you as the person taking the specimen handed it to another person, sign this box
Name / Signature / Designation of person delivering sample to lab
As the recipient of the specimen YOU MUST ENSURE Details on specimen match
Date and time specimen received in lab
Name and position of person accepting specimen ie BMS,MLA, MTO and grade-please print
Signature of person accepting specimen
Transport details of specimen i.e. received at room temperature, on ice etc
Date and time lab number assigned
Name and position of person assigning lab number ie BMS,MLA,MTO and grade
Signature of person assigning lab number

## APPENDIX 18 B

### Example of a Chain of Evidence Form

A copy of this form must accompany each specimen associated with forensic/ legal investigations. All specimens and related documentation must remain within the custody of the appropriate signatory at all times.

#### Specimen Collection and Transportation

##### Patient details:

Hospital no.	<input style="width: 100%;" type="text"/>		
M/F	<input style="width: 30%;" type="text"/>	Date of Exam:	<input style="width: 30%;" type="text"/>
Surname:	<input style="width: 30%;" type="text"/>	Examining Dr:	<input style="width: 30%;" type="text"/>
First name:	<input style="width: 30%;" type="text"/>	Designation:	<input style="width: 30%;" type="text"/>
DOB:	<input style="width: 30%;" type="text"/>	Signature:	<input style="width: 30%;" type="text"/>

Relevant patient details:

##### Specimen details:

Taken by:	<input style="width: 30%;" type="text"/>	Date taken:	<input style="width: 30%;" type="text"/>
Designation:	<input style="width: 30%;" type="text"/>	Time taken:	<input style="width: 30%;" type="text"/>
Signature:	<input style="width: 30%;" type="text"/>	Type of specimen:	<input style="width: 30%;" type="text"/>

All individuals handling or transporting this specimen and form to the Laboratory must complete the section below. When transferring this specimen and form to another individual the new custodian. In the presence of the previous bearer, must complete the next available section. Laboratory personnel should follow the same procedure

##### Transportation Details (Specimen Custodians)

1.	Name:	<input style="width: 25%;" type="text"/>	Date:	<input style="width: 15%;" type="text"/>	Time:	<input style="width: 15%;" type="text"/>
	Designation:	<input style="width: 25%;" type="text"/>				
	Signature:	<input style="width: 25%;" type="text"/>				
2.	Name:	<input style="width: 25%;" type="text"/>	Date:	<input style="width: 15%;" type="text"/>	Time:	<input style="width: 15%;" type="text"/>
	Designation:	<input style="width: 25%;" type="text"/>				
	Signature:	<input style="width: 25%;" type="text"/>				
3.	Name:	<input style="width: 25%;" type="text"/>	Date:	<input style="width: 15%;" type="text"/>	Time:	<input style="width: 15%;" type="text"/>
	Designation:	<input style="width: 25%;" type="text"/>				
	Signature:	<input style="width: 25%;" type="text"/>				
4.	Name:	<input style="width: 25%;" type="text"/>	Date:	<input style="width: 15%;" type="text"/>	Time:	<input style="width: 15%;" type="text"/>
	Designation:	<input style="width: 25%;" type="text"/>				
	Signature:	<input style="width: 25%;" type="text"/>				

**On arrival at the laboratory explain the nature of the specimen and request the attendance of the senior doctor.**

## **NOTES**

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## NOTES

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## **NOTES**

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