GP Level 3 Safeguarding Children

Physical signs of Child Abuse

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Named Doctor for Safeguarding
Nov 2017

Aims

- When to suspect physical abuse
- Systematic way of assessing injury (bruises, bites, burns)
- Referral Pathway
- Summary

Obstacles to Identify abuse and neglect

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- Missing treatable cause
- Losing positive relationship with family
- Discomfort in suspecting or wrongly blaming parent
- Breaching confidentiality
- Understanding why it may have occurred therefore no intention to harm child
- Stress
- Personal safety
- Not knowing process/ what to do
- Fear of complaints

When you see an Injury -

What features in the history should make you suspect physical abuse?

History

- Significant injury with no explanation
- Explanation that doesn’t fit with pattern of injury seen
- Doesn’t fit with developmental stage of child
  - Bruises in babies
  - Bruising in non mobile children (including disabled)
- Varying history
- History of inappropriate child response (not crying)

History

- Multiple injuries
- Delayed presentation
- Child known to social care or subject to CPP
- Previous history of unusual injury/ illness
- Repeated attendance with injuries that may be due to neglect or abuse

(*careful history documented with timescales, events leading up to event and mechanism of injury*)

Physical Features

Physical Features

- Object shaped bruises
- Bruising or petechiae not caused by a medical condition
- Human bite mark (unlikely caused by a young child)
- Lacerations, abrasions, scars with unsuitable explanation
- Burn or scald with absent or unsuitable explanation
- One or more #s, or #s of different ages or occult #s
- Intracranial injury
- Signs of spinal injury/Intra-abdominal or intra-thoracic injury

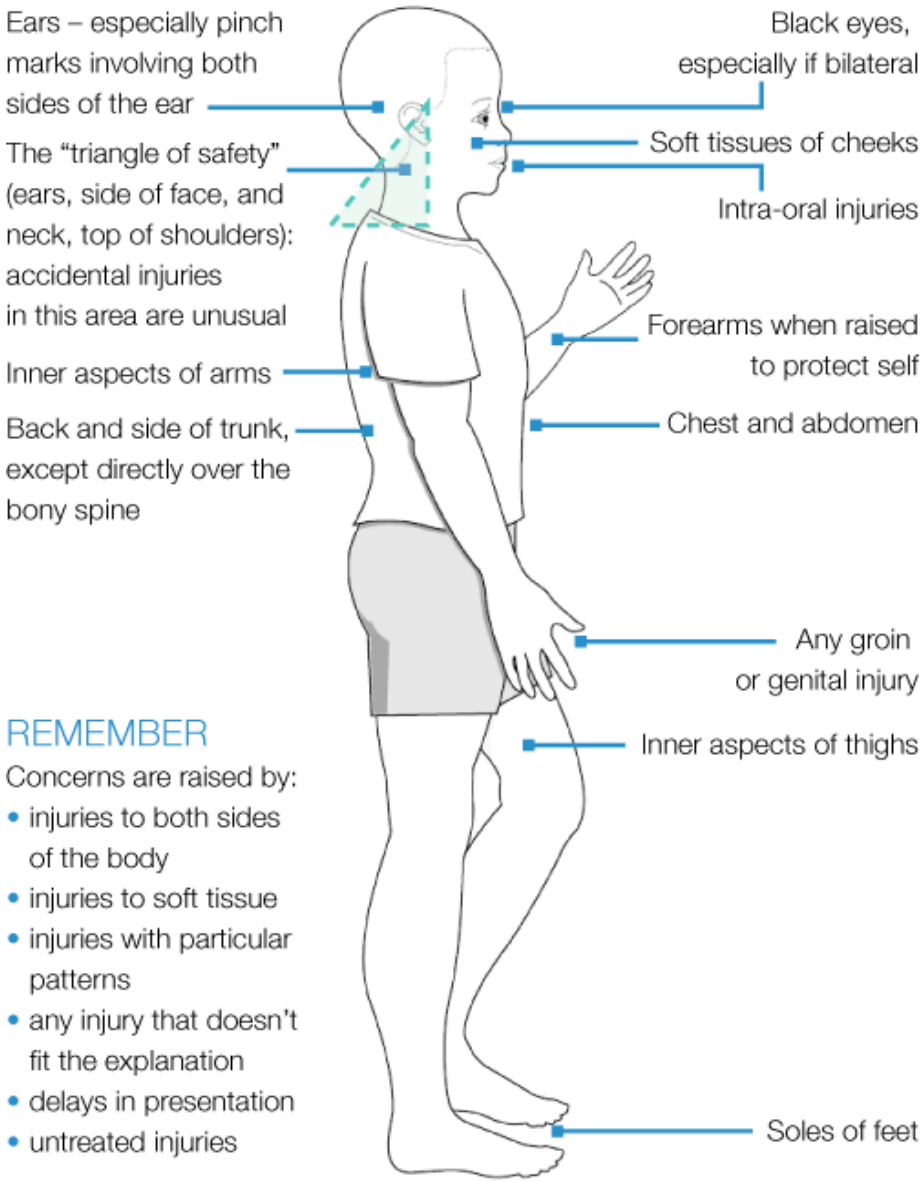
Bruises

- Commonest abusive injury
- Toddlers commonly sustain bruises
- Need to distinguish between unintentional and abusive bruises

Site

Site

- Away from bony prominences
- Face, Eyes, Ears, trunk, arms, buttocks and hand, genitalia, inner thigh
- (unintentional bruises to head usually in T-shape across forehead, nose, upper lip, chin)
- Multiple
- Clusters (?defensive)
- Petechia not caused by medical condition



REMEMBER

Concerns are raised by:

- injuries to both sides of the body
- injuries to soft tissue
- injuries with particular patterns
- any injury that doesn't fit the explanation
- delays in presentation
- untreated injuries

Shape/ Pattern

Shape/ Pattern

- Imprint of hand/ ligature/ implement
- Petechial Haemorrhages associated with bruising
- Bruised scalp and swollen eye from hair being pulled out violently
- Bruises associated with sexual abuse – lower abdomen bruises, grip mark patterns around buttocks, top of thighs, and genitalia

Assessment of Bruise

- History
  - History of injury
  - Medical history/ history of bleeding
  - Drug history
  - Family History

Description of Injury

- Site
- Size
- Shape (or pattern)
- Colour
- Depth – including presence of petechiae/ subcutaneous haematoma)

(Sugar, sugar, sugar, coffee….Drink!)

Can we age of bruise accurately?

Can we age a bruise accurately?

- "The simple answer to this question is **no**! It is not possible to age a bruise by examining it with the naked eye.
- **The three included studies detail small numbers of bruises and show that:**
- **Different colours appear in the same bruise at the same time**
- Not all colours appear in every bruise
- In general red / blue and purple colours were more commonly seen in bruises less than 48 hours old and yellow, brown and green bruises were most often seen in bruises over seven days old. However, the converse of this also applied: red / blue and purple were identified in up to 30% of observations in bruises older than seven days and yellow/brown or green were seen in up to 23% of bruises less than 48 hours old [1]
- **There is considerable variation in the way different observers interpret and describe colour[1]**
- **Yellow bruising was not seen before 24 hours**
- Yellow only appeared in bruises over 48 hours old
- One child had a blue bruise on the arm and a green / yellow bruise on the leg that were sustained at the same time
- The accuracy with which observers estimate the age of a bruise from a photograph is little more than 50% (24/44)
- The accuracy of estimating the age of a bruise to within 24 hours in vivo was only 40%

- http://www.core-info.cardiff.ac.uk/

Description of Injury

- Site
- Size
- Shape (or pattern)
- Colour
- Depth – including presence of petechiae/ subcutaneous haematoma)

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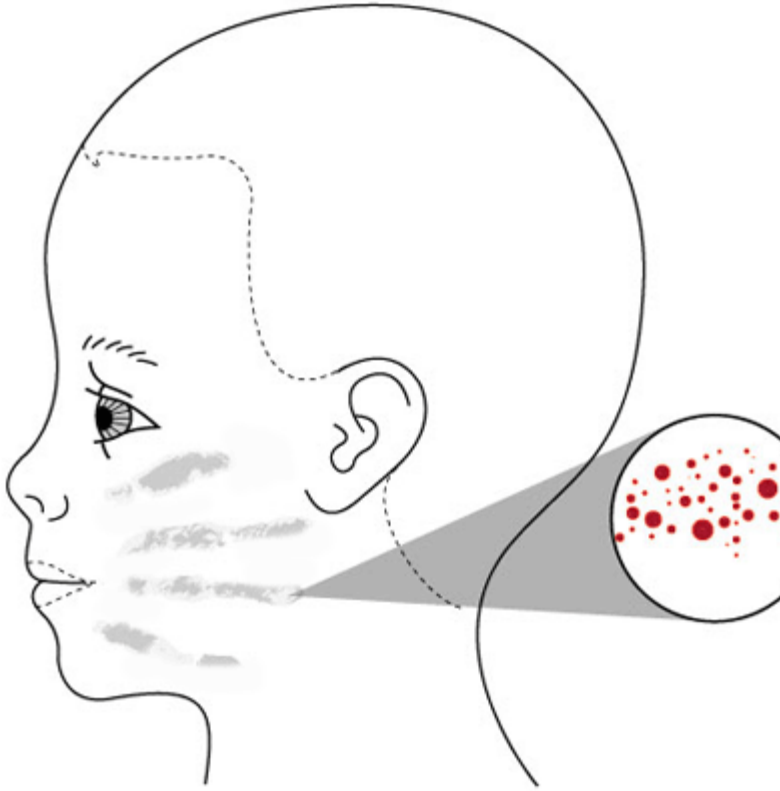
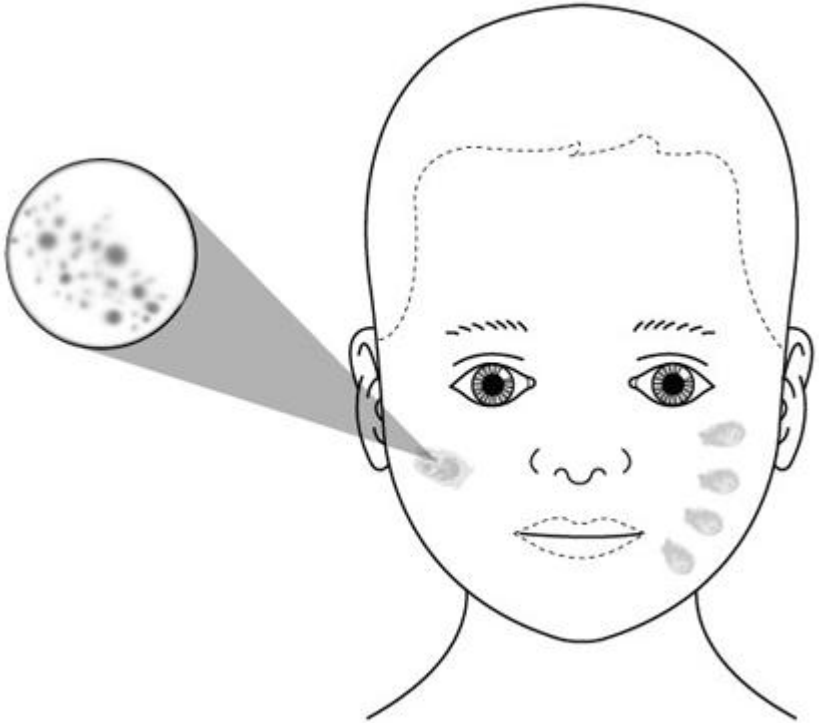
Description of Injury

- Clearly document
- Use body maps
- Measure each lesion
- and its relationship to landmark
- (Photography)





Differential Diagnosis of Bruise

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- Birth marks
- Vasculitic disorders
- Infection – meningococcal sepsis
- Drug related – aspirin, NSAID
- Erythema nodosum
- HSP
- Traumatic
  - Cultural – cupping, coining/ Self inflicted
- Connective Tissue disorders
- Malignancy

Assessment of Bruise

- History
  - History of injury
  - Medical history/ history of bleeding
  - Drug history
  - Family History

Bites

- Human bites always inflicted
- Can potentially identify perpetrator
- Suspect if see bruise with opposing curves
- Adult bites – intercanine distance >3mm
- Animal bites – puncture wounds, tear rather than compress flesh

Burns

Burns

- Burns are common in children
- 70% of unintentional burns in children in the under 3 – 90% at the home
- Parental inattention
  - Hot beverages, hot food etc
    - Scald over face, chest, upper arms
    - Deepest where hottest liquid touches skin, more superficial as it runs down body
  - Contact burn from eg hot iron/ hair straighteners/ oven door
    - suspicious if deep burn

Burns

- Cigarette ash
- Sunburn
- Flame burns – bonfire, BBQs, fireworks
- Friction burns
- Chemical burns (rare)
- Electric burns (rare)

Abusive Burns

- Immersion burns
  - stocking and glove distribution
  - Clear demarcation
  - Buttocks and legs
  - Bilateral and symmetrical
- Contact burns
  - Back/buttock (not finger tips and hands)
  - Multiple
  - Clearly demarcated and deep with shape of implement (iron/ cigarettes, hot plates etc)
- Friction burns/ Chemical burns

Oral Injuries

- Approximately 60% of all cases of physical abuse have some oral or facial signs
- As many as 33% have intraoral signs, da Fonseca et al 1992

Types of Orofacial Injuries

- Contusions / bruises
- Bites
- Neck; choke or cord marks
- Eye injuries
- Hair pulling
- Dental trauma (displaced / fractured/ discoloured from previous trauma)
- Intra-oral bruising, bleeding and contusions
- Torn Frenulum

Fractures

- 1/3 of children sustain a fracture before the age of 16
- 1/3 of children physically abused sustain fracture
- The younger the child – the more likely of abuse
- Abusive fractures are frequently occult – rib/ metaphyseal/ vertebral
- Multiple fractures common
- Consider Differential diagnosis

Differential Diagnosis of Fracture

- Unintentional
- Abusive
- Normal variant
- Birth injury
- Infection
- Malignancy
- Caffey's disease
- OI
- Metabolic bone disease of prematurity
- Nutritional

Fractures

Children <2 increased risk of physical injury and need to be investigated for occult injury (even in the absence of signs of physical abuse)

- Skeletal survey with repeated imaging in < 2
- CT scan in < 1, consideration in 1-2 year olds
- Ophthalmology examination within 24 hour

Referral Pathway

- Make an assessment in context of medical and social history, explanation given etc
- If concerns refer to Children's social care who will organise appropriate CP Medical
- Inform parents of concern
- If not sure – contact your safeguarding lead (but do not delay if not able to do soon)

- Don't automatically all send to Paediatric assessment unit

MANAGEMENT OF BRUISE, BITE & SUSPICIOUS/UNEXPLAINED MARK IN CHILDREN

PRESENTATION

Bruising which suggest the possibility of non-accident injury include:-

- Bruising in immobile babies.
- Bruising in children who are not independently mobile (including disabled).
- Bruises seen away from bony prominences.
- Bruises around mouth and cheeks, back, abdomen, upper arms, buttocks and ear lobes.
- Multiple bruises or petechia (dots of blood under the skin) in clusters.
- Multiple bruises of uniform shape.
- Bruises that carry an imprint of an implement or cord.
- Bruises with petechia around them.

MAKING AN ASSESSMENT

A mark/bruise/bite should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given. A discussion should take place with a Paediatrician and the child should be referred for assessment.

IMMOBILE BABIES/CHILDREN

In all cases of bruising/unexplained marks in immobile babies/children:-

- Take an accurate history from parent/carer.
- Refer to a Paediatrician (Bleep 733).
- Any concerns will need to be escalated to Social Care and discussed with parents.
- Complete information sharing form for Safeguarding Children's Team – via ICE.

MOBILE CHILDREN

- Be alert to multiple or large facial bruising
- Take history from the child and family where appropriate
- Does history fit the injury?

YES

Record assessment. Consider if any further action is required (Discuss with Peds, Bleep 733 if unsure).

NO

Refer to Peds Reg Bleep 733. Discuss with Social Care. Complete information sharing form for Safeguarding Children's Team – via ICE.

Document all information accurately and in a timely manner in the child's hospital records. Document with whom you discuss your concerns in the child's hospital records.

USEFUL CONTACTS:

Peeds Reg: Bleep 733

Hospital Safeguarding Children's Team: Bleep 153/080

Luton Social Care:	01582 547653	**Out of hours:**	0300 300 8123
Central Beds Social Care:	0300 300 8585	**Out of hours:**	0300 300 8123
Hertfordshire Social Care:	0300 123 4043	**Out of hours:**	0300 123 4043

Referrals to Social Care must be followed up by a written referral within 24 hours

LUTON & DUNSTABLE UNIVERSITY HOSPITAL

Cambridgeshire Community Services NHS
NHS Trust

Multi-Agency Referral Pathway for Child Protection Medicals for children 0-18 years living in Luton or Central Bedfordshire (South)

Social worker/Police/Health professional strategy discussion identifies need for child protection medical
*(The decision for a CP medical should **always** be made in consultation with the consultant or senior paediatrician on call who will decide the level of urgency)*

Normal working hours (weekdays 9am – 5pm)

REFERRAL TO EDWIN LOBO CENTRE (Community Paediatrics)

- ELC CP medical referral form to be completed and sent by e-mail to CCS-TR.ELCCPMedicals@nhs.net with phone call immediately to ensure referral received (01582 345945). This will be passed to the on call doctor who may need to discuss further with the referrer.
- If advice is required regarding appropriateness of referral - phone 01582 345945 to discuss with on-call doctor (advice available 9am – 5pm).

Appointment booked as appropriate

***Note: Last appointment for a CP medical is 4pm** (ELC premises closes at 5pm, therefore provision for child care or security is NOT available in the premises after that time)*

Medical admission required e.g:

- Child unwell and/or requires **urgent medical / surgical treatment** (physical or sexual abuse*, severe neglect).
- Child has **head injury** and requires medical investigations (includes all infants <1y with suspected abusive head trauma).

Out of hours (weekdays after 5pm; bank holidays and weekends 24h)

REFERRAL TO L&D HOSPITAL (Acute Paediatrics)

Telephone on call Dr 01582 497401 or bleep 733 (via switchboard 491166) to discuss referral and arrange admission if required.

- CP medical at appropriate time and place
- Specialist examination jointly with GUM, gynaecologist, FME (SARC) may be required.
- Child in hospital remains the responsibility of the paediatric consultant.

*Wherever possible, the child should be accompanied for a CP medical by a **social worker who knows the case** and an **adult who holds parental responsibility** to give written consent for examination and investigations (and sedation if required).*

*If concern is regarding recent or historical sexual abuse (and hospital admission for urgent medical/surgical treatment is not required), direct referral should be made to **BEDFORD SARC** (Emerald Centre). Call 01234 897052 to discuss referral.

Nov 2015

Summary

- When to suspect physical abuse
- Systematic way of assessing injury (bruises, bites, burns)
- Referral Pathway

Core info - Cardiff Child Protection Systematic Review

NICE Oct 2017 – Child abuse and Neglect Overview

RCPCH - Child protection Companion

Any Questions??

Safeguarding Children Team