WAIKATO CHILD AND YOUTH HEALTH

Safeguarding Children

GP CME

Nurses' Workshop

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- “Child Abuse means the harming (whether physically, emotionally or sexually), ill treatment, abuse, neglect or deprivation of any child or young person”
  - *(Section 2, Children Young Persons & Their Families Act 1989)*

- Notifications of child abuse doubled between 2004 and 2010
- Children in contact with Child, Youth and Family are five times more likely to have a Corrections’ sentence by age 19 or 20 than a young person with no contact with Child, Youth and Family.

Markers of Neglect

The Child's Needs	Effects of Neglect
Nutrition	•Failure to thrive/faltering growth •Stunting
Warmth, clothing, shelter	•Inappropriate clothing •Cold injury •Sunburn
Affection	•Withdrawn / hyperalert / wary •Attention seeking behaviour
Stimulation and education	•Developmental delay •Learning difficulties
Safe environment	•Frequent injuries (burns, cuts, fractures)
Hygiene and health care	•Ingrained dirt •Headlice •Dental caries

Physical Abuse

Injuries can be categorised into

- Accidental and unavoidable
- Accidental but avoidable
  - Neglectful (either a momentary lapse of supervision or in a chronic abusive environment)
- Inflicted (in a moment of rage or in a chronic abusive environment)
- Physical abuse may result in:
  - Bruising, lacerations, grazes
  - Fractures
  - Thermal injury (burns, scalds)
  - Traumatic brain injury
  - Intra-abdominal injury
  - Etc

Identify – Vital Questions

- When did the injury occur?
- Where did the injury occur?
- Were witnesses present and who were they?
- What was the child doing? - what went wrong and what caused the injury?
- Was there a supervising adult?
- What is the child's previous injury history?
- Are the injuries single or multiple?
- What is the child's current growth & developmental capability?
- What was the child wearing?

More Vital Questions

- **Is the child safe from further injury?**
- **Are other family members safe from harm?**
- **Older children may be asked**
  - **How are things at home – are you OK?**
  - **Who makes the rules, what happens when you break the rules?**
  - **What happens when your parents are angry with you?**
  - **Who can you go to at home if you are upset?**

Assess risk

- History of previous abuse or suspected abuse
- Family violence
- Parent indifferent or intolerant of child or report child as particularly troublesome
- Parents abused as children
- Frequent medical attendance
- Children with disability and chronic illness

Assess risk

- Alcohol and drug use
- Mental illness including post natal depression
- Parent very young
- Parents with medical or cognitive challenges
- Frequent changes of address - more than two over last twelve months
- Severe social stress
- Severe isolation and lack of support

Why intervene?

- Rights of the child
  - Child's safety is the immediate concern
  - Consequences to the child and others
  - Vulnerability of the child
    - Young children are most vulnerable
    - Other children in household
- Vulnerability of the caregiver
- ***If you don't intervene, no-one else will***

What to do if you suspect child abuse

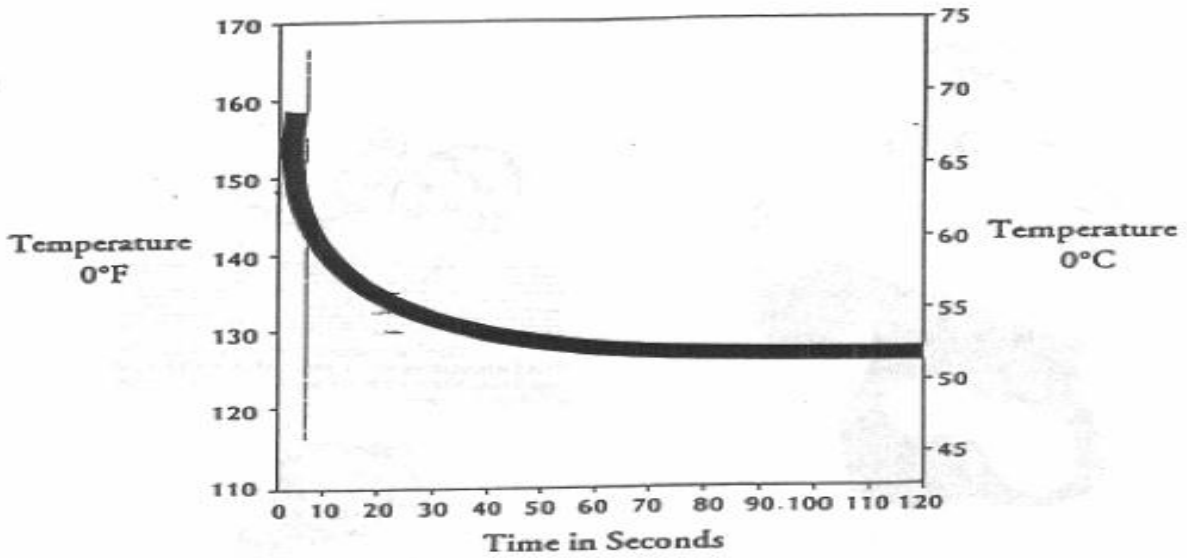
- Share the responsibility for making children and young people safe
  - You don't have to prove that abuse has occurred - but you do have to consider it, document it, and discuss it!
- Be aware of your own biases
- Be honest, be professional
- Discuss with a colleague, CPASS (or your local DHB service), or CYFS
- NOTIFY CYFS OR POLICE!!!

Thermal Injuries

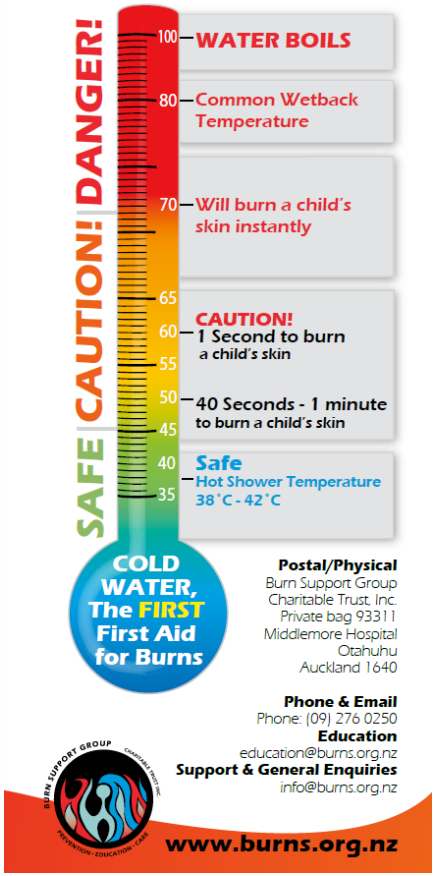
- Burns include:
  - Scalds from hot liquids
  - Contact burns from hot objects
  - Flame burns
  - Electrical burns
  - Chemical burns

- Most burns are accidental or from neglect
- A UK study estimates that of the children admitted to burns units, 10% sustained burns that were the result of abuse
- Burns due to neglect outnumber intentional burns by a ratio of greater than 9:1
- Scalds cause immediate and severe pain

Thermal Injuries (cont)



Time versus temperature graph for skin scalding to occur. Adapted from Feldman et al., 1978, based on original work by Moritz & Henriques, 1947.



- Degree of burn is directly related to:
  - Temperature of the fluid/surface
  - Exposure time

http://www.burns.org.nz/sites/default/files/hot-water.pdf

http://www.qpsltd.co.nz/pdf/hot_water_cylinder.pdf

What do we know about burns?

- Most burns to children are accidental or neglectful
- Most child abuse/neglect occurs in poor households
- A few are the result of deliberate abuse, often by a caregiver in a moment of rage due to toileting or behavioural problems
- A very few are abuse in the context of deliberate, chronic, abuse (emotional, physical, sexual) and neglect
- The more severe the burn, the more likely it is the result of abuse or assault
- Certain burn types show a pattern of injury that makes it more likely that they are abusive
- Most child abuse occurs in the broad context of family violence, and there are ‘red flags’ around the child and injury which mandate consideration of abuse

Thermal Injuries - Spill scald

- 17 month old boy
- Pulled a boiling saucepan off the stove onto himself

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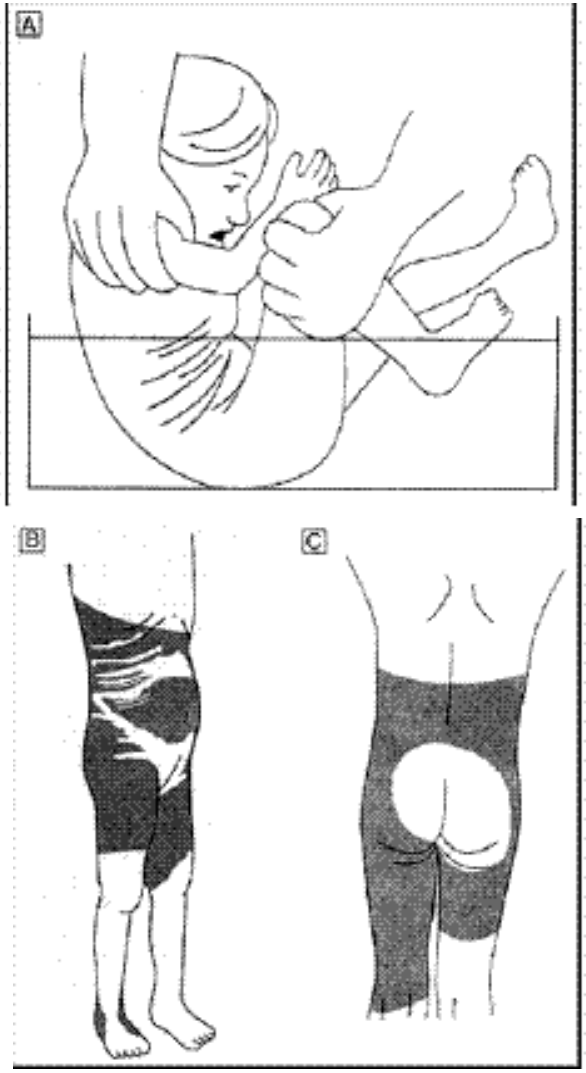
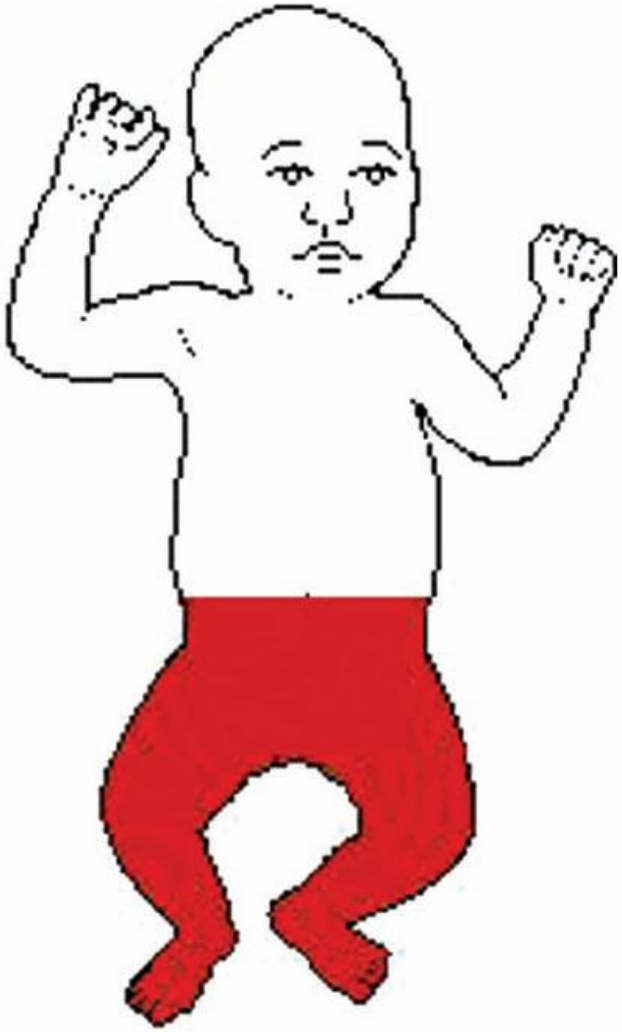
2010;95:170-177

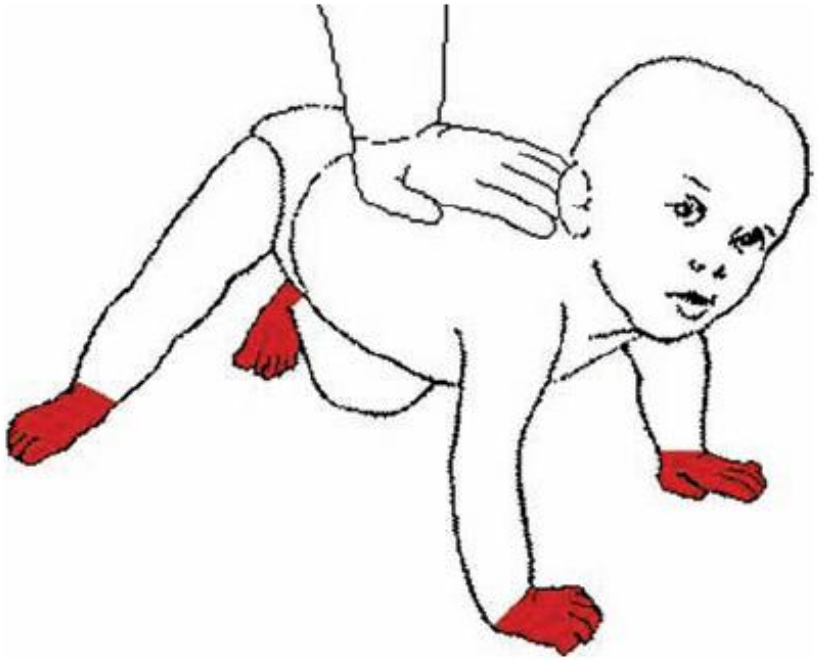
Scalds – Inflicted



- Sparing of skin despite immersion may occur due to:
  - Presence of clothing
  - Limbs/Trunk may be bent
    - Crook of the elbows
    - Behind the knees
    - “Zebra stripe” pattern
  - Body part may press against the surface of the bath (which is cooler)

Scalds – Inflicted (cont)





Which injuries may indicate child abuse?
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Scald Triage Tool- http://www.core-info.cf.ac.uk/

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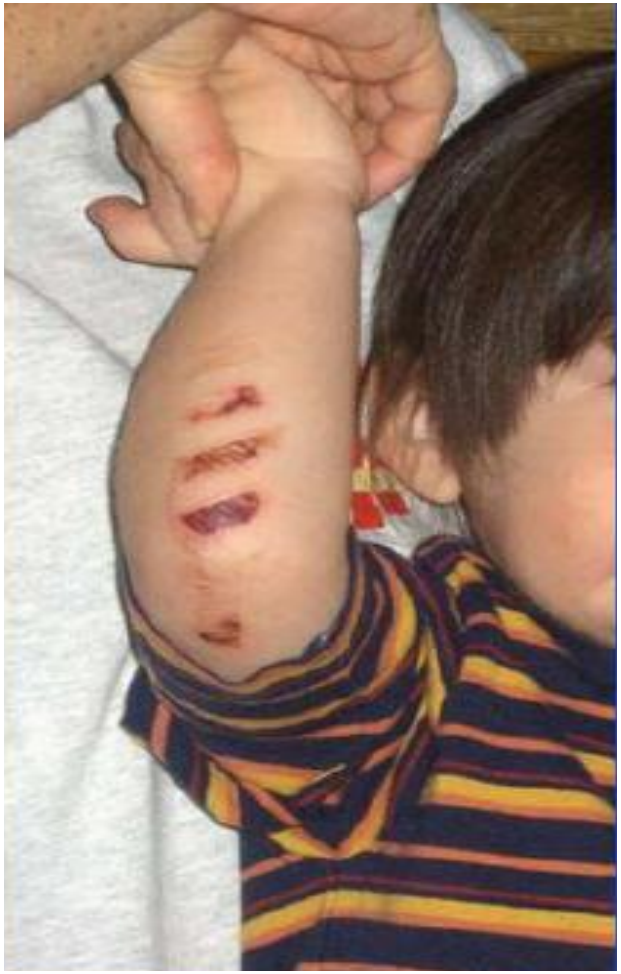
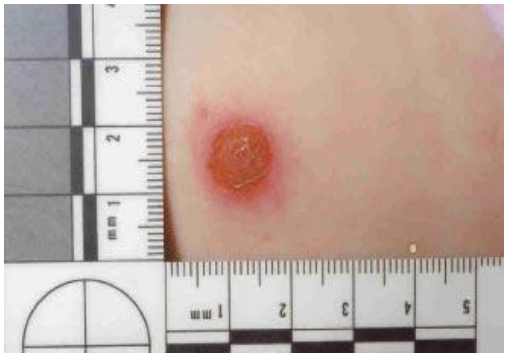
Intentional Scald must be excluded	Intentional Scald must be considered	Intentional Scald unlikely (but consider neglect)
Physical features **Mechanism**: Immersion **Agent**: Hot tap water **Pattern**: ■Clear upper limits ■Scald symmetry (extremities) **Distribution**: ■Isolated scald buttock/perineum +/- lower extremities ■Isolated scald lower extremities **Clinical features** ■Associated unrelated injury ■History incompatible with examination findings ■Coexisting or old fractures **Historical/Social features** ■Passive, introverted, fearful child ■Previous abuse ■Family violence ■Numerous prior accidental injuries – frequent ED visits ■Sibling blamed for scald	**Physical features** **Pattern:** ■Uniform scald depth ■Skin fold sparing (eg “Zebra stripe”) ■Central sparing of buttocks **Distribution:** ■Glove and stocking ■1 limb glove/stocking **Clinical features** ■Previous burn injury ■Neglect/faltering growth ■History inconsistent with assessed development **Historical/Social features** ■Trigger, such as: Soiling/enuresis/misbehaviour ■Differing historical accounts ■Lack of caregiver concern ■Unrelated adult presenting child ■Child known to CYFS or other social services ■Family Mental Health problems	**Physical features** **Mechanism:** ■Spill injury ■Flowing water injury **Agent:** Non tap water (eg hot drink) **Pattern:** •Irregular margin and burn depth •Lack of glove/stocking distribution **Distribution:** ■Asymmetric involvement of lower limbs ■Head, neck and trunk or face and upper body **Notes:** ■It can be difficult to distinguish between accidental and neglectful burns or scalds, as they have many overlapping features. Most childhood burns are the result of neglect. ■In all severe scalds, a site visit is desirable (include measurement of hot water temp at tap if tap water scald). *Burns 32 (2006):222-228*

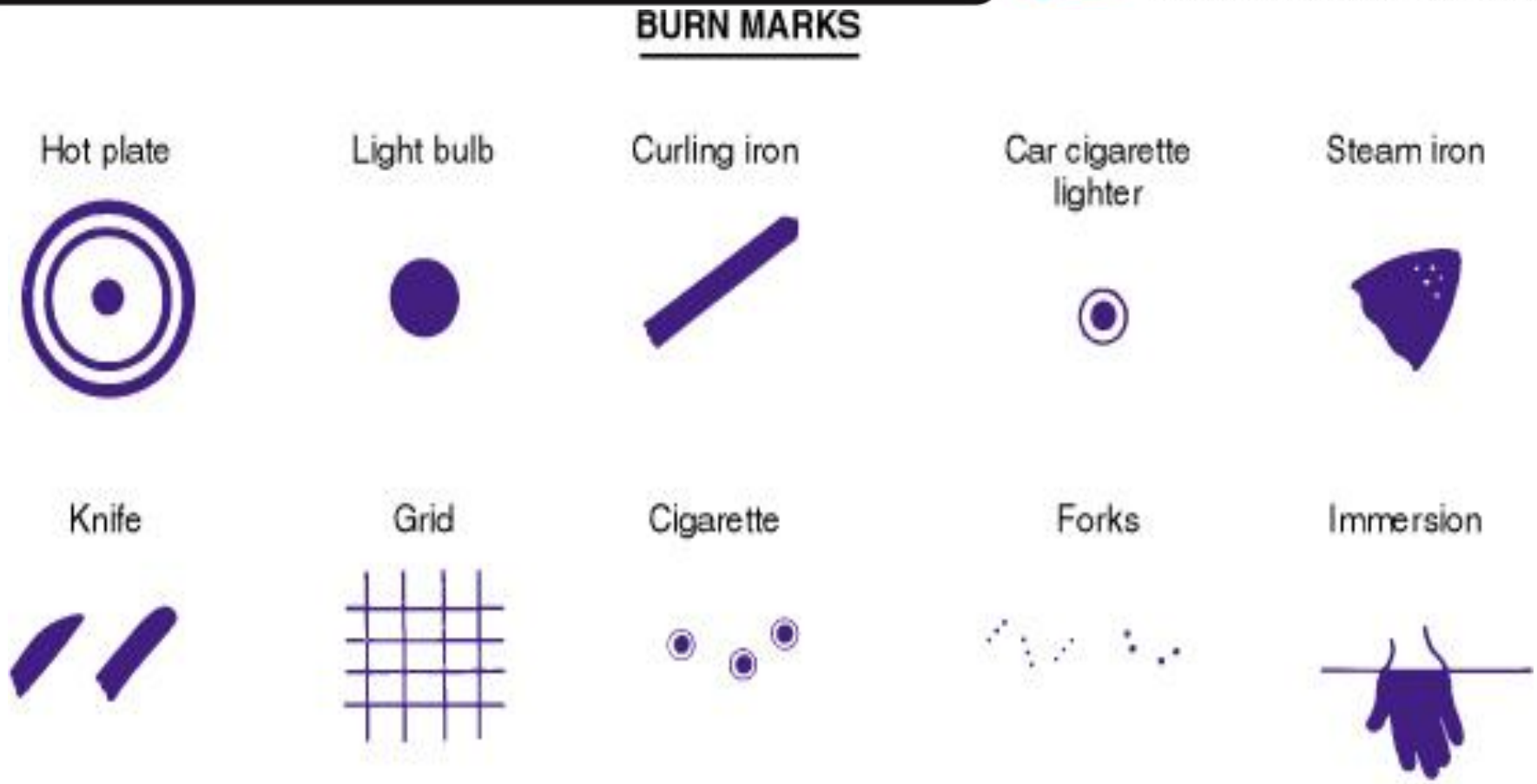
Thermal Injuries – contact burns



- 4 year old boy
- Burnt arm on BBQ grill when reached for a sausage
- Has another burn on upper thigh



Intentional Burns - patterned



Red Flags – Thermal Injuries

- History inconsistent with injury
- Delay in seeking treatment
- Person who had care of the child unable to be contacted to provide history
- Surprising lack of pain described
- Child is < 1 yr and developmental age suggests couldn't have self-inflicted injury
- Bilateral/symmetrical limb scalds or burns, full thickness contact burn, multiple contact burns
- Burns or other injuries of different ages

Community Resources

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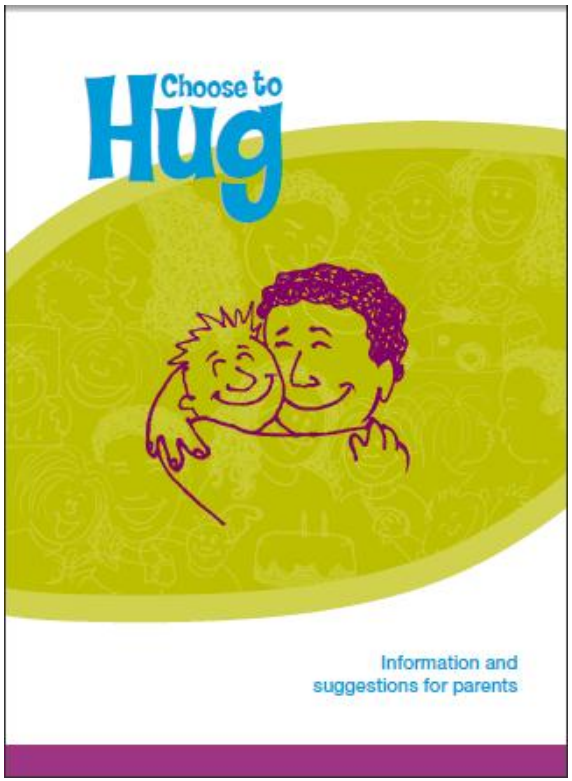
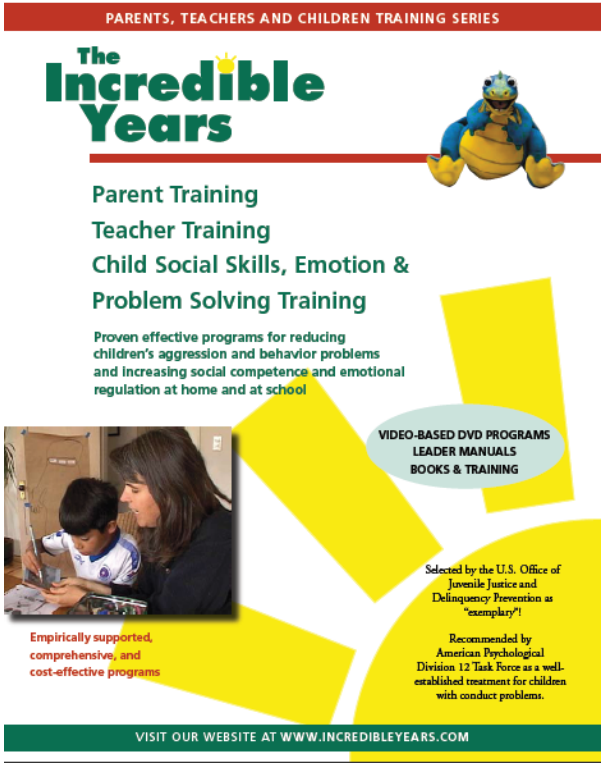
These are resources available for parents:





http://www.occ.org.nz/__data/assets/pdf_file/0006/3759/OCC_Choose_to_Hug.pdf
http://www.skip.org.nz/
http://www.incredibleyears.com/

What do we know about bruising in children?

- Bruising is strongly related to mobility
- Once children are mobile they sustain bruises from everyday activities and accidents
- Bruising in a baby who is not yet crawling, and therefore has no independent mobility, is very unusual
- Only one in five infants who is starting to walk by holding on to the furniture has bruises
  - (If they don't cruise, they don't bruise)
- Most children who are able to walk independently have bruises
- Bruises usually happen when children fall over or bump into objects in their way
- Children have more bruises during the summer months (especially in the northern hemisphere or colder parts of NZ)

Patterns of Bruises

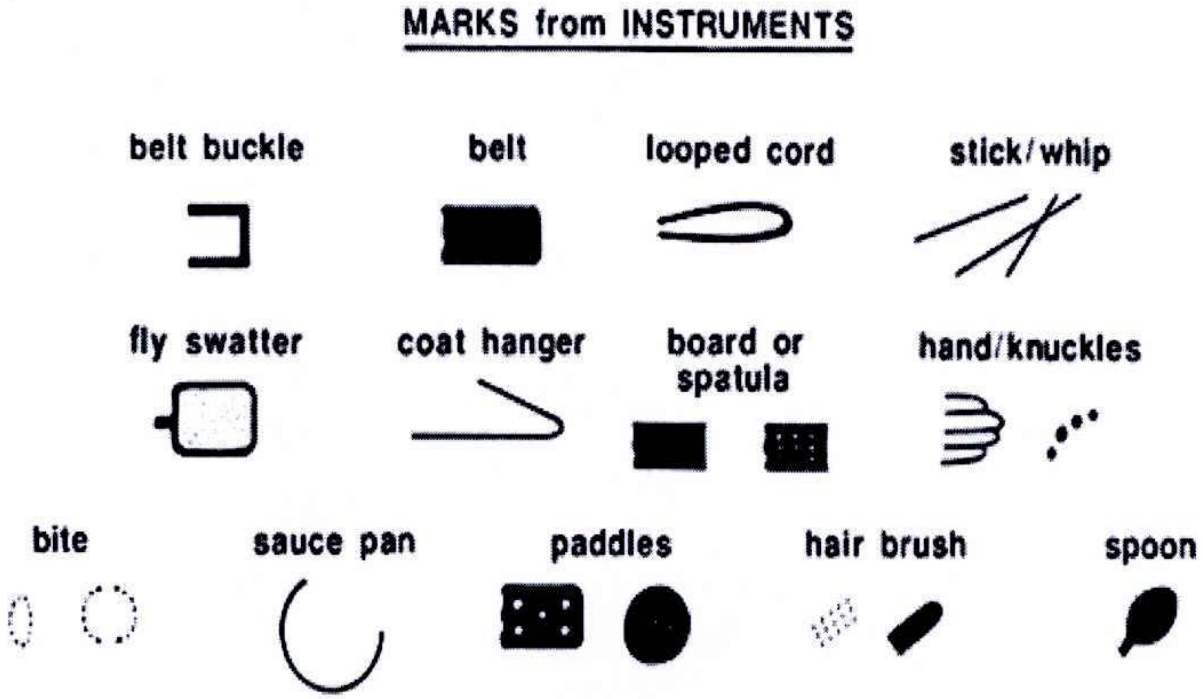
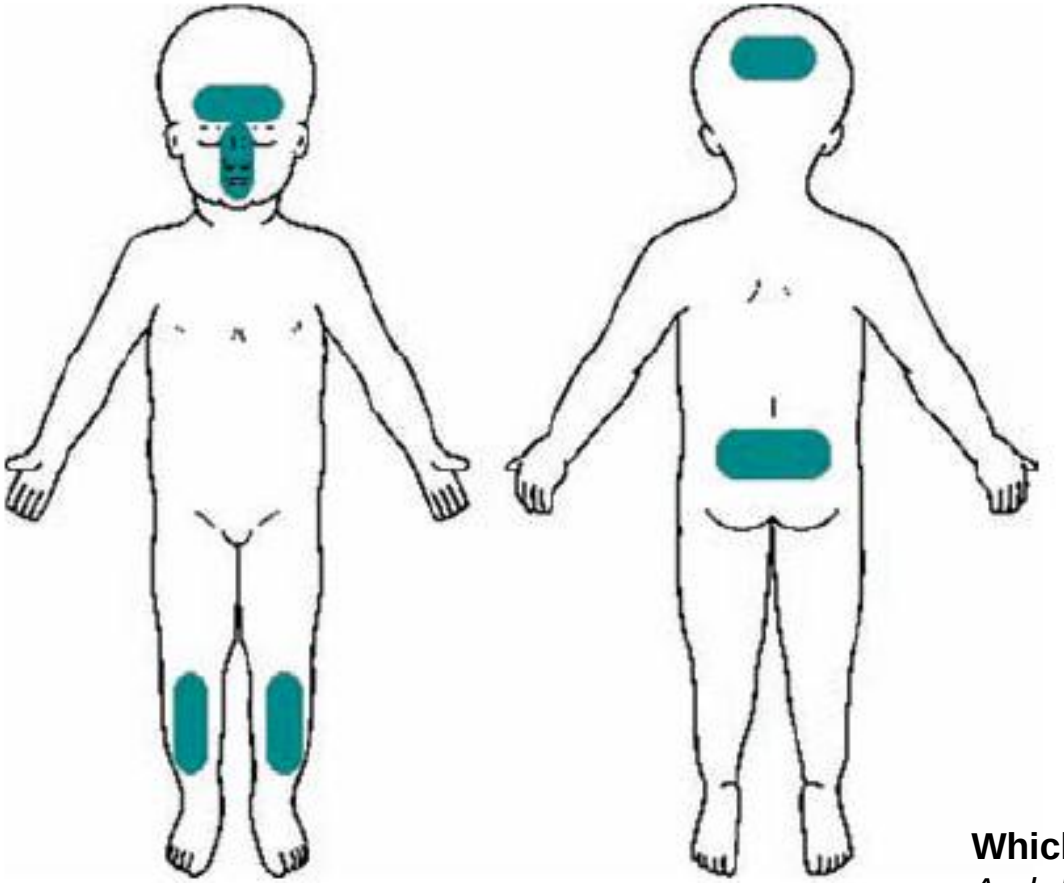


FIGURE 35–2 A variety of instruments may be used to inflict injury on a child. Often the choice of an instrument is a matter of convenience. Marks tend to silhouette or outline the shape of the instrument. The possiblility of intentional trauma should prompt a high degree of suspicion when injuries to a child are geometric, paired, mirrored, of various ages or types, or on relatively protected parts of the body. Early recognition of intentional trauma is important to provide therapy and prevent escalation to more serious injury.

Common Sites of Accidental Bruises



The commonest site for accidental bruises in mobile children is the knees/shins. In young children (<6 years), accidental bruising to the head occurs predominantly in a 'T' shape across the forehead, nose, upper lip and chin, and in more than a third (37%) bruising is also found on the back of the head. It has been clearly shown that accidental bruising occurs on the front of the body and over bony prominences and <6% of accidental bruises to the face are found on the cheeks or periorbital area.

Which injuries may indicate child abuse?
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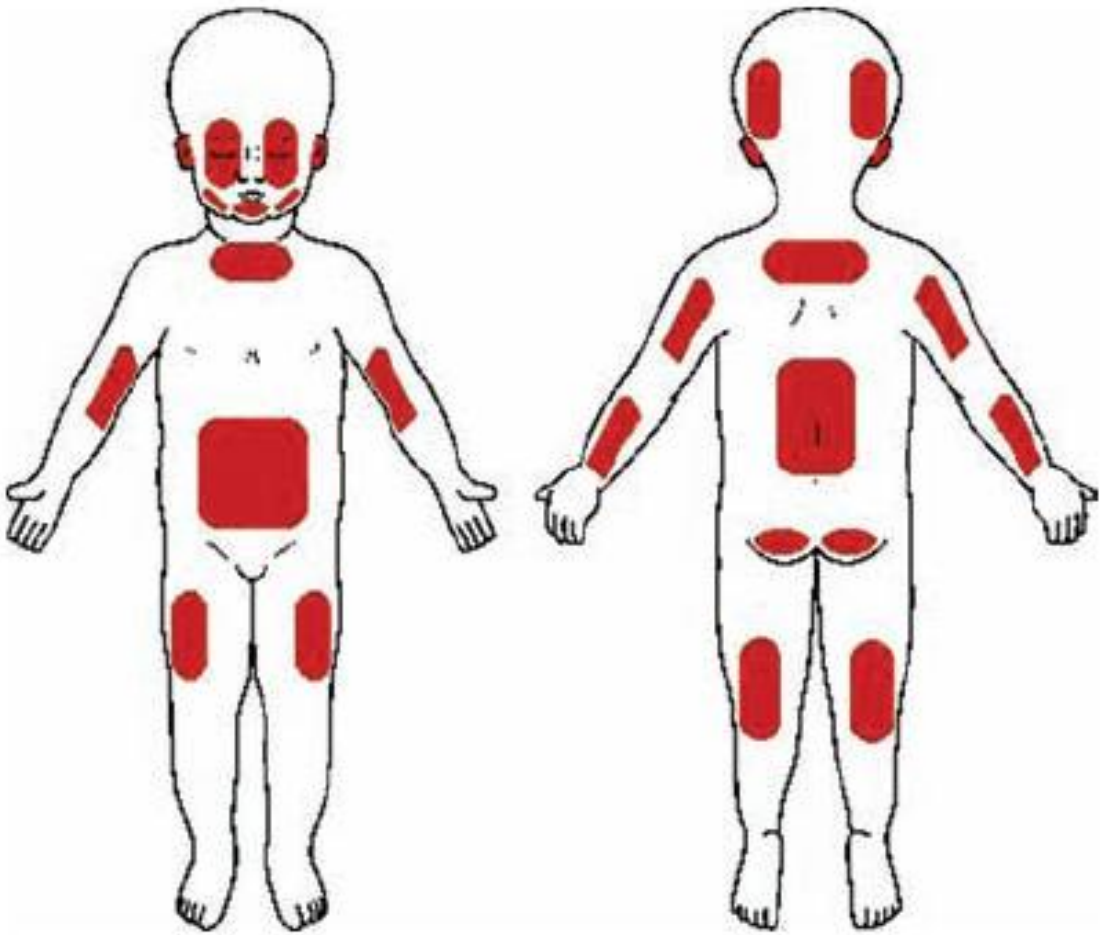
Questionable Sites of Bruises



In contrast, abusive bruises are found predominantly on the head and neck, where the bruising occurs on the ear, neck and cheeks, all of which are extremely rare sites of accidental bruises. Any part of the body may be bruised as a consequence of abuse, but specific areas such as the forearms, upper limb and adjoining area of trunk, or outside thigh may indicate 'defensive bruising' where the child has tried to protect themselves from the blows being rained upon them.

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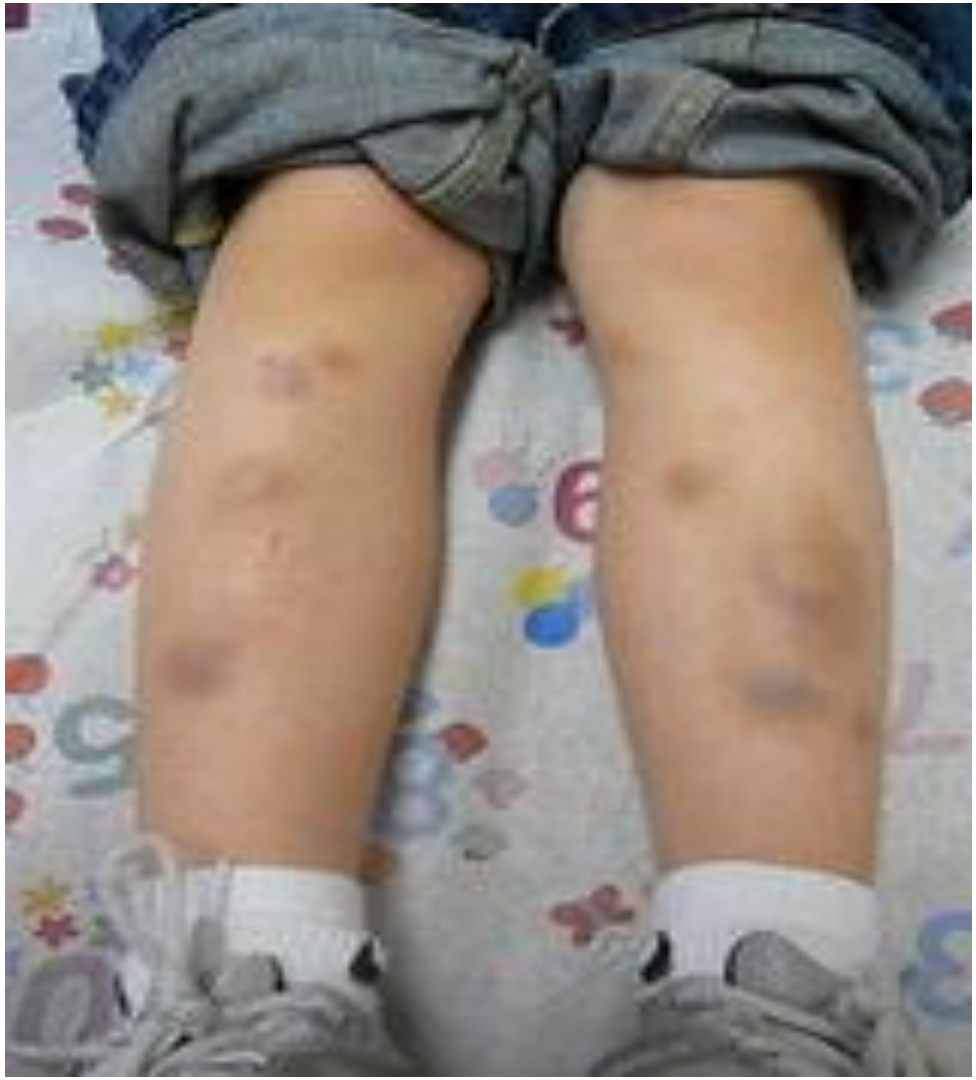
Which of these are red flags?

- Bruising in children who are not independently mobile (aren't cruising)
- Bruising in babies
- Bruises that are seen away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry an imprint
- Bruises with *petechiae* (dots of blood under the skin) around them.

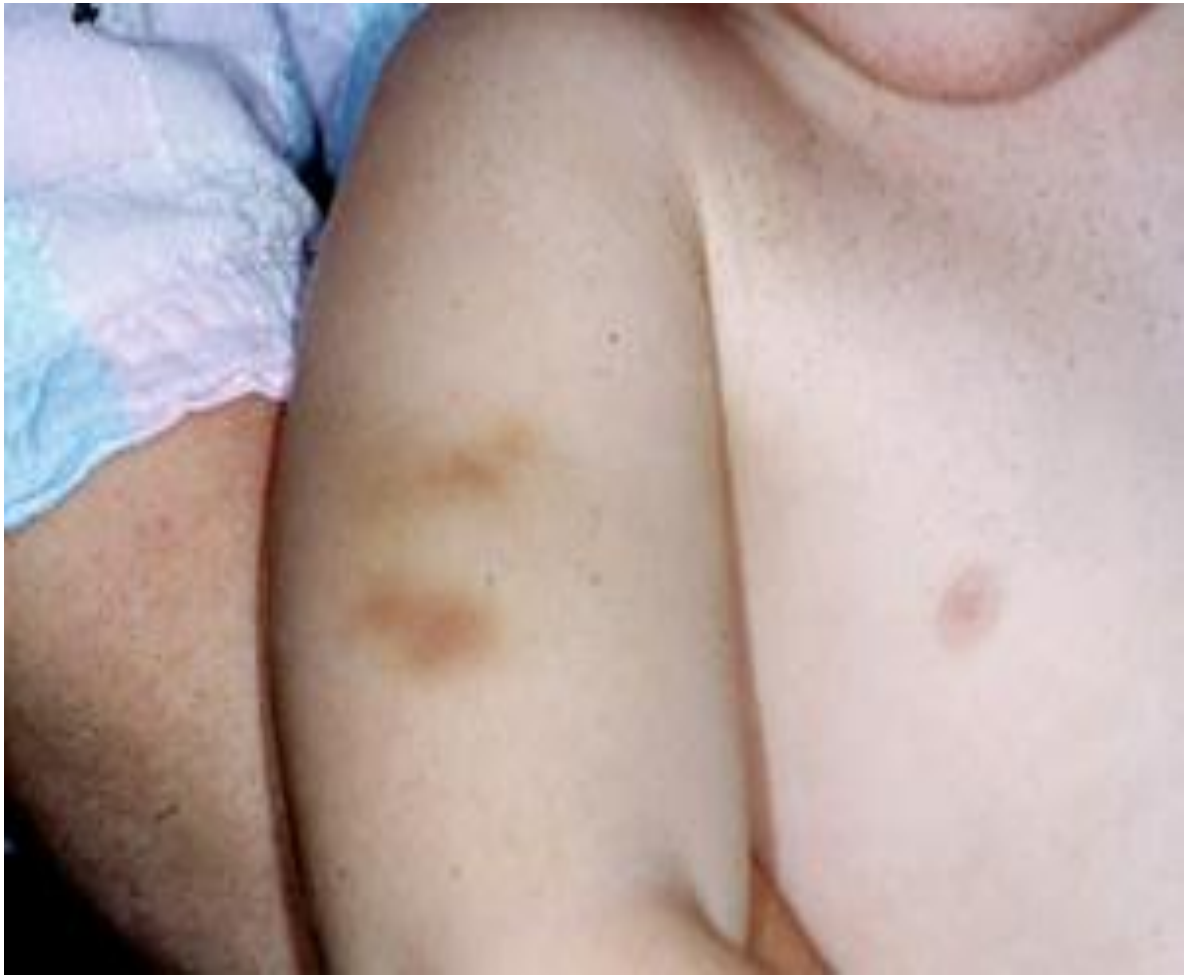
All the above!

Bruises - Case 1



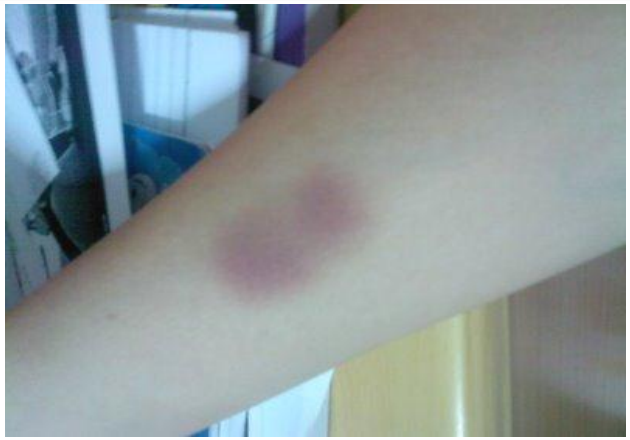
- 3 year old boy

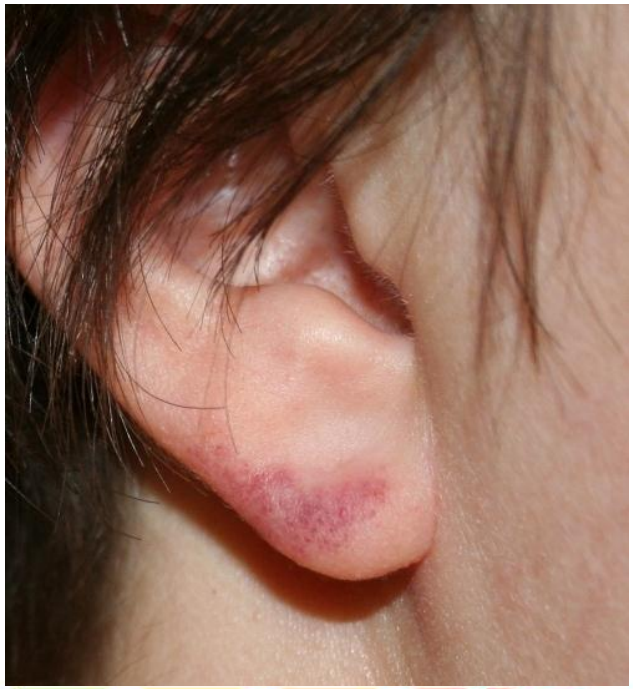
Bruises - Case 2



- 3 year old boy

When should you be concerned?





- Abusive bruises often occur on soft parts of the body,
  - Cheeks
  - Abdomen
  - Back and buttocks
- The head is by far the commonest site of bruising in child abuse
- As a result of defending themselves, abused children may have bruising on the forearm, face, ears, abdomen, hip, upper arm, back of the leg, hands or feet
- Non-accidental head injury or fractures can occur without bruising

Physical Abuse - Red flags include

- Un-witnessed or unexplained injury
- Delay in seeking medical care
- Patterned bruises or burns
- Injuries of different ages
- Unusual site of injury
- Injuries to the face, head and neck
  - black eyes, boxed ears
- Fractures in non-ambulant children
- Burns other than splash burns
- http://ep.bmj.com/content/95/6/170.full

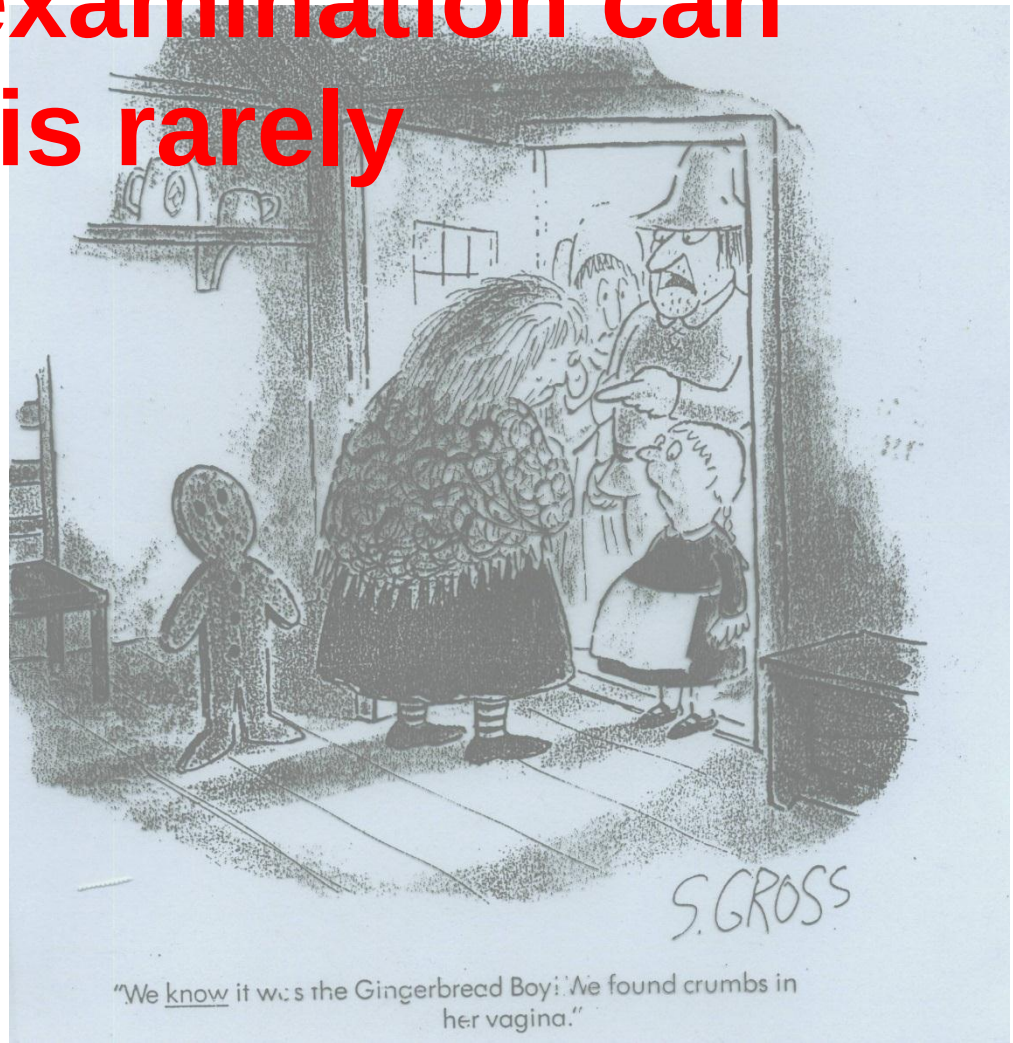
Useful links

- Child Matters CPS http://www.childmatters.org.nz/
- Child Youth and Family http://www.cyf.govt.nz/
- Children's Commissioner http://www.occ.org.nz/
- Safekids NZ http://www.safekids.org.nz/
- Starship Hospital Parent information http://www.kidshealth.org.nz/
- Welsh Child Protection Systematic Review Group http://www.core-info.cf.ac.uk/
- Your local DHB Child Protection team
- Auckland Burn Support Group Charitable Trust http://www.burns.org.nz/

Sexual Abuse Take home messages

- Involvement of a child or young person in sexual activity, includes exposure to inappropriate behaviour, porn etc.
- Activity may be “consensual” or nonconsensual.
- Age difference of four years - unless forced when can be same age.
- **The medical examination does not prove or disprove abuse.**
- **Most red bottoms and bowel and bladder problems are not sexual abuse.**
- **What the child has to say is the most important**
- **Sexual abuse hurts the “heart” but healing does happen.**
- Significant long-term effects on mental and physical health in over half (Otago Womens’ Health Survey)

The medical examination can be useful but is rarely abnormal



Physical signs and symptoms

- 63% are referred with physical symptoms #
- Body can only react in a few ways.
- Local injury causes redness, bruising or bleeding.
- Sometimes there may be hints of cause from injury patterns.
- Most physical symptoms are no more likely to be due to sexual abuse than not # .

Kelly P. J Paeds Child Health 42 (2006): 112-7

BUT

- 95% of children with a clear history of abuse will be normal on examination.
- Physical findings are more likely if there was bleeding noted at the time.
- Red bottoms are more likely related to hygiene, local irritation, infection elsewhere in the body, worms, nappy rash than sexual abuse - the difference is in the history.

Urgent examination when

- Possibility of forensic information (eat your heart out CSI).
- Sudden onset of bleeding
- critical to get the child’s clothing as forensic evidence more often found there.

4-year-old female

Rachel is a 4-year-old girl who lives with her mother who is a patient in your practice. Rachel's parents have recently separated. Rachel spends weekends with her Dad and weekdays with her Mum. The mother says she has noticed that Rachel seems to be touching herself a lot lately. She is also naughty and non-compliant when returning from her Dad's house and takes about 2 days to settle back into her usual routine. Rachel also often has a red vulva and bottom on the day after access.

The mother says her ex-husband would never hurt Rachel but when she asked Rachel about her visit to her Dad's, Rachel replied that she and Daddy played games and Daddy touched her fanny. There is a custody case going on and the mother is concerned that her ex-husband thinks she is being malicious. The mother is distraught. The child looks well and wonders why mother is crying.

WHAT DO YOU DO?

WHAT DO YOU SAY / EXPLAIN TO THE MOTHER?

Adobe Acrobat Document