Paediatric Pearls

by Dr Julia Thomson, Paediatrician

Edited this month by: Dr. Jacqueline Driscoll – GP Trainee and academic fellow with a special interest in safeguarding.

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Monthly paediatric update newsletter for all health professionals working with children – put together by Dr Julia Thomson, Paediatric Consultant at Homerton University Hospital, London, UK. Housed at www.paediatricpearls.co.uk where comments and requests are welcome!

There is new guidance from the RCPCH about perplexing presentations (PP) or Fabricated Induced Illness (FII) in children available at https://childprotection.rcpch.ac.uk/wp-content/uploads/sites/6/2021/03/Perplexing-Presentations-FII-Guidance.pdf

Some highlights:

- Think about FII earlier and with the same rigor as organic disease. There does not yet have to be evidence of harm to the child to consider the diagnosis. The term *perplexing presentation* allows for this.
- The term PP is used to describe the commonly encountered situation when there are alerting signs of possible FII (not yet amounting to likely or actual significant harm), when the actual state of the child's physical, mental health and neurodevelopment is not yet clear, but there is no perceived risk of immediate serious harm to the child's physical health or life. The essence of alerting signs is the presence of discrepancies between reports, presentations of the child and independent observations of the child, implausible descriptions and unexplained findings or parental behaviour.
- There does not have to be deliberate attempt to deceive by parents or caregivers. Parental behaviour may be motivated by anxiety, erroneous belief about the child's state of health and/or by gain for the parent/s.
- Unless there is a risk of immediate serious harm to the child's health or life, professionals should share with the child/young person and parents their concern about the perplexing nature of the some aspects of the presentation and explain the need to share information with other professionals to gather information and inform care.
- A Health and Education Rehabilitation Plan agreed by professionals and families is a cornerstone of care.

LESSONS FROM THE FRONT LINE

A 16 year old girl presented to the ED department accompanied by her boyfriend with a 1 week history of foul smelling vaginal discharge. She had travelled abroad 3 weeks previous to a holiday destination for a labiaplasty with vaginal tightening as she did not like the look and feel of her own genitals. This was carried out in a private hospital by a registered doctor. She chose to have the procedure and wasn't coerced into it. A parent travelled with her and paid for the procedure. Is this FGM?

The definition of Female Genital Mutilation according to the FGM Act 2003 is:

"A person is guilty of an FGM offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris. To excise is to remove part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips). To infibulate is to narrow the vaginal opening by creating a seal, formed by cutting and repositioning the labia."

It is an offence for any person (regardless of their nationality or residence status) to:

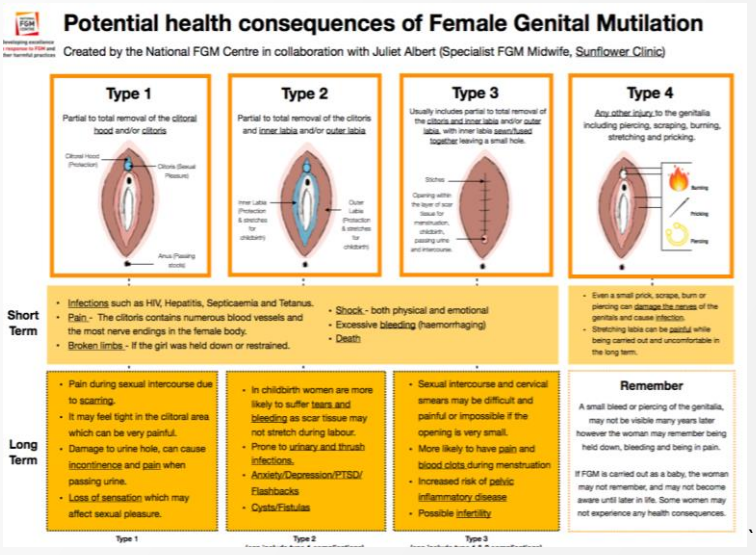
- perform FGM in England and Wales (section 1 of the 2003 Act)
- assist a girl to carry out FGM on herself in England and Wales (section 2 of the 2003 Act)
- assist (from England or Wales) a non-UK person to carry out FGM outside the UK on a UK national or UK resident (section 3 of the 2003 Act)

The Act also places a MANDATORY DUTY on healthcare workers, social care workers and teachers to notify the police if they discover FGM during the course of their work. See https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack and http://nationalfgmcentre.org.uk/wp-content/uploads/2018/04/Legal-Factsheet-16.35.08.pdf.

What happened next?

The police were informed and CAIT (child abuse investigation team) attended ED to interview the girl. The duty social worker was informed and a MASH referral generated. A body map was completed. Our gynaecology colleagues came to review the wound and discharge. The wound was healing well and the discharge was in fact from an STD not the operation. The girl refused admission and given she was not at this time considered to be at risk of further abuse, the team were advised by the police that there was no basis for keeping her in hospital. She did agree to a follow up with gynaecology.

The National FGM centre has lots of very helpful resources available on their website including this info-graphic highlighting the health consequences from different types of FGM http://nationalfgmcentre.org.uk/knowledge-hub-resources/.



When is a burn a sign of child abuse?

A helpful paper has just been published to offer guidance on this tricky question:

Hollen L, Bennett V, Nuttall D, et al. Evaluation of the efficacy and impact of a clinical prediction tool to identify maltreatment associated with children's burns. *BMJ Paediatrics Open* 2021;**5**:e000796. doi:10.1136/e000796.full.pdf (bmj.com)

The authors developed a Burns Risk assessment for Neglect and maltreatment in children Tool (BuRN-Tool) as a clinical prediction tool for use in children presenting with burns.

They studied 2443 children. The 334 children with BT score ≥3 were five times more likely to be discussed with a senior clinician and more likely to have a safeguarding referral generated.

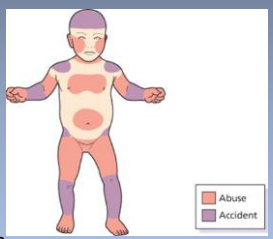
Burns Risk assessment of Neglect and maltreatment in children Tool – BuRN-TOOL

	Feature	Information	Score *(circle)* YES
1	Age	Less than five years old	Scald 2 / Burn 2
		Older than five years old	Scald 0 / Burn 1
2	Severity of injury	Is any of the Scald/burn defined as: • Full thickness (Dry, white or charred)?	2
3	Symmetry of the Scald	Did the Scald affect both sides of the body?	1
4	*Atypical location* for Scalds only: if uppermost location includes any of: *(Yes to any = 1)*	if uppermost location includes any of: • Back • Buttocks • Groin • Within the hair line It is classified as *Atypical*	1
5	Concern about supervision *(Yes to any = 1)*	• Are you concerned that there was NO appropriate adult supervision? • Was the child less than 5 years old and alone? (No adult in the vicinity)	1
6	Concern about an inappropriate explanation *(Yes to any = score of 2)*	• Are there concerns that the explanation is not consistent with stage of development? • Are there concerns that the explanation does not fit the scald pattern seen? • Is it a bath scald?	2
7	Previous/current SS/SW involvement? *(Yes to any = 3)*	Do any of the following apply to the child/family? • Child/family that currently has a social worker? • Child/family that has a social worker in the past?	3
		Total Score	
		Action to be taken	
	Score: 0-2	Tool does not indicate a child protection concern, HOWEVER IF YOU REMAIN CONCERNED following your assessment, please follow your department's Child Protection Pathway.	
	Score: 3-12	Tool indicates a child protection concern; please follow your Child Protection Pathway for escalating your concerns. (A higher score is indicative of a higher level of concern)	
	Discussed with Senior Colleague.	☐ Yes ☐ No	Who?
	Was a Child Protection Pathway Initiated?	☐ Yes ☐ No	
	Reason for action taken where this differs from that recommended by the BuRN-Tool.		

What do we know?

☛ Burns are common injuries in young children. 10-24% are associated with physical abuse or neglect. Neglect arising from lack of adequate supervision and lack of attention to safety in the home is more common than deliberate mistreatment.

☛ Children < 3 years presenting with a burn from any cause are 7 times more likely to suffer maltreatment by age 6 than children with no history of burns.



What does the paper add?

An evidence based tool encompassing age, severity of the burn, location, explanation given, previous involvement from CSC to help risk assessment.

Do you know the 4 key questions a child protection conference (CPC) focusses on?

1. What is working well in your family? **2.** What are the professionals worried about in relation to the children and family? **3.** What needs to happen to ensure the children are safe and well cared for in the future? **4.** What information is not agreed upon and needs to be clarified?

This video outlines what to expect at a CPC and is a helpful resource to share with families so that they know what it entails: https://chscp.org.uk/child-protection-conferences-3/