Paediatric Pearls Safeguarding issue

(Emergency Department update)

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Should you have child protection concerns in the Emergency Department.....

Think "is this non-accidental injury (NAI)?" in every case you see. It may seem a bit of a suspicious way to view parents but you have a responsibility as a care-giver working with children to consider whether they are safe at every encounter and it will only be a fleeting thought with most families you deal with. Ask the paediatric nurses for advice and refer to the paediatric registrar or myself if you have concerns. Don't ever think "is it worth the fuss?". Some of Victoria Climbie and Baby Peter's care-givers thought that; the government's 2009 reply to Lord Laming's progress report on implementation of his initial safeguarding recommendations can be found at http://publications.dcsf.gov.uk/eOrderingDownload/DCSF-Laming.pdf Our guideline is on the intranet accessible via paediatric or A and E pages; all you need do is refer to us and we will do the rest. Unless you strongly disagree with our assessment please leave the social work referral to us as well.

Training!

All staff, clinical and non-clinical, who come into contact with children should be able to recognise child abuse, document their concerns, know what to do and who to contact and understand the next steps of the safeguarding process. Contact our named nurse for safeguarding children, Teresa McLeary, if you have not yet had training (Level 1 is part of induction for ALL staff, level 2 has to be completed by the end of ST3 by ALL staff who come into contact with children (not just paediatricians) and updated every 3 years). You can log on to www.e-lfh.org.uk and do both levels 1 and 2 on-line.

FROM THE LITERATURE:

"Every year, about 4–16% of children are physically abused and one in ten is neglected or psychologically abused. During childhood, between 5% and 10% of girls and up to 5% of boys are exposed to penetrative sexual abuse, and up to three times this number are exposed to any type of sexual abuse. However, official rates for substantiated child maltreatment indicate less than a tenth of this burden."

Gilbert RE, Spatz Widom C, Browne K, Fergusson D, Webb E, Janson S. Burden and consequences of child maltreatment in high-income countries. Lancet 2008; published online Dec 3. DOI:10.1016/S0140-6736(08)61706-7.

A and E clinical question

Which fractures should I be suspicious about?

All fractures in a non-mobile child
Spiral fractures of the humerus
Multiple fractures, possibly of different ages
Any rib, spine or skull fractures with no history of significant trauma
Any fractures where the story does not fit the injury (a fall < 3 feet rarely produces a fracture.)

Further reading: Child Protection Companion, publ by RCPCH, London 2006. Essential reading and downloadable in full from www.rcpch.ac.uk

This month's featured NICE guideline: *When to suspect child maltreatment (CG89 issued July 2009)*

This guideline covers alerting features in people under the age of 18 years of **physical, sexual** and **emotional** abuse, **neglect** and **fabricated or induced illness**.

The alerting features are divided into those that lead one to *consider* maltreatment (within the differential diagnosis) and those which cause one to *suspect* maltreatment (a more serious level of concern but with no absolute proof). Examples are listed below with more available at www.nice.org.uk/nicemedia/pdf/CG89QuickRefGuide.pdf

PHYSICAL abuse: Consider with any serious or unusual injury with an absent or unsuitable explanation. Suspect with unusual shaped bruises or burns or injuries in non-bony areas of the face or body.

SEXUAL abuse: Consider where there is pregnancy in 13–15 year olds or 16-17 year olds where there is a clear power difference between young woman and putative father. Consider in anogenital warts or with a gaping anus with no history of a neurological disorder or constipation. Suspect where there are STIs in <13 year old and no evidence of vertical transmission, or where there is an anal fissure with no evidence of constipation or Crohn's disease.

EMOTIONAL abuse: Consider if the child is withdrawn, fearful, has low self-esteem or conversely is over-friendly to strangers and does not seek comfort from the appropriate person. Consider in deliberate self harm, encopresis and secondary enuresis. Suspect if the child is persistently stealing food or has sexualised behaviours or preoccupations.

NEGLECT: Consider if there are severe and persistent infestations (of eg. head lice), faltering growth, animal bites in an inadequately supervised child, persistent non-attendance at doctors' or dentists' appointments. Suspect if a child is persistently smelly or dirty or not seeking medical advice compromises the well-being of the child.