Paediatric Pearls Safeguarding issue

(GP update)

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Should you have child protection concerns....

We all have a responsibility as children's care-givers to act on any safeguarding concerns we have. 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 . GPs should link in with their regional designated doctor for safeguarding for both training and advice. In Waltham Forest this is* ***Dr Christine Sloczynska****, consultant community paediatrician based at Wood Street. In Redbridge contact . Children with injuries you are concerned about should be discussed with the on-call paediatric registrar. Non-urgent concerns should be referred directly to your local* ***children's social care*** *(previously called social services) department or to their out of hours service. You can discuss sexual abuse cases directly with* ***the Havens****, Whitechapel (0207 247 4787 24hrs.) and they will advise you on a case by case basis which referral route to take. Please ensure that you have easily accessible information on referral pathways for safeguarding with up to date contact details and please make sure that* ***your staff are trained and kept up to date****.*

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. GPs should have at least level 2 training and it needs updating 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.

GP clinical question

Is a yellowing bruise more than 3 days old?

Contrary to what we used to say and think, there is actually very little evidence that we can accurately age bruises with the naked eye and paediatricians in court will shy away from doing that. Recent studies demonstrate wide intra- and inter-observer variability both in-vivo and using photographs. It is more important to assess the shape and position of bruises in the light of the child's developmental stage and the history. Absence of bruising in a child you are worried about is no comfort either; up to 80% of children with rib fractures have no associated bruising.

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.