

HYWEL DDA UNIVERSITY HEALTH BOARD



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SAFEGUARDING CHILDREN AND YOUNG PEOPLE IN EMERGENCY DEPARTMENT/ OUT OF HOURS SERVICE PROCEDURE

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Brief Summary of Document:	This clinical procedure document is to help clinicians to identify early and respond to child abuse and neglect in emergency care settings.
Scope:	For the purpose of this procedure, the Children Act 1989 defines a child as being anyone who has not reached their 18 th birthday. The term child therefore includes “children” and “young people”. The fact that a child has become sixteen years of age, is living independently, or is in Further Education, or is a member of the Armed Forces, or is in hospital, or in a prison or young offenders institution does not change their status or their entitlement to services or protection under the Children Act 1989
To be read in conjunction with:	Social Services and Wellbeing (Wales) Act 2014 All Wales Child Protection Procedures (2008) (pending national update) 692 – Paediatric Admission Policy (pending approval)
Owning Committee	Strategic Safeguarding Sub Committee

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Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
0.2	New Policy	July 2014
0.3	Amendment to Appx 2	October 2014
1.0	Amendments as recommended by CPRG	13.05.15
2	Full review	25.7.2019

Glossary of terms

Term	Definition
CPR	Child Protection Register
CSA	Child Sexual Abuse
ED	Emergency Department
FGM	Female Genital Mutilation
FII	Fabricated or Induced Illness
FME	Forensic Medical Examiner
MIU	Minor Injuries Unit
OOH	Out of hours

Keywords	Safeguarding, Child Protection, Child Abuse, Child Sexual Abuse, CSA, Emergency Department, ED, Out of Hour Service, OOH
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1. INTRODUCTION

Safeguarding encompasses promoting the welfare of children, protecting children from maltreatment, preventing impairment of children's health or development, and ensures children grow up in safe circumstances. Child protection is part of safeguarding and refers to activities undertaken to prevent children suffering, or likely to suffer from significant harm.

Emergency Departments (ED) /Minor Injury Units (MIU) may be the first point at which children who have been subjected to abuse or neglect come into contact with health professionals who are able to act for their protection. Therefore, there is a clear need for health professionals to both protect children and young people who present with suspected abuse and/or neglect and retain an active role in seeking to prevent abuse. For children and young people who present to the hospital for injuries related to neglect or abuse, ED personnel may be their first contact and opportunity for initiating safeguarding procedures.

Abused children and young people have higher rates of ED attendance use before diagnosis compared to other patients, but do not necessarily have distinguishable features to identify them as a “high risk” population for screening (Guenther et al, 2009). Emergency Department teams are therefore required to rely on their clinical skills and judgment to identify signs and symptoms consistent with abuse.

Aside from the more common forms of abuse and neglect, those caring for children must also be trained to recognise other forms of abuse which may occur, such as child sexual exploitation (CSE), fabricated or induced illness (FII) gang-related and peer violence, human trafficking, domestic violence, forced marriage and crimes perpetrated in the name of honour. Similarly, undertaking training to recognise female genital mutilation (FGM) is vital in order to fulfil health professional's mandatory duty in England and Wales to report known cases of FGM in under 18-year-olds to the police (WHC, 2015).

Further to the above, the Home Office recommends that all professionals interacting with children undertake 'Prevent' training that aims to safeguard vulnerable people from being radicalised to supporting terrorism or becoming terrorists themselves (HMG, 2015).

Staff should be particularly aware of families with complex and multiple problems. Parental factors such as substance misuse, domestic abuse and mental health problems can indicate that children living under these circumstances are at an increased risk of harm (Adverse Childhood Experiences (ACE) Study, 2015).

All health care organisations are legally required to make arrangements to safeguard and promote the welfare of children and young people, and to co-operate with other agencies to protect individual children and young people from harm. Essential guidance for staff working in emergency settings includes the NICE guidance *Child maltreatment: when to suspect maltreatment in under 18s* (NICE, CG89, updated Oct. 2017), the General Medical Council (GMC, 2018) child protection guidance and the RCPCH *Child Protection Companion*.

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2. SCOPE

This procedure applies to all staff working within Emergency Departments, Minor Injury Units (MIU) and OOH.

The Children Act 1989 defines a child as being anyone who has not reached their 18th birthday. The term child therefore includes “children” and “young people”. The fact that a child has become sixteen years of age, is living independently, or is in Further Education, or is a member of the Armed Forces, or is in hospital, or in a prison or young offenders institution does not change their status or their entitlement to services or protection under the Children Act 1989.

However, for the purpose of this procedure, the principles of referring to a Consultant Paediatrician will apply as follows.

- Referrals will be accepted for children who are between the ages of 0 to 15 years of age inclusive. (15 years and 364 days).
- Children with complex health needs already under the care of a paediatrician with shared tertiary care will be admitted up to their 16 years of age inclusive (16 years and 364 days) provided the child's presenting complaint relates to their ongoing condition.
- Child protection medicals will be performed following safeguarding policies up to their 15 years of age inclusive (15 years 364 days).

3. AIM

This clinical procedure document is developed to help clinicians, nurses and other health professionals to detect and respond to child abuse and maltreatment in emergency care settings.

Doctors, nurses and health professionals working in Emergency/MIU and Out of Hours Departments (OOH) must understand their responsibilities regarding safeguarding children and work within the principles and standards outlined in the All Wales Child Protection Procedures (2008).

Training and other professional development opportunities are available in Hywel Dda University Health Board (HDUHB) so that doctors, nurses and other health professionals are knowledgeable, reflective, confident and competent in relation to safeguarding children practice

4. CHILD WELFARE PRINCIPLE AND CHILDREN RIGHTS

The United Nations Convention of the Rights of the Child (Article 19) states that all children have a right to be protected from ‘all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.’

All professionals should consider the child's welfare as the paramount consideration and always act in a child's best interests. Children are best protected when professionals are clear about their role and responsibilities.

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All practitioners must act on any concerns they have about safety or welfare of a child and it is vital that all practitioners have the confidence to act if they believe that a child may be being abused or neglected.

Taking action will be justified, even if it turns out that the child is not at risk of, or suffering, abuse or neglect, as long as the concerns are honestly held and reasonable, and the practitioner takes action through appropriate channels.

This procedure is developed on the basis that it is child centred. The importance of early recognition, that safeguarding is everyone's responsibility, the need to share information and contribute to safeguarding plans in a timely way to help children and young people who have been or are at risk of abuse, to have very good outcomes.

GMC Guidance Protecting Children and Young People (updated May 2018) clearly directs that all children have a right to be protected from abuse and neglect – all practitioners have a duty to act on any concerns they have about the safety or welfare of a child. All practitioners must consider the needs and well-being of children – this includes practitioners who treat adult patients.

Children, young people and their families have a right to receive confidential medical care and advice – but this must not prevent practitioners from sharing information if this is necessary to protect children and young people from abuse or neglect.

5. FRAMEWORK

This Procedure should be read in conjunction with

- Children Act 2004
- All Wales Child Protection Procedures 2008 (AWCPP) (pending national update)
- Facing the Future: Standards for Children in Emergency Care Settings
- Child Protection Procedures in Emergency Departments (P.Sidebotham, T.Biu, and L.Goldsworthy Emerg Med J. 2007 December; 24(12): 831–835
- Social Services and Well-being (Wales) Act 2014
- CYSUR Regional Threshold Document; 'The Right Help at the Right Time' (2017).

6. ROLES & RESPONSIBILITIES

It is crucial that all staff in Emergency Departments/MIU and urgent care settings can identify children and young people who are or may be at risk of abuse or neglect. Identification involves the early recognition of vulnerable children and young people, targeting support for the most vulnerable and being clear about how and where help can be accessed. Additionally, all health staff must be able to follow the AWCPP (2008) on what to do when abuse or neglect is suspected. Staff must also be prepared to reflect on interactions with children and young people and amend practice to ensure a child-focused approach.

Child protection is everyone's responsibility. All staff must be able to act on their concerns. Staff must know who to contact if they have concerns about possible abuse or neglect.

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Each Emergency Department/MIU/OOH Services should identify a Lead for safeguarding children, who will be responsible for:

- Advice and support to staff on safeguarding children issues within the department.
- Monitor the implementation of national and local policies & procedures within the department in relation to safeguarding children.
- Liaise with internal and external agencies on safeguarding children matters.
- Monitor safeguarding children training needs and compliance within the department.
- Liaise with the audit & clinical governance lead within the Emergency Department/MIU/OOH Services to ensure quality and safety issues are assured.

The Emergency Department/MIU/OOH Services will have 24/7 access to a consultant paediatrician via the most senior clinician in the department and / or ED Consultant on call for advice and support for the protection of children and young people. In addition to this, the Health Board safeguarding children team will also provide advice and support on individual cases, safeguarding supervision and training.

Staff must facilitate effective communication between themselves, the patient and any accompanying adults by ensuring appropriate interpretation/translation facilities are in place to meet the needs of people presenting with communication difficulties in relation to language/sensory loss/cognitive impairments.

Staff are expected to apply the same professional standards across all protected characteristics and be sensitive with regard to issues of culture, disability, gender, language, language, racial origin, religion/belief, sexual orientation and/or sexual identity.

7. TRAINING & SKILLS

All staff working with children and young people must be appropriately skilled and trained in safeguarding to provide a high quality service to this vulnerable group of children.

The Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document (ICD 2018) clearly specifies the standards for all staff working in the Emergency Department/MIU/OOH Services. In order to achieve and maintain this quality standard, it is important for the appraisers to specifically target this quality standard during the annual appraisal of the medical and nursing staff.

The core Level 3 Safeguarding Children Training is the basic standard that is required for all medical and nursing staff working within the Emergency Department/MIU and OOH and must be updated every 3 years. In addition to the Level 3 Safeguarding Children Training provided within the Health Board, other training opportunities can be accessed through local or national training events to ensure compliance with the ICD (2018). Over a three-year period, professionals should be able to demonstrate refresher education, training and learning equivalent to a minimum of eight hours for those requiring Level 3 core knowledge, skills and competencies.

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All identified staff members should ensure that they are trained in Child Sexual Exploitation (CSE), Female Genital Mutilation (FGM) Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV), Modern Slavery and Extremism so that they are able to recognise, act and/or seek advice regarding these situations with confidence as and when they arise in the ED/MIU/ OOH and help children, young people and their families.

8. STANDARDS

Standards	Metrics
1. All staff who regularly look after children must have up to date Level 3 Safeguarding Children Training.	Staff training logs demonstrating compliance. ESR
2. All Emergency Departments / MIU nominate a lead consultant and a lead nurse responsible for safeguarding	Evidence of a lead consultant and a lead nurse is included within the service Standard Operating Procedure document
3. All Emergency Departments/MIU settings have guidelines for safeguarding children	Evidence that guideline is available and accessible
4. All staff in emergency care settings are able to access child protection advice 24 hours a day from a paediatrician with child protection expertise	Evidence of access within the Paediatric rota
5. Information from the Child Protection Plan is available to staff in emergency care settings	Evidence of how and when to access duty social worker is included in the Standard Operating Procedure document
6. Systems are in place to identify children and young people who attend frequently	Electronic system that records attendance frequency
7. The primary care team, including GP and Health Visitor/School Nurse and named social worker, are informed, within an agreed timescale, of each attendance by a child on the child protection register or where there is a new safeguarding concern.	Evidence that discharge summaries are sent to the GP and Health Visitor/School Nurse and named social worker
8. A review of the notes is undertaken by a senior doctor or nurse when a child leaves or is removed from the department without being seen	Case note audit
9. When treating adults, staff must recognise the potential impact of a parent's or carer's physical and mental health on the wellbeing of dependents, and take appropriate action, including when domestic abuse is suspected	Evidence is included in induction and training

9. IDENTIFICATION

There is currently no evidence that any screening tools help in the identification or management of child abuse. Staff should be reminded that the information units in appendix 1 (21) act as an aide-memoir and should not exclude clinical acumen. Staff can access NICE Guidelines (NG 76) on Child Abuse and Neglect.

If there are sufficient safeguarding/child protection concerns, it is important to discuss with the senior clinician / nurse and make appropriate decisions as to the subsequent management of the child.

Whenever there are significant child protection concerns, it is very important to check the child protection register by contacting Social Service Department (during in-hours) and Dyfed Powys Police or the on-call duty social worker during out of Hours (via switchboard).

Non mobile babies pose significant vulnerabilities. When they present with bruising or minor injuries, protecting them from significant harm is of paramount importance to both baby and the clinician. They must not be discharged from ED, OOH or MIU without consultation with a Consultant Paediatrician. A policy for the management of non mobile children is in development.

10. CHILD PROTECTION REGISTER:

The presence of a child's name on the child protection register, or any other database, should not be used as an indicator of risk, nor should it be used as the sole basis for decision making in relation to possible concern. It is nevertheless an important piece of information that may or may not be directly relevant to the presentation.

11. REFERRAL PROCESS

Suspicion about child abuse may take the form of 'concerns' rather than 'known facts'. Child welfare concerns can arise in many different contexts, including when a child is already known to Local Authority Children's services.

Concerns can and must be shared with Local Authority Children's Services through a Multi-Agency Referral Form (MARF). While concerns will not necessarily trigger an investigation, they help to build up a picture, along with concerns from other sources, which suggests that a child may be suffering harm.

Where there is concern surrounding the history and/or nature of the injury or condition the child must be discussed with a senior practitioner in the Emergency Department/OOH/MIU Services as soon as possible.

If the nurse has significant child protection concerns about a child, the nurse must discuss the concerns with the doctor immediately, prior to the doctor seeing the patient and document their concerns clearly.

If, following discussion with a senior clinician in ED, when significant concerns in a child up to 15 yrs and 364 days persist, the senior clinician in ED may discuss with

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the on call Consultant Paediatrician for advice as soon as possible regarding further assessment and management.

In a child / young person aged over 16 yrs, the senior clinician / nurse in ED must contact the ED Consultant.

The practitioner who identified concerns in ED must refer the child to Local Authority Children's Services in line with the All Wales Child Protection Procedures (2008). This is done using the Multi-Agency Referral Form (MARF) electronically, within 24 hours. This form may also be downloaded from the HBUHB intranet Safeguarding Children's website. Professionals must contact their line manager/safeguarding lead if they require advice/guidance. Staff can telephone a referral and follow up with MARF as per All Wales Child Protection Procedures (2008).

If there is a difference in opinion between the nurse and the medical staff, whoever has safeguarding/child protection concerns may discuss independently with on call Consultant Paediatrician as well or the Safeguarding Children Team Monday – Friday 09.00 – 17.00 hrs. The practitioner in the Emergency Department must also do a referral to Local Authority Children's Services as soon as possible via the MARF.

When a situation arises where immediate protection of a child arises, refer to All Wales Child Protection Procedures (2008). Also refer to Flow chart p.19

Referrals must be made to Local Authority Children's Services as soon as a problem, suspicion or concern about a child becomes apparent, and certainly **within 24 hours**. Referrals can be made via telephone and followed up with a MARF

Outside office hours, referrals must be made to the Local Authority emergency duty service or the police.

It is the responsibility of the Local Authority duty social worker/duty social work team manager to inform a referrer of action being taken within a maximum of 7 working days. If no information is received within this time, the referrer must contact the Local Authority Children's Services department to ascertain the outcome of the referral.

12. SUBSEQUENT MANAGEMENT

If a child up to 15 yrs and 364 days needs admission to a ward, the senior doctor in Emergency Department must discuss this with the Consultant Paediatrician at the earliest opportunity and refer the child to be admitted under paediatric care.

If a young person aged 16 yrs and over requires admission to a ward, the senior doctor in the Emergency Department must discuss this with the relevant speciality consultant.

The nurse who is responsible for the care of the child in the Emergency Department/OOH/MIU Services will be responsible for

- Informing and updating the nurse in charge of the shift of any concerns regarding the child.
- Liaising with the nurse in charge on the paediatric ward.

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- Informing the Health Board Safeguarding Children team via the duty desk 01267 674116 (0900-17.00 Mon-Fri).

The doctor in the Emergency Department/OOH/MIU Services must hand over to the on-call paediatrician / clinician.

This must be documented clearly in both Emergency Department and child's in-patient records.

If any referral has been made to Local Authority Children service or police, this should be clearly stated in the documentation as to:

- What was discussed by whom and when?
- What decisions were made?
- What action needs to be taken by whom and when?
- Any further follow-up arrangements to be done?

13. EFFECTIVE COMMUNICATION

Decisions about child protection are best made with others – consulting with colleagues and other agencies that have appropriate expertise will protect and promote the best interests of children and young people.

All Emergency Department/OOH/MIU Services attendances must be notified to the child's primary care team.

If there are minor concerns or the practitioner is unsure that there is a child protection issue for a child attending the Emergency Department/OOH/MIU Services, they must be notified to the Local Authority Safeguarding children services, the next working day. Parents must be informed of the referral.

Staff must be encouraged to share concerns with other agencies, to respond to requests for information in relation to child protection, and to question other professionals where there are differences in opinion.

Concerns about possible child abuse or neglect should normally be shared openly with the parents or carers unless to do so might further increase the risk to the child, or could compromise any criminal investigation.

14. CHILD SEXUAL ABUSE (CSA)

14.1. When should you be concerned?

Children who have been sexually abused may present in many ways. Some children make clear disclosures of recent or historic sexual abuse and others may present with concerning signs or symptoms. Some will be referred by social workers as part of section 47 enquiries.

14.2. Alerting features

Alerting features that should prompt you to consider or suspect CSA are described in NICE guidance: 'When To Suspect Child Maltreatment' see appendix 1, **A7** pp 39-41. <https://www.nice.org.uk/guidance/cg89/evidence/full-guideline-pdf-243694625>

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14.3. What should you do?

Once concerns regarding CSA have arisen in the Emergency Department/OOH/MIU Services, the case must be discussed with the senior clinician and nurse in the ED who must discuss this with the relevant Local Authority Childrens Services (during in-hours) and Dyfed-Powys Police or the Local Authority on-call duty social worker during out of Hours (via switchboard). Advice can also be sought from with the Consultant Paediatrician on call.

14.4. In acute cases

In acute cases, the immediate health needs of the child are paramount and must not be neglected in the absence of a paediatrician with appropriate skills. In this situation, key issues to identify include:

- Management of acute trauma; such as bleeding or urinary retention
- Emergency contraception
- Post Exposure Prophylaxis following Sexual Exposure (PEPSE) for HIV, Hepatitis B and bacterial infections – this should be dealt with by sexual health services

14.5. Child protection procedures:

Referrals must be made to Local Authority Childrens services as soon as a problem, suspicion or concern about a child becomes apparent, and certainly **within 24 hours**.

Outside office hours, referrals must be made to the Local Authority emergency duty social worker or the police.

In cases of historic/non-acute abuse, the child must be referred to the relevant Local Authority Children's Services Department.

14.6. HDUHB Interim position for Child Sexual Abuse Examinations

This approach will take effect immediately whilst Hywel Dda University Health Board in conjunction with partner agencies looks at revising the existing Child Sexual Abuse Medical Examination arrangements.

For children and young people aged 13 years and above who require Child Sexual Abuse Medical examination, Dyfed Powys Police should request that a medical examination be conducted by a Forensic Medical Examiner (FME).

The Paediatric team will not accompany the FME for Child Sexual Abuse Medical Examinations for children aged 13 years and above.

The Paediatric team will respond to requests for Child Protection Medical Examinations as per the All Wales Child Protection Procedures (2008).

Children under 13 years of age should receive their examination in the Cardiff SARC Centre out of hours.

This is in line with practice that is taking place in Cardiff and Swansea areas.

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It is further requested that Dyfed Powys Police confirm that FME's currently deployed make referrals to Sexual Health Services for sexual health assessments

Hywel Dda Sexual Health Central Booking and Advice Line 01267 248674
(Monday- Friday 9.15am-4.30pm)

15. CONTACTS

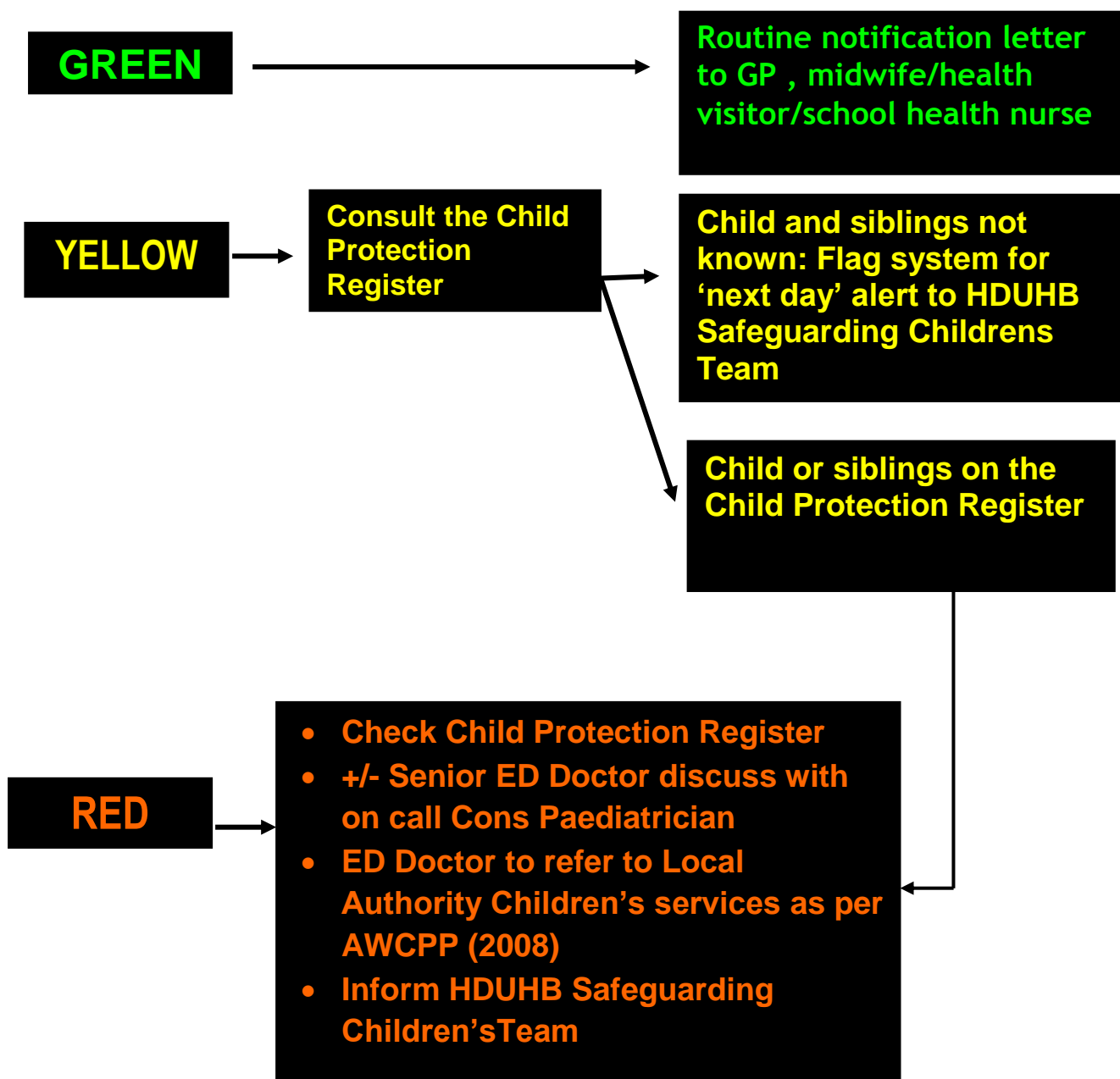
If you are concerned about a child contact in hours, contact the Health Board Safeguarding Children Team: Tel: 01267 674116

LOCAL AUTHORITY CHILDREN SERVICES CHILD ASSESSMENT TEAMS

COUNTY	TELEPHONE IN-HOURS	TELEPHONE OUT OF HOURS	E-MAIL
Carmarthenshire	01554 742322	01558 824283 0300 333 2222	CRTChildren@carmarthenshire.gov.uk
Ceredigion	01545 574000	0845 6015392	Contact-socservices@ceredigion.gov.uk
Pembrokeshire	01437 776444	08708 509508	CCAT@pembrokeshire.gov.uk
Powys	01597 827666	01597 827666	people.direct@powys.gov.uk
POLICE	101		

16. INDIVIDUAL CASES AFTER ASSESSMENT OF THE CHILD, ESTABLISH LEVEL OF CONCERN

GREEN = No Concern
YELLOW = Minor concern or not sure
RED = More than minor concern, need further advice



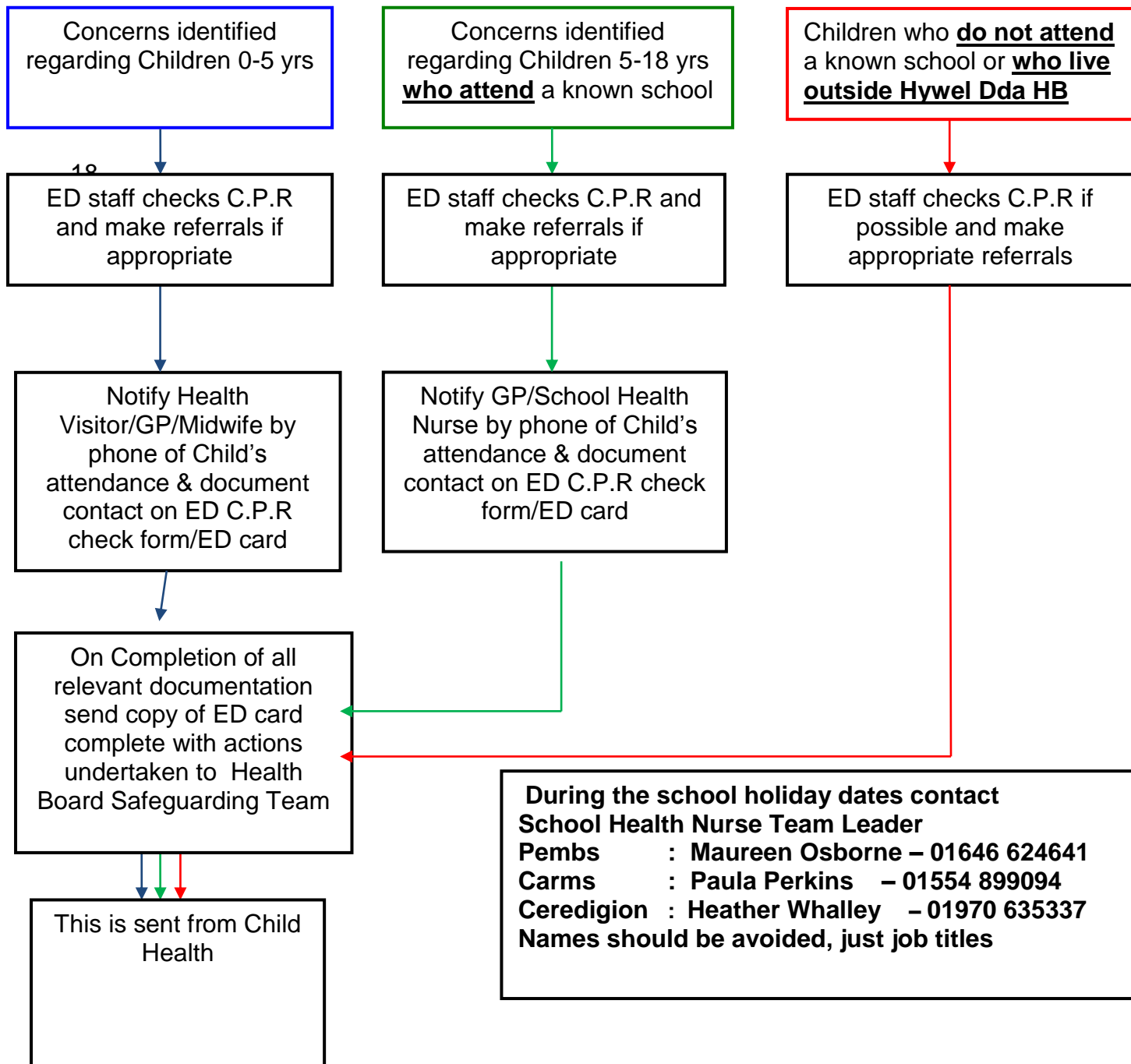
17. ED/MIU/OOH SERVICES SAFEGUARDING CHILDREN INFORMATION SHARING PROCESS

(Guidance for ED/MIU/OOH staff to follow when Safeguarding concerns have been identified within the A & E/MIU Department)

0-5 years 18years

5-18 years

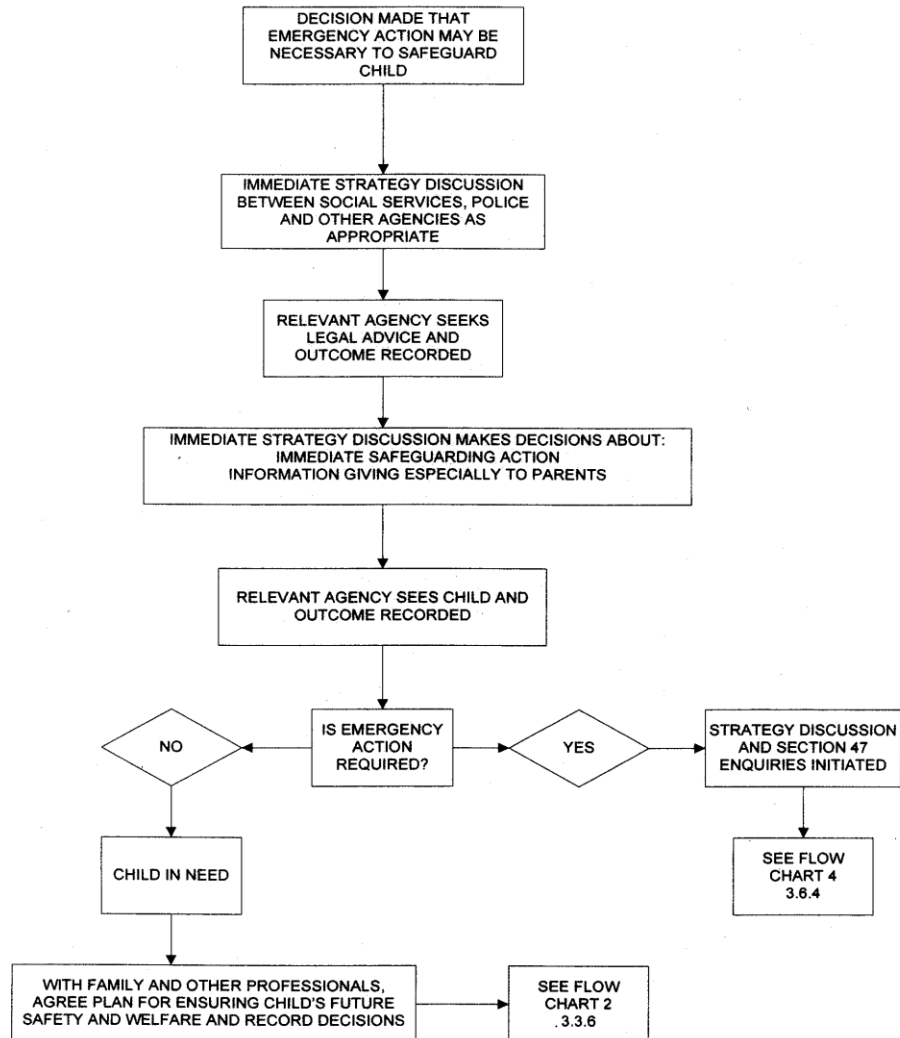
0-



18. AWCPP FLOWCHART

All Wales Child Protection Procedures 2008

3.6.3 Flow chart 3: Urgent action to safeguard children



19. REFERENCES AND FURTHER INFORMATION:

1. Adverse Childhood Experience (ACE) Study (2015)
<http://www.wales.nhs.uk/sitesplus/888/page/88524>
2. All Wales Child Protection Procedures (2008)
<http://www.awcpp.org.uk/areasofwork/safeguardingchildren/awcpprg/index.html>
3. Child protection procedures in emergency departments P Sidebotham, T Biu, L Goldsworthy. *Emerg Med J* 2007;**24**:831-835 doi:10.1136/emj.2007.051011.
4. Children Act (1989) <http://www.legislation.gov.uk/ukpga/1989/41/contents>
5. Children Act 2004 <http://www.legislation.gov.uk/ukpga/2004/31/contents>
6. CORE-INFO leaflets:
http://www.nspcc.org.uk/Inform/trainingandconsultancy/learningresources/coreinfo/coreinfo_wda54369.html
7. CYSUR (2017) CYSUR Regional Threshold Document; 'The Right Help at the Right Time'
8. Guenther E, Olsen C, Keenan H, Newberry C, Dean JM, Olson LM. Randomized prospective study to evaluate child abuse documentation in the emergency department. *Acad Emerg Med*. 2009; 16:1–9.
9. GMC (2012) <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/protecting-children-and-young-people>
10. GMC (2018) Protecting Children and Young People https://www.gmc-uk.org/-/media/documents/protecting-children-and-young-people---english-1015_pdf-48978248.pdf
11. HMG (2015) Revised *Prevent Duty Guidance*: for England and Wales
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance_England_Wales_V2-Interactive.pdf
12. ICD (2018) Safeguarding Children and Young People: Roles and Competences for Health Care Staff Intercollegiate Document.
13. Leaman A M , Holt A, R G Pummi Ramakrishnan Emergency Department attendance by children at risk of abuse *Emerg Med J* 2010 **27**: 26-28
http://www.gmc-uk.org/guidance/ethical_guidance/13257.asp
15. NICE guideline NG 76 Child abuse and neglect
<https://www.nice.org.uk/guidance/ng76/resources/child-abuse-and-neglect-pdf-1837637587141>

16. NICE guideline CG89 When to suspect child maltreatment:
<http://www.nice.org.uk/nicemedia/live/12183/44914/44914.pdf>
17. NSPCC Publications & Learning Resources:
http://www.nspcc.org.uk/inform/trainingandconsultancy/learningresources/learningresources_wda47881.html
18. RCPCH (2018) Facing the Future: Standards for Children in Emergency Care Settings (2018) https://www.rcpch.ac.uk/sites/default/files/2018-06/ftf_emergency_standards_digital_-_website_version.pdf
19. RCPCH Child Protection Companion
<https://www.rcpch.ac.uk/resources/child-protection-companion-about>.
20. RCPCH Child Protection Evidence Systematic Review Group:
<https://www.rcpch.ac.uk/key-topics/child-protection/evidence>
21. Social Services and wellbeing (wales) Act (2014)
http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf
22. The College of Emergency Medicine Professional Standards in Safeguarding Children <http://www.collemergencymed.ac.uk/Shop-Floor/Professional%20Standards/Further%20Resources/Safeguarding%20Children>
23. United Nations (1989) https://downloads.unicef.org.uk/wp-content/uploads/2010/05/UNCRC_united_nations_convention_on_the_rights_of_the_child.pdf?_ga=2.8834230.202239503.1557486946-1684172814.1557486946
24. WHC (2015) 051- Mandatory Reporting Duty for Female Genital Mutilation in England and Wales.
<http://howis.wales.nhs.uk/sitesplus/documents/862/051%20-%20Female%20Genital%20Mutilation.pdf>

20. APPENDIX 1

INFORMATION UNITS

Definitions of terms used in this guidance

The alerting features in this guidance have been divided into two, according to the level of concern, with recommendations to either 'consider' or 'suspect' maltreatment.

Consider

For the purposes of this guidance, to consider child maltreatment means that maltreatment is one possible explanation for the alerting feature or is included in the differential diagnosis.

Suspect

For the purposes of this guidance, to suspect child maltreatment means a serious level of concern about the possibility of child maltreatment but is not proof of it.

Unsuitable explanation

For the purposes of this guidance, an unsuitable explanation for an injury or presentation is one that is implausible, inadequate or inconsistent:

- with the child or young person's
 - presentation
 - normal activities
 - existing medical condition
 - age or developmental stage
 - account compared to that given by parent and carers
- Between parents or carers
- Between accounts over time.

An explanation based on cultural practice is also unsuitable because this should not justify hurting a child or young person.

Using this guidance

If a healthcare professional encounters an alerting feature of possible child maltreatment that prompts them to consider, suspect or exclude child maltreatment as a possible explanation, it is good practice to follow the process outlined below:

1. Listen and observe

Identifying or excluding child maltreatment involves piecing together information from many sources so that the whole picture of the child or young person is taken into account. This information may come from different sources and agencies and includes:

- any history that is given
- report of maltreatment, or disclosure from a child or young person or third party[3]
- child's appearance
- child's behaviour or demeanour
- symptom
- physical sign
- result of an investigation
- interaction between the parent or carer and child or young person.

2. Seek an explanation

Seek an explanation for any injury or presentation from both the parent or carer and the child or young person in an open and non-judgemental manner.

Disability

Alerting features of maltreatment in children with disabilities may also be features of the disability, making identification of maltreatment more difficult.

Healthcare professionals may need to seek appropriate expertise if they are concerned about a child or young person with a disability.

3. Record

- Record in the child or young person's clinical record exactly what is observed and heard from whom and when.
- Record why this is of concern.

At this point the healthcare professional may consider, suspect or exclude child maltreatment from the differential diagnosis.

4. Consider, suspect or exclude maltreatment

Consider

At any stage during the process of considering maltreatment the level of concern may change and lead to exclude or suspect maltreatment.

When hearing about or observing an alerting feature:

- Look for other alerting features of maltreatment in the child or young person's history, presentation or parent– or carer–interaction with the child or young person now or in the past.

Then do one or more of the following:

- Discuss your concerns with a more experienced colleague, a community paediatrician, child and adolescent mental health service colleague, or a named or designated professional for safeguarding children.
- Gather collateral information from other agencies and health disciplines, having used professional judgement about whether to explain the need to gather this information for an overall assessment of the child.
- Ensure review of the child or young person at a date appropriate to the concern, looking out for repeated presentations of this or any other alerting features.

Suspect

If an alerting feature or considering child maltreatment prompts a healthcare professional to suspect child maltreatment they should refer the child or young person to children's social care, following All Wales Child protection Procedures via MARF.

This may trigger a child protection investigation, supportive services may be offered to the family following an assessment or alternative explanations may be identified.

Exclude

Exclude maltreatment when a suitable explanation is found for alerting features. This may be the decision following discussion of the case with a more experienced colleague or after gathering collateral information as part of considering child maltreatment.

5. Record

Record all actions taken in 4 and the outcome.

A1 BRUISES

A1.1 What do we know about bruising?

- 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.
- 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.

A1.2 Where would you expect to see bruising from an accidental injury?

- The shins and the knees are the most likely places where children who are walking, or starting to walk, get bruised.
- Most accidental bruises are seen over bony parts of the body – such as the knees and elbows – and are often seen on the front of the body.
- Infants who are just starting to walk unsupported may bump and bruise their heads – usually the forehead, nose, and center of their chin or back of the head.
- It is common to have fractures, particularly rib or metaphysical fractures, without any bruising.
- Accidental bruising in children with disability is related to the child's level of mobility, equipment used, muscle tone and learning ability.

A1.3 When should you be concerned?

There are some patterns of bruising that may mean physical abuse has taken place.

- Abusive bruises often occur on soft parts of the body – such as the abdomen, back, buttocks, ears, neck, genitalia and hands.
- The head is by far the commonest site of bruising in child abuse.
- Other common sites include the ear and the neck.

- As a result of defending themselves, abused children may have bruising on the forearm, upper arm, back of the leg, hands or feet.
- Clusters of bruises are a common feature in abused children. These are often on the upper arm, outside of the thigh, or on the body.
- Bruises which have *petechiae* (dots of blood under the skin) around them are found more commonly in children who have been abused than in those injured accidentally.
- Abusive bruises can often carry the imprint of the implement used or the hand.
- Non-accidental head injury or fractures can occur without bruising.
- Severe bruising to the scalp, with swelling around the eyes and no skull fracture, may occur if the child has been “scalped” – i.e., had their hair pulled violently.

A2 Bites (refer to p24)

- Suspect child maltreatment if there is a report or appearances of a human bite mark that is thought unlikely to have been caused by a young child.
- Consider neglect if there is a report or appearance of an animal bite on a child who has been inadequately supervised.

A2.01 The features which suggest that a skin lesion on a child is a bite include the following:

- An annular appearance of the lesion made by two opposing concave arcs
- Irregularities within the arc secondary to individual tooth characteristics
- A central ecchymotic area within the bite mark can occur
- Individual characteristics within the bite mark can be further analysed by forensic dentists to assist in identifying or excluding perpetrators

A2.02 Implications for practice

- A human bite on a child should be suspected if there are any 2-5cm oval / circular injury, with a circumscribed annular border, with or without central ecchymosis

- Any suspicious lesion must have photographs taken with a right-angled measuring device and these need to be taken in each plane if the injury is on a curved surface
- Early referral of suspicious injuries to forensic dentists is mandatory to enable possible identification of a specific perpetrator

A3 Lacerations (cuts), abrasions and scars

- Suspect child maltreatment if a child has lacerations, abrasions or scars and the explanation is unsuitable. Examples include lacerations, abrasions or scars:
 - on a child who is not independently mobile
 - that are multiple
 - with a symmetrical distribution
 - on areas usually protected by clothing (for example, back, chest, abdomen, axilla, genital area)
 - on the eyes, ears and sides of face
 - on the neck, ankles and wrists that look like ligature marks.

A4 THERMAL INJURIES

A4.01 What do we know about scalds in children?

- A child will be scalded far more quickly than an adult. It takes only one second for a child to sustain a scald when exposed to liquid at 60°C (the average hot water setting in British homes is 55°C).
- A scald will cause immediate and severe pain.

A4.02 What are the features of accidental scalds in children?

- Accidental scalds usually occur as “spill injuries”, where a toddler reaches out and pulls a hot drink or cooking liquid over themselves.
- This typically leads to a scald affecting the upper trunk, face and/or arms.
- The scald usually has an irregular edge, is variable in depth and deepest at the initial point of contact.
- Children may accidentally scald themselves from hot flowing water, by turning on the hot tap in a sink or bath for example. In this case too, the scald is generally asymmetrical with an irregular edge, and usually involves the limbs.

A4.03 What are the features of intentional scalds in children?

Most research in this field deals with scalds that require hospital admission.

- Intentional scalds from hot tap water usually affect the back or lower limbs with or without the buttocks or perineum. Intentional scalds are often bilateral and symmetrical.
- They may also affect both arms and/or both legs in a “glove” or “stocking” manner.
- Characteristically, there is a clear upper limit to the scalded skin area, which is of uniform depth.
- Burns include scalds from hot liquids, contact burns from hot objects (such as an iron), burns caused by flames, chemical and electrical burns.
- Most burns are accidental. It is estimated that of the children admitted to burns units, 10-14 per cent sustain burns that are the result of abuse.
- Burns due to neglect outnumber intentional burns by a ratio of nine to one.

If a practitioner suspects that a child has sustained a significant burn they should always seek the attention of a burns specialist.

A4.04 What are the features of accidental burns on children?

- Toddlers sustain accidental contact burns when they reach out and grab hot objects. These burns are typically on the *palm of the hand*, and are *often a single burn*.
- Hair straighteners may leave a burn on each side of the hand or ankle. A small child may pull the flex of a hot object, such as an iron, down on themselves. Again, this is likely to cause a single burn on an exposed area of skin, or at most two burn areas. The edge may not be well demarcated if the skin has only had a glancing contact with the object.

A4.05 What are the features of intentional burns on children?

- Intentional contact burns are frequently multiple. They have a clearly demarcated edge, and the shape may match that of the implement used – e.g. the grid of a hairdryer or iron.
- Burns involve areas of the body other than the hands for example the back, shoulders or buttocks.
- Cigarette burns are very commonly described as intentional burns, though there is no study in the current scientific literature which sets out to distinguish between intentional and accidental cigarette burns.

- Several case reports describe intentional cigarette burns on the hands or trunk of the children. These may be multiple, circular in shape with a central cratered lesion one to two millimetres in width and of uniform depth. There is no detail in the literature on the features of accidental cigarette burns on children.
- Intentional immersion scalds may not affect the skin behind the knee, in the crook of the elbow or the central part of the buttocks: the limbs may be bent at the time of immersion or the buttocks may press against the surface of the bath, which is cooler than the liquid the child is immersed in.
- Intentional scalds may be accompanied by other intentional injuries or signs of neglect. Fractures which are not clinically apparent (occult fractures) may be detected on skeletal x-ray images.

We know very little about the incidence and characteristics of less serious intentional scalds.

A4.06 What social/historical features are associated with intentional scalds?

- Previous child abuse or domestic abuse
- A trigger event such as minor misbehaviour by the child, or a toileting accident.
- Previous burns or repeated previous hospital attendance for accidental injuries.
- A sibling blamed for causing the scald.

A4.07 What other intentional burns and scalds may a child be subjected to?

- There are case reports of small infants who have been burned by boiling oil, put in the microwave, held in flames, had acid poured into their ears or been burnt with other caustic substances.
- These burns are usually very deep and may be extensive, and are found on unusual parts of the body.

A4.08 Traditional remedies using heat

- Intentional burns may be inflicted on a child as part of a cultural belief or traditional remedy. This is particularly common in areas of south-east Asia. Such treatments include moxibustion – burning the moxa herb under a glass over the part of the body that is affected to draw out the illness.
- Other remedies include cupping, which causes superficial circular burns, usually found on the back, and the rubbing of bruised skin with a hot, freshly boiled egg, which can cause a superficial burn.

- Hypersensitivity reactions reactions eg, to detergents, laxatives or cetirimide shampoo.

A4.09 Conditions that mimic intentional burns

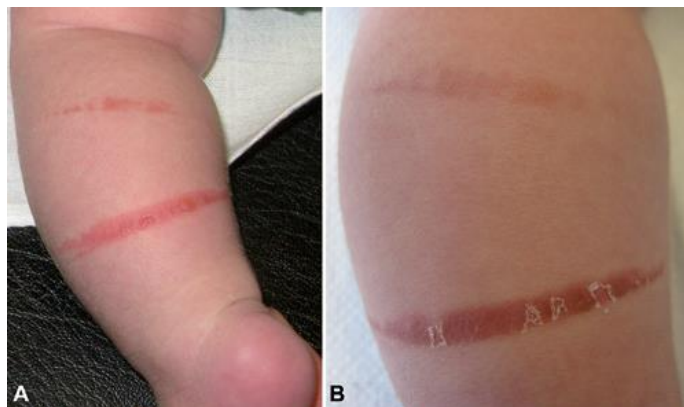
Accidental caustic burns

These may occur, and parents may be unaware of the cause. One example was a child who had an extensive caustic burn to the buttocks. On examining the child's clothing and car seat, it became apparent that it had been caused by leaking batteries. In these circumstances, the caustic material may not cause pain immediately. It is essential with unexplained burns to examine the child's clothing and establish what happened over the previous 24 hours

A4.10 Skin conditions

Many skin conditions may mimic burns. These include:

- *Photodermatitis* – a blistering skin condition caused by a combination of a chemical and sunlight. This can occur where perfume or plant oils, such as those found in citrus fruit, wild parsnip and other wild plants are present on the skin and the child is subsequently exposed to sunlight. Gradual reddening of the skin occurs, followed by a blistering rash over the affected area. This will often appear out of the blue, and it is essential to take a detailed history.
- *Skin diseases* such as impetigo, where the rash is usually scaly (unlike a burn) and may spread to other areas of the skin, particularly where two areas of skin touch one another – e.g., the inside of the arm and the side of the chest.
- *Hereditary skin disorders* such as congenital curvilinear hyperpigmentation, causing a loop-like raised area of skin on the back of the calves (see fig below.)



A5 FRACTURES:

A5.01 Fractures are a normal part of growing up

- Accidental fractures are common in children: up to 66 per cent of boys and around 40 per cent of girls will sustain a fracture by their 15th birthday.
- 85 per cent of accidental fractures are seen in children over five years of age. However, they can also be indicative of abuse.
- Abusive fractures indicate a serious assault on a child.

A5.02 What do we know about fractures in child abuse?

- Fractures occur in a significant proportion of physically abused children; studies record figures ranging from 11-55 per cent.
- 80 per cent of these fractures are in children under 18 months.
- Any bone in the body can be broken as a result of child abuse.
- Many abusive fractures are not clinically obvious unless x-rays are taken, especially in infants under two years.
- Fractures, particularly rib fractures, may not be accompanied by bruising.

A5.03 How do you know if a child has a fracture?

- Fractures in very young children may present with non-specific symptoms and may only be revealed by x-ray or other radiological tests.
- Fractures may not be obvious even on x-ray immediately after the injury; they are easier to identify once the bones show some signs of healing.

A5.04 How do you find the fractures?

- Abused children frequently have multiple fractures and these may be of different ages.
- Where physical abuse is suspected, specialised x-rays should always be taken of children under two years and may need to be taken of some older children.

A5.05 Two types of x-ray may be used:

A5.06 Skeletal survey

This is a series of plain x-rays of all the bones in the body; detailed guidelines are available in *Standards for radiological investigations of suspected non-accidental injury* (RCPCH/RCR, 2017)

https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr174_suspected_physical_abuse.pdf

Although acute rib fractures and metaphyseal fractures are particularly difficult to see:

- Oblique views of the chest increase the recognition of rib fractures
- Repeat skeletal survey images 11 to 14 days later may show healing fractures not originally visible.

A5.07 Radionuclide bone scan

- A radionuclide bone scan uses a radioisotope to identify a hot spot, a healing reaction, at the site of a fracture.
- It is a specialised x-ray which is particularly good at detecting recent fractures and may show additional fractures not evident on the skeletal survey. However, a bone scan will miss skull fractures and may miss metaphyseal fractures.

As either test may miss different fractures, consideration should be given to performing both.

A5.08 Does a skeletal survey or bone scan lead to an excessive radiation dose for the child?

Any x-ray carries a radiation dose, and this must be balanced against the potential gain from performing the x-ray. A skeletal survey varies in the amount of radiation, but is roughly equivalent to the radiation from 7-20 transatlantic flights.

A bone scan is higher than this but the risk from radiation is still regarded as low. The risk of harm from the x-ray is far outweighed by the benefit of detecting fractures in an infant **less than two years of age** and protecting them from further abuse.

A5.09 Can you tell how old a fracture is?

Although a recent fracture can be distinguished from an old fracture, radiologists can estimate the age only in weeks, not days. Despite fractures showing predictable x-ray features over time as they heal, dating of fractures in abused children can be difficult if:

- No accurate description of the cause or timing of the injury has been given
- Further injury to an already broken bone occurs
- The bone has not been immobilised, which may alter the rate of healing.

A5.10 When should you be concerned that a child may have been abused?

The following apply in the absence of organic bone disease.

- Rib fractures are highly indicative of abuse in children who have not been in a major accident.
- A femoral fracture in a child who is not walking can be suggestive of abuse.
- A spiral fracture is the commonest fracture of the femur in abused children younger than 15 months; in all other age groups, a mid-shaft fracture is the commonest accidental or abusive femoral fracture.
- Metaphyseal fractures in very young children are more likely to be due to abuse than to accidental causes.
- A spiral or oblique fracture of the shaft of the humerus is more likely to be due to abuse than accidental causes in young children.
- A supracondylar fracture is highly suggestive of accidental injury.
- In infants, it is difficult to distinguish accidental from abusive skull fractures because the commonest type of fracture from both causes is a simple linear fracture.
- Tibia and fibula fractures in children under 18 months are indicative of abuse.
- Multiple fractures are frequently seen in abused children; these may show different stages of healing.
- In the literature there are examples of abusive fractures to the vertebrae, pelvis, hands and feet, scapula, clavicle and first rib. Skeletal surveys and bone scans must therefore be carefully scrutinised to exclude the possibility of such fractures.

A5.11 Good practice recommendations

- The practitioner needs to adopt a forensic approach to the assessment of a child with suspected physical abuse, matching the history to the clinical findings to determine the likelihood of intentional injury. Ask the question: 'Does the explanation match the clinical findings?'
- The explanation for injury should always be considered in the context of the child's development.
- Children less than two years of age are at an increased risk of severe physical abuse. When physical abuse is suspected, thorough investigation to exclude occult injury (e.g. fractures, intracranial injury, retinal haemorrhages and intra-abdominal injury) is required.
- A full skeletal survey with repeat imaging: a single skeletal survey will miss fractures and a second radiological investigation is required.
- CT head scan in children less than one year of age and considered between 12 and 24 months.

- Ophthalmology examination within 24 hours.
- This investigation strategy is not limited to infants and toddlers and should be considered according to severity of injury in older children.
- Caution should be exhibited with ageing injuries. This is an imprecise science: fractures can be aged by a radiologist from inspection of the extent of healing on X-rays in broad time frames only. Bruises cannot be aged accurately from an inspection of their colour.

A5.12 Glossary

a. Metaphyseal fracture

Also known as a *bucket handle, chip or corner fracture*, this occurs at the growing end of the bone and only in children. Recent fractures are very difficult to see but become more obvious after 11 to 14 days. They are thought to happen when the baby has been pulled or swung violently and the relatively weaker growing point of the bone breaks, although there may be no outer sign of a fracture.

They have been noted to occur accidentally following birth injuries, following serial casting of talipes (club foot) or as a consequence of inappropriate physiotherapy to newborn babies

b. Radionuclide bone scan

A radionuclide bone scan uses radioactive dye that the body disposes of rapidly and causes no harm. On a radionuclide bone scan a *hot spot* is an area of bone where more dye is taken up than expected. This may be due to a fracture, which would then be confirmed with a conventional x-ray.

c. Spiral fracture

This refers to the direction in which the bone is fractured. It implies that there has been a twisting force to cause the fracture. Spiral fractures can also occur accidentally in the femur once the child is walking.

d. Supracondylar fracture of humerus

This refers to a fracture of the upper arm, immediately above the elbow.

A6 HEAD INJURIES IN CHILDREN

A6.01 What do we know about abusive head trauma (AHT) in children? NAHI??

Abusive head trauma that involve injury to the brain or bleeding within the structures around the brain are the most serious form of physical child abuse, and they have some of the most severe consequences for the child's future well-being.

They are the leading cause of death among children who have been abused.

Brain injury may arise from shaking, shaking and impact, or impact injuries. The condition occurs most commonly in children less than two years of age, with an estimated prevalence of 1:3,000 in babies of less than six months of age.

Boys appear to suffer more head injuries than girls, from any cause. Apart from children who die as a result of an inflicted head injury, those who survive may have significant long-term disabilities: 31 to 45 per cent experience ongoing problems – including cerebral palsy, visual problems, epilepsy, learning and behavioural problems.

Physical abuse is rarely a single event. Many children who suffer inflicted head injury have suffered from previous episodes of physical abuse. It is vital that any suspicion of physical abuse to a baby or very young child is fully investigated to identify the condition and prevent future physical abuse of greater severity.

Once recognised, AHT must receive prompt and appropriate treatment to minimise the risk of death or serious long-term problems.

A6.02 How do I know if a child may have suffered an AHT? NAHI?

Some children will present with clear signs of head injury, even if the cause is not immediately obvious. They will either be unconscious or show signs of brain injury such as fitting, paralysis or extreme irritability. However, some children may present with less obvious signs, such as increased head circumference, poor feeding or excessive crying.

Children who have suffered a traumatic brain injury from any cause may sustain a combination of injuries. Those who have a brain injury in association with a skull fracture are more likely to have a non-inflicted injury. This is due to the nature of serious head injuries after falling from a height or motor vehicle crashes. However, some features are particularly indicative of inflicted brain injury, even when a skull fracture is present. These include

- retinal haemorrhages
- rib fractures
- bruising to the head and/or neck,
- apnoea.

However, it is also important to look for features such as other injuries – e.g., bruises, burns, bites, oral injuries or fractures. These need careful interpretation, as well as investigations for other possible causes, as part of the child's assessment.

Given the importance of these features, it is essential that any child where an inflicted head injury is suspected should have a thorough examination to exclude such co-existing injuries. This should include an eye examination by a paediatric ophthalmologist and a skeletal survey with oblique views of the ribs.

A6.03 What tests need to be performed to identify AHT?NAHI?

If an AHT is suspected in a child who is acutely unwell, then a CT scan should be performed, with a skull X-ray or a 3D reconstruction of the CT scan, to look for skull fractures. If the CT scan is abnormal, or it is normal but the child has ongoing symptoms or signs of brain injury, then MRI (a medical imaging technique) with DWI should be performed. This will show detailed sectional images of the brain and give much more detailed information about any brain injuries present, and perhaps assist in predicting the likely long-term outcome.

These tests and their interpretation are highly specialised and should be reviewed by a neuroradiologist with clinical experience of these injuries.

- CT scan – computerised tomography: a radiological test to identify any acute brain injury or bleeding in or around the brain
- MRI – magnetic resonance imaging
- DWI – diffusion weighted imaging

A6.04 What findings on neuroimaging suggest an AHT?NAHI?

Brain injuries of all types are reported in inflicted and non-inflicted head injury. Studies of CT and MRI findings have shown that the features seen in AHT include areas of bleeding around the brain itself, most commonly subdural haemorrhages (SDHs), with or without subarachnoid haemorrhages (SAHs). The features that may distinguish AHT from non-inflicted injury are:

- Multiple SDHs/SAHs
- SDHs over the surface of the brain or in the groove that separates the two halves of the brain.

Damage to the brain itself from lack of oxygen and interrupted blood supply is more common in inflicted than non-inflicted head injury. This contributes to poor outcomes for these children. Extradural haemorrhages are more common in non-inflicted injuries.

Any child with an unexplained brain injury will, of course, require a thorough investigation – e.g., for metabolic or haematological conditions, before it can be concluded that the abnormalities are due to abuse.

- Subdural haemorrhages (SDH) – bleeds over the surface of the brain between the dura mater and the arachnoid mater, the two membranes that surround the brain (the dura mater underlies the skull)
- Subarachnoid haemorrhages (SAH) – bleeds over the surface of the brain underlying the arachnoid mater
- Extradural haemorrhages – bleeds outside the dura mater

A7 Child Sexual Abuse

A7.01 Ano-genital signs and symptoms

- Suspect sexual abuse if a girl or boy has a genital, anal or perianal injury (as evidenced by bruising, laceration, swelling or abrasion) and the explanation is absent or unsuitable.
- Suspect sexual abuse if a girl or boy has a persistent or recurrent genital or anal symptom (for example, bleeding or discharge) that is associated with behavioural or emotional change and that has no medical explanation.
- Suspect sexual abuse if a girl or boy has an anal fissure, and constipation, Crohn's disease and passing hard stools have been excluded as the cause.
- Consider sexual abuse if a gaping anus in a girl or boy is observed during an examination and there is no medical explanation (for example, a neurological disorder or severe constipation).
- Consider sexual abuse if a girl or boy has a genital or anal symptom (for example, bleeding or discharge) without a medical explanation.
- Consider sexual abuse if a girl or boy has dysuria (discomfort on passing urine) or ano-genital discomfort that is persistent or recurrent and does not have a medical explanation (for example, worms, urinary infection, skin conditions, poor hygiene or known allergies).
- Consider sexual abuse if there is evidence of one or more foreign bodies in the vagina or anus. Foreign bodies in the vagina may be indicated by offensive vaginal discharge.

A7.02 Sexually transmitted infections (STI)

- Consider sexual abuse if a child younger than 13 years has hepatitis B unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household or blood contamination.
- Consider sexual abuse if a child younger than 13 years has anogenital warts unless there is clear evidence of mother-to-child transmission during birth or non-sexual transmission from a member of the household.
- Suspect sexual abuse if a child younger than 13 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection unless there is clear evidence of mother-to-child transmission during birth or blood contamination.
- Consider sexual abuse if a young person aged 13 to 15 years has hepatitis B unless there is clear evidence of mother-to-child transmission during birth, on

sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity with a peer.

- Consider sexual abuse if a young person aged 13 to 15 years has anogenital warts unless there is clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, or that the infection was acquired from consensual sexual activity with a peer.
- Consider sexual abuse if a young person aged 13 to 15 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection unless there is clear evidence of mother-to-child transmission during birth, blood contamination, or that the sexually transmitted infection (STI) was acquired from consensual sexual activity with a peer.
- Consider sexual abuse if a young person aged 16 or 17 years has hepatitis B and there is:
 - no clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household, blood contamination or that the infection was acquired from consensual sexual activity **and**
 - a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
 - concern that the young person is being exploited.
- Consider sexual abuse if a young person aged 16 or 17 years has anogenital warts and there is:
 - no clear evidence of non-sexual transmission from a member of the household or that the infection was acquired from consensual sexual activity **and**
 - a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
 - concern that the young person is being exploited.
- Consider sexual abuse if a young person aged 16 or 17 years has gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection and there is:
 - no clear evidence of blood contamination or that the STI was acquired from consensual sexual activity **and**
 - a clear difference in power or mental capacity between the young person and their sexual partner, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) **or**
 - concern that the young person is being exploited.

A8 Clinical presentations

A8.01 Pregnancy

- Be aware that sexual intercourse with a child younger than 13 years is against the law and therefore pregnancy in such a child means the child has been abused.
- Consider sexual abuse if a young woman aged 13 to 15 years is pregnant.
- Consider sexual abuse if a young woman aged 16 or 17 years is pregnant and there is:
 - a clear difference in power or mental capacity between the young woman and the putative father, in particular when the relationship is incestuous or is with a person in a position of trust (for example, teacher, sports coach, minister of religion) or
 - concern that the young woman is being exploited or
 - concern that the sexual activity was not consensual.

A8.02 Apparent life-threatening event

- Suspect child maltreatment if a child has repeated apparent life-threatening events, the onset is witnessed only by one parent or carer and a medical explanation has not been identified.
- Consider child maltreatment if an infant has an apparent life-threatening event with bleeding from the nose or mouth and a medical explanation has not been identified.

A8.03 Poisoning

- Suspect child maltreatment in cases of poisoning in children if:
 - there is a report of deliberate administration of inappropriate substances, including prescribed and non-prescribed drugs or
 - there are unexpected blood levels of drugs not prescribed for the child or
 - there is reported or biochemical evidence of ingestions of one or more toxic substances or
 - the child was unable to access the substance independently or
 - the explanation for the poisoning or how the substance came to be in the child is absent or unsuitable[4]or
 - there have been repeated presentations of ingestions in the child or other children in the household.
- Consider child maltreatment in cases of hyponatraemia (abnormally low levels of sodium in the blood) and a medical explanation has not been identified.

A8.04 Non-fatal submersion injury

- Suspect child maltreatment if a child has a non-fatal submersion incident (near-drowning) and the explanation is absent or unsuitable [4] or if the child's presentation is inconsistent with the account.
- Consider child maltreatment if a non-fatal submersion incident suggests a lack of supervision.

A8.05 Attendance at medical services

- Consider child maltreatment if there is an unusual pattern of presentation to and contact with healthcare providers, or there are frequent presentations or reports of injuries.

A8.06 Fabricated or Induced Illness

- Consider fabricated or induced illness if a child's history, physical or psychological presentations or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture. Fabricated or induced illness is a possible explanation even if the child has a past or concurrent physical or psychological condition.
- Suspect fabricated or induced illness if a child's history, physical or psychological presentations or findings of assessments, examinations or investigations leads to a discrepancy with a recognised clinical picture and one or more of the following is present:
 - Reported symptoms and signs only appear or reappear when the parent or carer is present.
 - Reported symptoms are only observed by the parent or carer.
 - An inexplicably poor response to prescribed medication or other treatment.
 - New symptoms are reported as soon as previous ones have resolved.
 - There is a history of events that is biologically unlikely (for example, infants with a history of very large blood losses who do not become unwell or anaemic).
 - Despite a definitive clinical opinion being reached, multiple opinions from both primary and secondary care are sought and disputed by the parent or carer and the child continues to be presented for investigation and treatment with a range of signs and symptoms.
 - The child's normal daily activities (for example, school attendance) are being compromised, or the child is using aids to daily living (for example, wheelchairs) more than would be expected for any medical condition that the child has.
- Fabricated or induced illness is a likely explanation even if the child has a past or concurrent physical or psychological condition.

A8.07 Inappropriately explained poor school attendance

- Consider child maltreatment if a child has poor school attendance that the parents or carers know about that has no justification on health, including mental health, grounds and home education is not being provided.

A9 Neglect – failure of provision and failure of supervision

Neglect is a situation involving risk to the child or young person. It is the persistent failure to meet the child or young person's basic physical or psychological needs that is likely to result in the serious impairment of their health or development. This may or may not be deliberate. There are differences in how parents and carers choose to raise their children, including the choices they make about their children's healthcare. However, failure to recognise and respond to the child or young person's needs may amount to neglect.

There is no diagnostic gold standard for neglect and therefore decision-making in situations of apparent neglect can be very difficult and thresholds hard to establish. It is essential to place the child or young person at the centre of the assessment.

8.01 Provision of basic needs

- Consider neglect if a child has severe and persistent infestations, such as scabies or head lice.
- Consider neglect if a child's clothing or footwear is consistently inappropriate (for example, for the weather or the child's size).

Take into account that instances of inadequate clothing that have a suitable explanation (for example, a sudden change in the weather, slippers worn because they were closest to hand when leaving the house in a rush) or resulting from behaviour associated with neurodevelopmental disorders such as autism would not be alerting features for possible neglect.

- Suspect neglect if a child is persistently smelly and dirty.

Take into account that children often become dirty and smelly during the course of the day. Use judgement to determine if persistent lack of provision or care is a possibility. Examples include:

- child seen at times of the day when it is unlikely that they would have had an opportunity to become dirty or smelly (for example, an early morning visit)
- if the dirtiness is ingrained.
- Suspect neglect if you repeatedly observe or hear reports of any of the following in the home that is in the parents' or carers' control:
 - a poor standard of hygiene that affects a child's health
 - inadequate provision of food
 - a living environment that is unsafe for the child's developmental stage.

Be aware that it may be difficult to distinguish between neglect and material poverty. However, care should be taken to balance recognition of the constraints on the parents' or carers' ability to meet their children's

needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs.

- Be aware that abandoning a child is a form of maltreatment.

Malnutrition

- Consider neglect if a child displays faltering growth because of lack of provision of an adequate or appropriate diet. NICE has produced a guideline on faltering growth.

Supervision

- Achieving a balance between an awareness of risk and allowing children freedom to learn by experience can be difficult. However, if parents or carers persistently fail to anticipate dangers and to take precautions to protect their child from harm it may constitute neglect.
- Consider neglect if the explanation for an injury (for example, a burn, sunburn or an ingestion of a harmful substance) suggests a lack of appropriate supervision.
- Consider neglect if a child or young person is not being cared for by a person who is able to provide adequate care.

Ensuring access to appropriate medical care or treatment

- Consider neglect if parents or carers fail to administer essential prescribed treatment for their child.
- Consider neglect if parents or carers repeatedly fail to bring their child to follow-up appointments that are essential for their child's health and wellbeing.
- Consider neglect if parents or carers persistently fail to engage with relevant child health promotion programmes, which include:
 - immunisation
 - health and development reviews
 - screening.
- Consider neglect if parents or carers have access to but persistently fail to obtain treatment for their child's dental caries (tooth decay).
- Suspect neglect if parents or carers fail to seek medical advice for their child to the extent that the child's health and wellbeing is compromised, including if the child is in ongoing pain.

Emotional, behavioural, interpersonal and social functioning

Emotional and behavioural states

- Consider child maltreatment if a child or young person displays or is reported to display a marked change in behaviour or emotional state (see examples below) that is a departure from what would be expected for their age and developmental stage and is not fully explained by a known stressful situation that is not part of child maltreatment (for example, bereavement or parental separation) or medical cause. Examples include:

- - recurrent nightmares containing similar themes
 - extreme distress
 - markedly oppositional behaviour
 - withdrawal of communication
 - becoming withdrawn.
- Consider child maltreatment if a child's behaviour or emotional state is not consistent with their age and developmental stage or cannot be fully explained by medical causes, neurodevelopmental disorders (for example, attention deficit hyperactivity disorder [ADHD], autism spectrum disorders) or other stressful situation that is not part of child maltreatment (for example, bereavement or parental separation). Examples of behaviour or emotional states that may fit this description include:
 - Emotional states:
 - fearful, withdrawn, low self-esteem
 - Behaviour:
 - aggressive, oppositional
 - habitual body rocking
 - Interpersonal behaviours:
 - indiscriminate contact or affection seeking
 - over-friendliness to strangers including healthcare professionals
 - excessive clinginess
 - persistently resorting to gaining attention
 - demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
 - failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
 - coercive controlling behaviour towards parents or carers
 - lack of ability to understand and recognise emotions
 - very young children showing excessive comforting behaviours when witnessing parental or carer distress.
- Consider child maltreatment if a child shows repeated, extreme or sustained emotional responses that are out of proportion to a situation and are not expected for the child's age or developmental stage or fully explained by a medical cause, neurodevelopmental disorder (for example, ADHD, autism spectrum disorders) or bipolar disorder and the effects of any known past maltreatment have been explored. Examples of these emotional responses include:
 - anger or frustration expressed as a temper tantrum in a school-aged child
 - frequent rages at minor provocation
 - distress expressed as inconsolable crying.
- Consider child maltreatment if a child shows dissociation (transient episodes of detachment that are outside the child's control and that are distinguished from

daydreaming, seizures or deliberate avoidance of interaction) that is not fully explained by a known traumatic event unrelated to maltreatment.

- Consider child maltreatment if a child or young person regularly has responsibilities that interfere with the child's essential normal daily activities (for example, school attendance).
- Consider child maltreatment if a child responds to a health examination or assessment in an unusual, unexpected or developmentally inappropriate way (for example, extreme passivity, resistance or refusal).

Behavioural disorders or abnormalities either seen or heard about

Self-harm

- Consider past or current child maltreatment, particularly sexual, physical or emotional abuse, if a child or young person is deliberately self-harming. Self-harm includes cutting, scratching, picking, biting or tearing skin to cause injury, pulling out hair or eyelashes and deliberately taking prescribed or non-prescribed drugs at higher than therapeutic doses.

Disturbances in eating and feeding behaviour

- Suspect child maltreatment if a child repeatedly scavenges, steals, hoards or hides food with no medical explanation (for example Prader–Willi syndrome [8]).

Wetting and soiling

- Consider child maltreatment if a child has secondary day- or night-time wetting that persists despite adequate assessment and management unless there is a medical explanation (for example, urinary tract infection) or clearly identified stressful situation that is not part of maltreatment (for example, bereavement, parental separation).
- Consider child maltreatment if a child is reported to be deliberately wetting.
- Consider child maltreatment if a child shows encopresis (repeatedly defecating a normal stool in an inappropriate place) or repeated, deliberate smearing of faeces.

Sexualised behaviour

- Suspect child maltreatment, and in particular sexual abuse, if a pre-pubertal child displays or is reported to display repeated or coercive sexualised behaviours or preoccupation (for example, sexual talk associated with knowledge, emulating sexual activity with another child).
- Suspect current or past child maltreatment if a child or young person's sexual behaviour is indiscriminate, precocious or coercive.
- Suspect sexual abuse if a pre-pubertal child displays or is reported to display unusual sexualised behaviours. Examples include:
 - oral–genital contact with another child or a doll
 - requesting to be touched in the genital area
 - inserting or attempting to insert an object, finger or penis into another child's vagina or anus.

Runaway behaviour

- Consider child maltreatment if a child or young person has run away from home or care, or is living in alternative accommodation without the full agreement of their parents or carers.

Parent–child interactions

- *Consider emotional abuse if there is concern that parent– or carer–child interactions may be harmful. Examples include:
 - Negativity or hostility towards a child or young person.
 - Rejection or scapegoating of a child or young person.
 - Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining.
 - Exposure to frightening or traumatic experiences.
 - Using the child for the fulfilment of the adult's needs (for example, in marital disputes).
- Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).
- Suspect emotional abuse if the interactions observed in recommendation **above*** are persistent.
- Consider child maltreatment if parents or carers are seen or reported to punish a child for wetting or soiling despite professional advice that the symptom is involuntary.
- **Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child or young person and in particular towards an infant.
- Suspect emotional neglect if the interaction observed in recommendation in the previous point above** is persistent.
- Consider child maltreatment if a parent or carer refuses to allow a child or young person to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.