Catholic Medical Quarterly Volume 62(3) August 2012 p14-17

CHILD PROTECTION: AN UPDATE

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EDITORIAL NOTE

According to the NSPCC, nearly a quarter of young adults experienced sexual abuse during childhood. 17,727 sexual crimes against children under 16 were recorded in England and Wales in 2010-11. These figures are shocking and demonstrate that sexual abuse is a frequent criminal activity in sections of society.

INTRODUCTION

"Child protection is an important part of every doctor's business and it is a core activity for paediatricians. If one gets it wrong, it can cause untold misery and permanently mar a child`s life". (Royal College of Paediatrics and Child Health 2006)

DIAGNOSIS

There are some general principles which are worth bearing in mind. Certainly if you don't think of it, you won't diagnose it. A number of things may make one suspect it including an inconsistency between the presenting injury and the explanation given for it. Sometimes there is undue delay in seeking medical advice, or the injuries themselves may suggest it.

Accidental injuries usually cause bruising over bony prominences but bruising of soft yielding tissue suggests inflicted injury. Sometimes they are characteristic in themselves such as bite marks, cigarette burns, or bruises that suggest that an implement has been used. External injuries may also suggest an internal injury, and the non mobile child is very unlikely to cause a serious injury such as a fracture. Skull fractures with a CSF leak subcutaneously or intra cranial bleed are grave and many deaths occur in non accidental head injury in infants. A sudden and unexplained collapse in an infant may suggest an intracranial injury and require urgent diagnostic imaging such as CT or x ray. MRI may also be required acutely or during follow up over the next few days, spinal fractures may occur in the cervical region from a powerful blow to the head. Physical abuse nearly always leaves some sign on the skin and should alert doctors to the possibility of non accidental injury or maltreatment.

All under two year olds and some under threes should receive a full skeletal survey to determine if there are any current or old fractures. Certain fractures such as metaphaseal or long bone fractures may be particularly suggestive, such as rib fractures. Expert radiological interpretation will be required for evidential purposes and bleeding and bone diseases need to be excluded routinely. Interpretation of films is usually beyond clinicians and cases can be won or lost in court on details about bony disorders and their possible causation. The spiral fracture of a long bone is often

indicative of twisting injury and metaphyseal chips can become detached when ligaments around the bone are stressed. Carers beware! It can be caused by yanking a child up by one limb.

Burns and scalds may be inflicted or result from lack of supervision. The foot burn with blistering between the toes, or scald on the buttocks can result from a child being immersed in hot water. The so called “carpet burn”, may result from friction caused by dragging a child across a carpet surface. Sometimes a home inspection is needed to assess the likely cause, which also may reveal inadequate safeguarding around fires or stoves. How many homes have a guard around the hob? Saucepans with handle jutting out are a risk to toddlers. What is in the cupboard under the sink at just the right height for a young child to explore? Is grandma’s home as safe as mother’s?

This leads us to the concept of neglect which may also be grounds for intervention if it leads to significant harm. Significant harm is the threshold which justifies compulsory intervention under S 47, The Children’s Act 1989.

“When the question of whether harm suffered is significant, turns on the child’s health and development which shall be compared to that which can reasonably be expected of a similar child”.

One of the good ways of illustrating this is the height and weight chart which may show significant deviation in children who suffer abuse.

Neglect is the persistent failure to meet a child’s basic physical and /or psychological needs which is likely to result in serious impairment of the child’s health or development. It can present as a failure to provide adequate food, shelter, clothing or protection from common dangers or not seeking medical care when necessary. It can also include the taking of illegal drugs during pregnancy such as to harm the child or include mother`s abuse of drugs or alcohol such as to be incapable of meeting the child’s basic needs. A pregnant drug user’s protocol may be helpful.

Often maltreatment or neglect is associated with emotional abuse whereby the child may also witness domestic violence. This may also take the form of belittling or scape-goating the child who may then suffer lack of self esteem, or show violence towards other children or teachers. Violent verbally abusive children may be reflecting what happens in their homes.

Sexual abuse involves forcing or enticing a child to take part in sexual activities. Those may include or be non contact activities, such as involving children in watching or being involved with or producing pornography. Sometimes genital injury takes place and forensic evidence may be required. Depending on the age of the child it may be necessary to examine the child under clean conditions by forensically trained staff who can find the evidence by using an approved legal “chain of evidence” and produce results which may have to be presented in court. Generally speaking, this is beyond the scope of non specialists. A video interview of the child by trained staff is usually undertaken by the police who are guided by the official “best evidence practice” procedure. Specialist photography may also be required for evidential purpose. Counselling and support may be required for the child subjected to sexual abuse both acutely and historically. This should be by specifically trained staff with the aim of reducing post traumatic stress and long term sexual/psychological effects. Sexually transmitted diseases should be sought and treated appropriately.

The diagnosis of fabricated or induced illness is a particularly difficult, but great iatrogenic harm may occur as a result of falsified or exaggerated ill health or the wilful denial of treatment. The author had one example of an infant who suffered unexplained and recurrent collapses until it was discovered that the mother was adding valium to expressed breast milk!

MANAGEMENT OF CHILD ABUSE UNDER S 47,

"a duty is placed on the local authority to make enquiries, or cause enquiries to be made, where there is reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm".

Powers of intervention are given to these authorities to intervene in family life by order of the courts. Before this can take place agencies need to exchange information and a suitable Child Protection Plan devised, A good example of this is the Multi Agency Safeguarding Hub (MASH) introduced by Devon and Cornwall police in April 2010 currently being trialled in the South West of England. A dedicated team of social workers, health and education professionals work alongside police officers and process all the information coming within its confidential framework where sharing is on a needs to know basis . Amongst the agencies that can input MASH are social workers, health professionals including general practitioners, paediatricians, psychiatrists, community nurses, teachers and education welfare officers. The police themselves are the main referrers where a "121a" (notification has been made when they have been called to a domestic incident where young children are also present.) It may, and often is, a violent incident between adults but where children have witnessed it and may be judged to be at risk. Others who can access MASH include the general public, the probation service, the young offenders' team, and children and young persons' services and within the hub information is gathered and assessed by a senior social services manager and allocated a red, amber or green category.

A red priority requires an immediate response which must be completed within 4 hours. In that time an emergency strategy meeting will have been convened and the child put in a place of safety. This may for example follow a presentation in an A/E department which resulted in admission and if necessary an emergency police place of safety or an emergency care order signed by a magistrate. This secures the child in the immediate term and can be replaced by an interim care order of the court. The children's ward may well be the immediate place of safety if there is no safe home with a relative.

An amber priority is less urgent but still requires conclusion within 72 hours and may result in the child being taken into short term foster care or the ward or placement with a relative pending investigation and an agreed plan between the mother and social services produced by a child protection conference.

A green priority denotes that the situation must be resolved and documented within 5 working days. These are cases that can usually be resolved within the family, sometimes placing the child with a grandparent if it is not thought safe to be at home with the mother. In some cases the mothers own health needs must be met, or in other cases an injunction sought against an abusive partner or boyfriend.

A child protection conference which has statutory status is chaired by a senior social services manager and all the professionals involved with the child and the police give verbal and written reports. The parent and grandparent together with the child if over ten, will be present and will hear all that is said, though some sensitive police reports may be given to the chairman outside of the meeting. A detailed child protection plan is then drawn up which will include considerations of the child's health, safety, emotional, psychological and educational needs. The parents own health needs will be discussed and a key worker appointed to be a point of contact and a core of agents appointed who will visit the home on a planned or random basis to see if the child protection plan is being implemented. There will be one or more review child protection conferences usually at six monthly intervals. After review the case may be stood down from child protection to a lesser, "Child in Need", category (S 17 of the act), or it may be closed.

If the child protection plan is failing, the next step is to call a public law meeting where the family attend with their solicitor and the local authority is represented by a senior social services manager and lawyer for the local authority. Such a meeting may resolve the outstanding matters or it may proceed to a civil court where care orders and in the final instance, freeing for adoption or guardianship may take place. It is outside the scope of this paper to discuss the legal process in detail but the purpose of this paper is to outline the MASH process which has recently been acknowledged as an example of best practise and may be introduced across the country.

In parallel to these civil proceedings the police may be holding their own enquiries and gathering evidence from their forensic teams which will lead to criminal charges being brought by the Crown Prosecution Service in the Crown Court. Again, it is beyond the scope of this paper to detail the need for medical evidence, but paediatricians, child psychiatrists, radiologists and others may be called to give expert witness under oath. Other professionals such as junior doctors may be called as witnesses to fact. The distinction being the expert interprets the factual evidence.

There is some comfort in the knowledge that the number of children subject to protection orders is declining slowly. However, the number of children exposed to premature sexualisation and pornography is still largely unknown but likely to be substantial and their future psycho sexual health may suffer life-long impairment. Above all, the child needs to be understood and believed.

Churches, women's refuges, youth groups and other bodies have their own safeguarding protocols for children and vulnerable adults. That of the Catholic Church follows the Nolan and Cumberledge committees and was adopted by the bishops' conference. It lays down a procedure which includes sharing information with civil authorities and was thought to be an example of good practice by the Holy Father during his state visit in 2010. Unfortunately, it was not adopted by Benedictine schools and as a result of a recent enquiry, changes to the governance of these schools has been recommended. There can be no exceptions where the safety of children is concerned. The Church has a real calling to the highest standards of protection for all whom she serves.

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