ROYAL CHILDREN'S HOSPITAL HANDBOOK
CHILD ABUSE AND NEGLECT

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DEFINITIONS

Physical Abuse - includes inflicted physical violence directed against children such as bruises, burns and scalds, head injuries, fractures, abdominal injuries, suffocation, drowning and includes intentional poisoning with drugs or other substances and the syndrome known as Munchausens Syndrome by Proxy.

Neglect - is the failure of parents to adequately provide for the safeguard the health, safety and wellbeing of the child.

Sexual Abuse - is the involvement of dependent , developmentally immature children and adolescents in sexual activities that they do not fully comprehend and to which they are unable to give consent.

Emotional Abuse - is the distortion of the parent-child relationship that deprives children of the consistent nurturing of body and mind that would enable them to develop fully.

MANDATORY REPORTING

In accordance with Victorian legislation, professionals are mandated to notify Child Protection Services of Health and Community Services Victoria if they believe on reasonable grounds that a child has suffered, or is likely to suffer, significant harm as a result of physical injury or sexual abuse, and the child's parents have not protected or are unlikely to protect the child from such harm.

INTERVIEWING PARENTS

- Ask open, not leading questions
- Use verbatim quotes whenever possible
- A nonjudgemental, compassionate approach is suggested.

CONSULTATIONS and **MEDICAL ADVICE** regarding abused children is available from Gatehouse Centre for the Assessment and Treatment of Child Abuse. 345 6391, After Hours via RCH switchboard 345 5522

NOTIFICATION - to Protective Services (H&CS)
During working hours to the regional team (according to the child's address). Phone numbers under H for Health and Commmunity Services - Protective Services Teams in A-Z White Pages.
After hours - 24 hour crisis line - 131 278

1. Physical Abuse & Neglect

Presentations:

a) Bruises and welts - especially:

- sides of face, behind the ears, the upper lip and fraenulum;
- buttocks and lower back;
- upper arms and legs;
- scalp;
- genitalia;
- bruises in different stages of healing;
- multiple bruises of same age on different parts of the body;
- linear bruises;
- bruises made by belt buckles, ropes, hand prints or fingerprints;

b) Burns - especially if:

- circumferential;
- absence of splash pattern;
- spare skin folds (held in hot water with hips flexed);
- shape of instrument - cigarette burn;

c) Fractures - especially if:

- old untreated fractures;
- different stages of healing in multiple fractures;
- metaphyseal fractures;
- epiphyseal separations;
- unusual fracture sites (ribs, vertebrae, scapulae, sternum, metacarpals);
- fractures in long bones in children <1 year old;

d) Brain injury/whiplash injury (commonest cause of death due to child abuse). The whiplash shaken infant syndrome should be considered in any young infant with an unexplained decrease in level of consciousness. (NB. males under 2 months of age.) Shaking leads to shearing forces on cerebral vessels causing scattered subdural haemorrhages.

Examine for retinal haemorrhages, dislocated lenses, bloody CSF from atraumatic tap.

Tin ear syndrome = ipsilateral subdural haemorrhages - consider in a child with bruised pinna and decreased conscious state.

e) Abdominal injury.

Second commonest cause of death due to child abuse.

- Ruptured liver;
- Ruptured spleen;
- Traumatic pancreatitis;
- Renal injury;

f) Inadequate growth, psychosocial dwarfism.

g) Inadequate nutrition, FTT , fad diets.

h) Poor hygiene.

i) Developmental delay due to lack of stimulation.

j) Poisoning.

k) Thermal injury.

l) Munchausen's Syndrome by Proxy.

Examination:

A thorough physical examination is performed.

- record measurements;
- age estimate of lesion (colour of bruise is only a rough guide to age);
- use diagrams whenever possible;

Note the following:

a) skin markings, lacerations, burns, ecchymoses, linear contusions, contusions with shapes resembling an instrument, circular contusions on trunk or limbs (finger pressure points), bites etc;

b) - torn fraenulum, contused gums, loose teeth, dental trauma petechiae on soft palate;

c) nasal trauma, septal haematoma in an infant;

d) ear trauma including barotrauma;

e) eye trauma including hyphaema, periorbital haematoma, haemorrhage;

f) chest injuries;

g) blunt abdominal trauma;

h) limb trauma, fractures, dislocations, limp, localised tenderness;

i) head trauma - haematomas, lacerations, conscious state;

j) growth - percentiles;

k) development;

l) emotional state;

m) parent-child interaction;

Investigations:

1. Bruising or blunt abdominal trauma;

   - FBE (include platelets);
   - clotting studies PT, KPPT;

2. Suspicion of underlying fracture;

- x-ray suspected site of fracture, not spots on bone scan;
- bone scan - children less than 3 years with suspected physical abuse;
- skull x-ray is better than bone scan at detecting skull fracture;
- skeletal survey = skull, thorax and abdomen (not pelvis), limbs. It may be alternative if bone scan not available. (note large dose of irradiation to the child); It may miss posterior rib fractures.

3. Photographs.

4. Psychosocial assessment of child and family. Always involve Social Worker, multi-disciplinary assessment may be indicated.

5. Children with moderate or severe injuries should be admitted. When a child is not admitted, a decision should be made as to where and with whom the child should be discharged.

6. Case Conference.

- should be held for each child admitted to hospital;
- should be arranged by Health and Community Services (H&CS) after notification;
- hospital staff are expected to attend case conferences as requested;

7. Medical Reports.

- should be prepared on request by senior medical person responsible for child's care;
- should be in language appropriate for non-medical professionals;
- should be clear, concise, informative and include an opinion about the injury, its cause(s) and recommendations for continuing care of the child;

8. Court Appearances.

Advice is available from the Gatehouse Centre for the Assessment and Treatment of Child Abuse regarding Court procedures and preparations for appearing in Court.

2. Sexual Abuse

The physical examination should be conducted by trained, experienced personnel with adequate light and magnification after gentle careful explanation to the child and the family.

A full paediatric assessment is required.

Note: the child's emotional state;

- bruising, abrasions, lacerations;
- other signs of trauma (eg. fractures);

External genitalia should be carefully examined for bruises, oedema, lacerations and erythema.

Evaluation should include:

1. The nature of sexual contact (oral, rectal, penile, vaginal).
2. The time and circumstances of the abuse.
3. Identification of the perpetrator(s).
4. Vaginal discharge or perineal complaints - including treatment for constipation.
5. Non-specific complaints and behavioural patterns which may be indicators of sexual abuse.

Position of the child during examination:

- Children <2 years can be examined in "frog leg" position on a parents lap. Grasp labia and apply traction forward and downward to inspect hymen.
- Lateral buttocks separation test needs to be performed with the child in the left lateral position.
- Adequate visualisation of the posterior hymenal rim can often be achieved with the child in the prone knee-chest position.
- Ask the child to point with a finger to the area or areas of the alleged assault.
- An otoscope may be used to examine the hymen when a colposcope is not available.
- Record any abnormalities including details of size, colour and estimate of age. Photography provides excellent documentation!

Note: Speculum examination is not usually required in pre-pubertal girls or adolescent girls who have not had intercourse.

Note: In the majority of sexually abused children the genitalia are normal.

- The collection of forensic specimens should be considered for children sexually abused within the last 72 hours.
- Semen fluoresces under a Woods lamp.
- Forensic swabs should be air dried, labelled and handed to police. Document the chain of transmission of forensic evidence.
- STD swabs and slides should be collected whenever forensic swabs are collected, when a vaginal discharge is noted or when factors in the history lead to suspicion of STD. Consider chlamydia slide and cultures from low vaginal swab in pre-pubertal children.
- Consider pregnancy prophylaxis (2 Neogynon plus 2 Maxolon stat. 12 hours later 2 Neogynon plus 2 Maxolon).
- Treatment and Follow-Up should be arranged as needed. All abused children and their parents should have access to appropriate counselling.