RECOGNITION AND MANAGEMENT OF MALTREATMENT IN INFANTS (CHILDREN UNDER THE AGE OF 1 YEAR)

This policy is targeted particularly for all health professionals in a community setting.

It may also be a useful guide for other settings, disciplines and agencies regarding identification of infants at risk of harm.

Responsibility for monitoring Review and update	Current Version	Review Date
CPU – Dr. Jean Herbison and Marie Valente	**First version**	**5 May 2015**

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1. Introduction

Following analysis of several serious critical incidents involving infants, Greater Glasgow and Clyde NHS Board have decided to implement a policy to be followed in all infants (i.e. children under the age of one year) where there is concern about their welfare and protection.

It is the responsibility of every professional to identify and act upon any concerning presentations in infants.

A policy on the Recognition and Management of Maltreatment in Infants (Children under the Age of 1 Year) has already been disseminated to practitioners based in acute services.

The purpose of this policy is to help community practitioners identify concerning presentations in children under one year of age and to provide guidance on how to respond.

2. Guidance

Children under the age of one year may present with various potential child protection concerns and in such cases a low threshold for seeking advice and onward referral should be applied.

- **Advice can always be sought on a 24/7 basis from the specialist child protection medical service on 0141 201 9225 <u>9am-5pm</u> (or through switchboard out of hours – 0141 201 0000).**

- **Also advice is available from the child protection advisors within the child protection unit at telephone number 0141 201 9225 (office hours Monday – Friday).**

It must always be remembered that the presence of an injury in an infant frequently indicates more severe abuse. The possibility of other internal injuries must always be considered e.g. brain, or abdomen.

When there is suspicion of abuse raised by history or injury of an <u>infant</u>, other investigations are usually required.

Suspicion should always be raised when there is:

a. Any injury or injuries presenting which are concerning in themselves. These injuries are referred to in Section 6 of this policy document. This is not an exhaustive list of concerning types of injury in infants.

b. Concerning history provided for presenting injury / injuries including:-

(b.1) Inconsistent history for nature of injury or injuries presented e.g. facial bruising of soft tissue area of cheek in immobile infant described as due to a simple fall.

(b.2) History re causation of injury not consistent with developmental stage of infant for example history given for an injury of fractured skull in a 2 month old infant as “rolled” off a sofa.

c. History of concerning injury or injuries is not able to be VALIDATED by an independent third party.

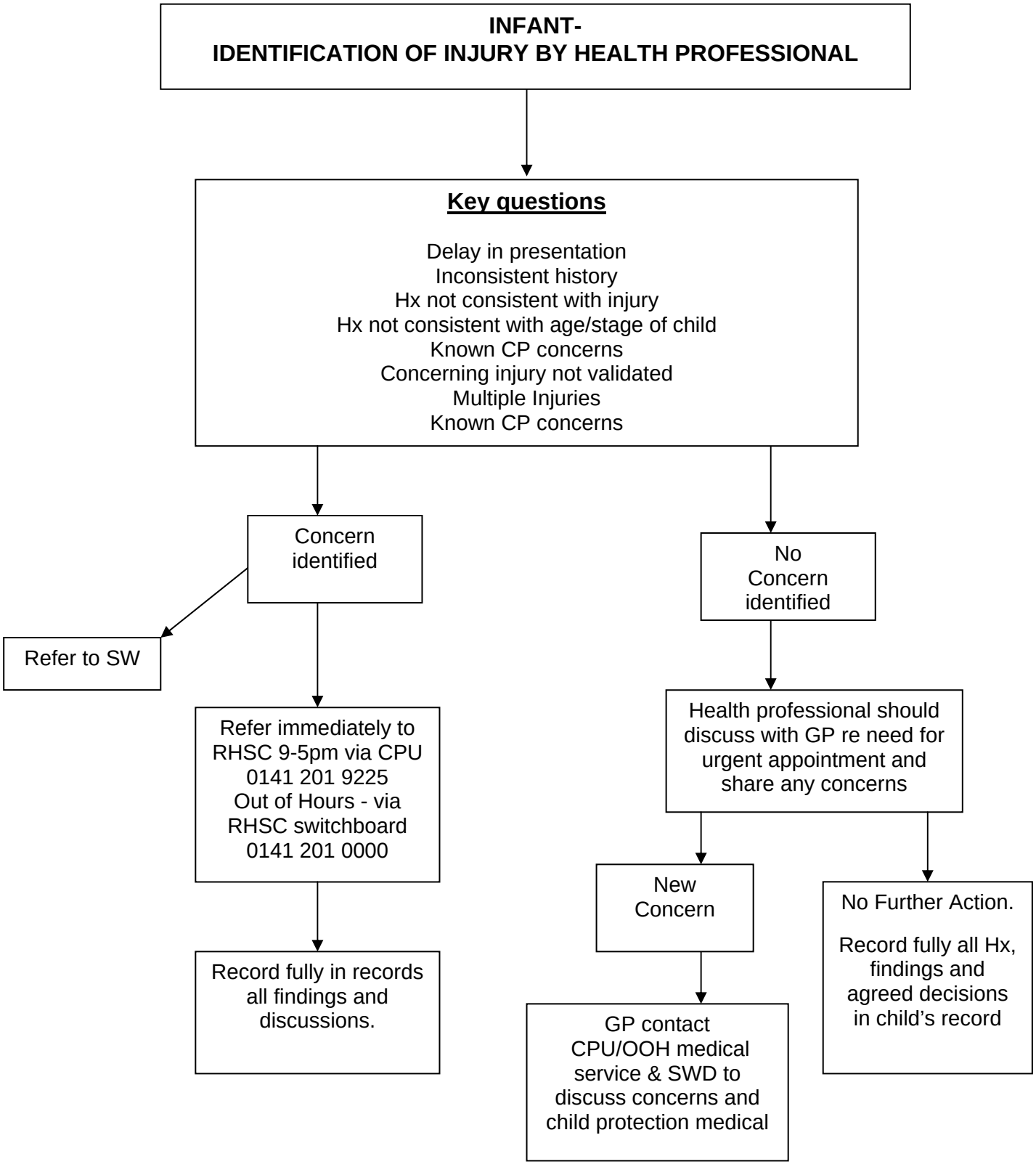
For example, a three month old baby presents with a swelling and bruising on her scalp – the incident was not witnessed by anyone other than the parent who provided the history of causation.

When a health practitioner is presented with any injury in a young child certain key questions must be considered –

1. *Has there been a delay in seeking medical attention for the injury?*
2. *Is the injury consistent with the presenting history?*
3. *Is there an inconsistent history given by parent/carer?*
4. *Is the history of injury consistent with the age/stage of development of the child?*
5. *In a concerning injury can the history be validated by anyone else?*
6. *Are there any known child protection concerns?*
7. *Are there multiple injuries?*
8. *Always look for other injuries.*
9. *Remember to consider the safety of other siblings.*

3. Flow Chart 1

For use by Primary Care Health Professionals where there is concern about an injury of an infant (children under the age of 1 year)



Arrangements for the safe transfer of an infant to hospital

The infant must always be escorted by a professional, dependent on circumstances this maybe a member of health staff, social work or police. This should be decided on discussion with social work.

In cases where health practitioners are concerned about abuse or neglect and have made a referral to SW by telephone, this should be followed up within 48 hrs using the Shared Referral Form.

It is now mandatory in cases where suspicion of abuse has been raised as described within this policy, that if the child is referred to hospital the consultant in charge of the child's care formally requests by discussion with the Team Leader (or equivalent) of social work department (or Stand-by Service out of hours), a child protection case discussion / case conference to be convened PRIOR to discharge of the child. A range of community professionals will be invited to that case discussion and key community health professionals should provide information in the form of a report and/or attend that case discussion/conference.

As per Child Protection procedures the case discussion/conference is convened, chaired and minuted by Social Work department. This will ensure that all appropriate inter agency information is gathered in a formal setting and formally minuted. Inter agency analysis will take place at the meeting with a formal inter agency action plan documented and follow-up noted.

In all of these cases action must always be taken to:

- Gain fullest information possible from health services and records including primary, secondary and tertiary care and from other agencies in particular Social Work.
- Cross check the context of the injury presented and any previous presentations or concerns re the index child and family, including siblings.

On rare occasions no injury will be presented or apparent but the history provided by the carer may be concerning enough in itself for example a history of a carer witnessing a baby being shaken. In these situations again full information should be gleaned and the flow chart above must be followed.

4. Signs and symptoms indicating concerns regarding neglect and emotional wellbeing

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs. An injury may or may not be apparent but there may be other cumulative concerns about the welfare or neglect of a child.

Health professionals should be alert to the following:

- Inappropriate parenting
- Problems such as drug misuse and/or alcohol misuse
- Parental mental health difficulties.
- Gender based violence.
- Previous unusual histories or presentations to hospital or health professionals.
- Patterns of non-engagement or failing to meet the health needs of a child.

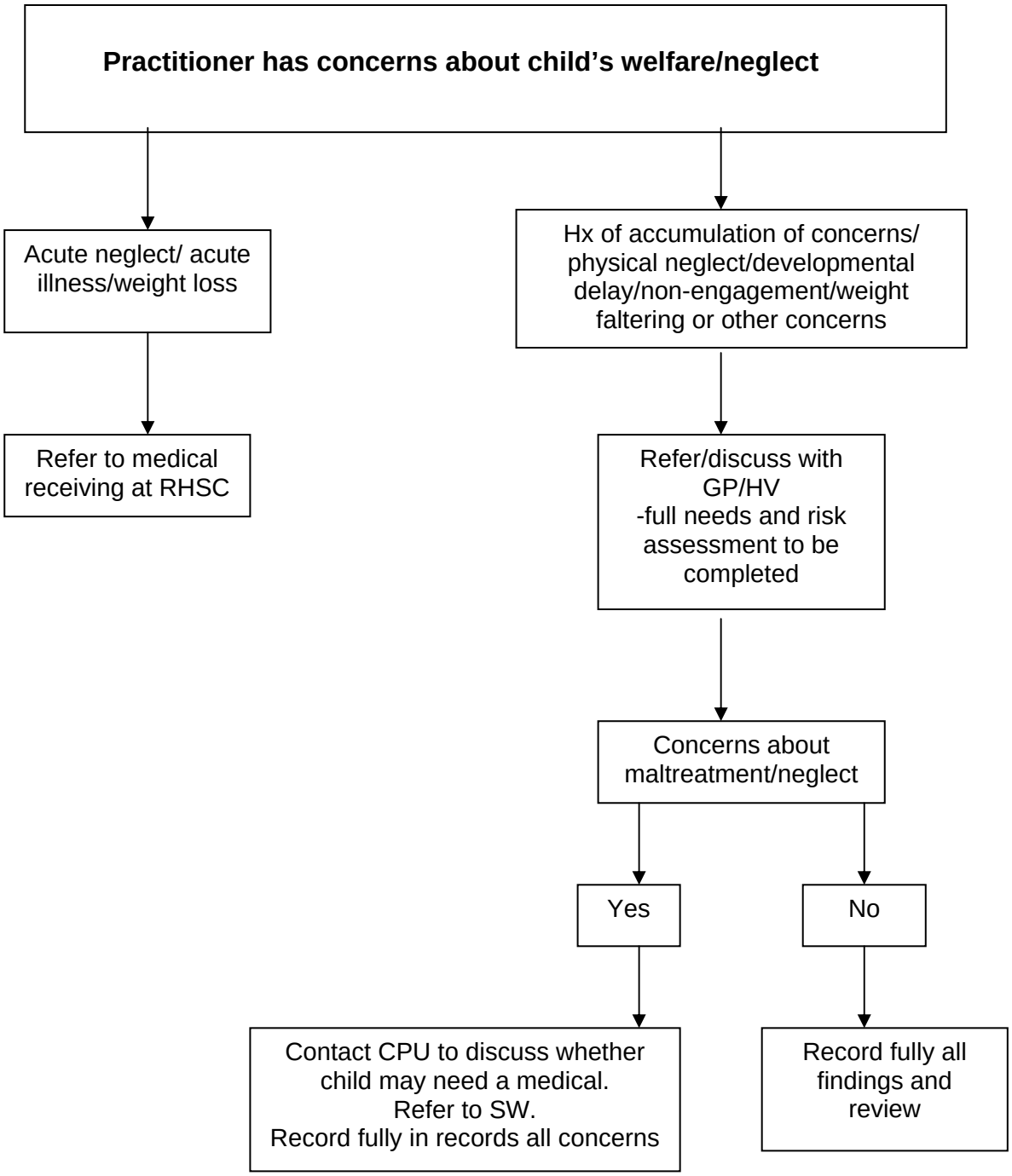
These risk factors and others can be indicators of a child being at increased risk of injury or neglect.

Practitioners should be aware of both the physical presentation of a child but also other issues that may indicate that a child is being emotionally neglected or abused- this could include feeding difficulties, attachment issues, being described as a 'difficult baby', or developmental delay.

Practitioners should record accurately all concerns they have about a child including using a chronology where appropriate. If a health practitioner is concerned that a child is being neglected or has concerns about their welfare a referral should be made to Social Work. (see flow chart 2)

5. Flow Chart 2

For use by Primary Care Health Professionals where there is concern about neglect/emotional well being of an infant under the age of 1 year



6. Physical Injuries

Types of injuries in infants that may cause concern:

'*Those who don't cruise, rarely bruise*' (Sugar, Taylor and Feldman 1999).

A systematic review of the international literature in infants under an age of 6 months suggests that any bruise in an infant under 6 months must be fully evaluated and a detailed history taken to ascertain consistency with the injury. Non-mobile children should not have bruises without a clear and usually observed explanation. Certain areas are rarely (less than 2%) bruised accidentally at any age including neck, buttocks and hands in children less than two years.

Common and important sites for non-accidental bruises are:

1. Buttocks and lower back
2. Slap marks on side of the face, scalp and ears
3. Bruises on external ear
4. Neck, eyes and mouth
5. Trunk, including chest and abdomen
6. Lower jaw

The face is the most commonly bruised site in fatally abused children. It is important to look for patterns such as implement marks, e.g. a belt, a stick. Obviously differential diagnosis includes bleeding disorder, drug induced bruising either accidentally or deliberate, birth mark including Mongolian blue spot, cultural practices including cupping or coining.

Bites
Bites are always non-accidental, though they can be animal or human (adult or child). Human bites are mostly paired crescent shaped arches of bruises. Because a set of crescentic marks are small it should not be assumed that it is a child bite mark as they can be due to the contact, simply being from the upper and lower incisors of an adult. Individual teeth marks may be seen, the marks may be distorted by the contours of the area bitten.

Fractures
It takes considerable force to produce a fracture in a child. Any explanation must be consistent with the child's developmental age. The younger the child is, the greater the likelihood of abuse. 80% of abused children with fractures are less than 18 months old whereas 85% of accidental fractures occur in children over 5 years. Infants with fractures less than 4 months of age are more likely to have been abused.

The following fractures are more suspicious of abuse in infants:

- Spiral fractures of the humerus are uncommon and strongly linked to abuse. Any humerus fracture other than a supracondylar fracture is suspicious of abuse in children. All humeral fractures in a non-mobile child are suspicious if there is no clear history of an accident.

* Multiple fractures are far commoner in abused children, P value less that 0.0001.

Ribs
In the absence of underlying bone disease or major trauma (such as a road traffic accident), rib fractures are highly specific for abuse and may be associated in some cases with shaking. It has been suggested that rib fractures can be caused by the resuscitation process (where there has been an arrest) but posterior rib fractures have never been described following resuscitation. Anterior or costchondral rib fractures have been described extremely rarely in 0.5% in resuscitation

Femoral fractures in children who are not independently mobile are extremely suspicious of abuse regardless of the type. Once a child is able to walk they can sustain a spiral fracture from a fall while running, so once again it is exceptionally important that a clear history is obtained. A transverse fracture of the femur is the commonest presentation and can be found in accidental and non-accidental injuries.

Metaphyseal Fractures
These are relatively rare fractures. In the neonatal period they can be related to birth injury, but outside the neonatal period under the age of 2 years are suggestive of abuse particularly if femoral. Epiphyseal fractures will only be found if looked for carefully and always require paediatric radiological opinion.

Skull Fractures
A history of a fall less than 3 ft – this rarely produces a fracture.

Particularly concerning skull fractures are:

- Occipital fractures
- Depressed fractures
- Growing fractures
- Fractures complex or multiple in severely injured or fatally injured children. It is twice as likely to be due to abuse.
- Wide fracture (with an x-ray 3.0mm or more)
- A fracture which has crossed the suture line or multiple or bilateral
- A fracture with associated intracranial injury
- A history of a fall less than 3 ft – this rarely produces a fracture

Intra Abdominal Injury
Intra abdominal injury is very uncommon and, when abusive, typically occurs in young children, and under 3 has a high mortality rate especially if the diagnosis is missed or delayed. Diagnosis can be difficult with delay in presentation and no history of trauma provided by the carer. There may be no signs of external injury and therefore one must have a low threshold of suspicion particularly if there are any other injuries in a child under 1 year of age.

Thermal Injuries
Patterns that suggest abusive burn and scald injuries include:

- Deep cratered circular burns, which heal to leave scars (cigarette burns)
- Glove and stocking circumferential scolds of limbs / buttocks from (forced emersion)
- Clearly outlined brand marked contact burns (hot objects – e.g. clothes, iron, fire grid, cooker/hot plate).
- Poured scald
- Friction or carpet burns (e.g. from dragging child across the floor).

Common sites for abusive burns include:

- Feet and hands, especially the backs of hands
- Buttock
- Face
- Multiple Sites

Other potential non-accidental injuries
A variety of other injuries are encountered in abusive circumstances. These include:

- Incised wounds
- Mouth injuries, for example fractured teeth, lacerations and bruises to lips and tongue, torn labial frenulum in infant or toddler, palatal burns from hot food or lacerations from cutlery or objects forced into the mouth.

The list above is not exhaustive and is explored in more detail in the Royal College of Paediatrics and Child Health (RCPCH) Child Protection Companion document issued to all members of RCPCH in April 2006.(ref 1) Up to date international evidence review is available via the Welsh systematic Review group see below (Ref 2)

- RCPCH 2nd edition of The Child Protection Companion (ref 1)
- www.core-info.cf.ac.uk (ref 2)