NHSGGC Public Protection Service

Pathways for children presenting to GPs where there is a concern of abuse or neglect

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1. Introduction

The aim of this guidance is to provide all GPs in NHSGGC (including those working in out of hours services) with care pathways for children who present with concerns about child maltreatment that may require a child protection (CP) medical opinion.

Rarely a child may require urgent medical treatment or present with a life threatening injury. In such cases the child should be transferred to hospital immediately by ambulance and contact also should be made with the senior Dr in the receiving A&E department.

If parents are uncooperative and refuse to take a child for a paediatric assessment or fails to attend this should be reported immediately to social work. If there is any immediate risk of harm the police **must** be contacted.

Social Work Referrals

It is the responsibility of the clinician who first assesses the child and has noted a concern of abuse or neglect to raise a formal notification of concern (NOC) with social work.

Advice and Support

If any practitioner requires advice or support or unclear about what to do please contact the Child Protection Service on 0141 451 6605 Mon – Fri – 09:00 -17:00 – Out of Hours Contact the Child Protection Consultant on call via Switchboard at RHC on 0141 201 0000.

Infants Under 1 Year

Particular attention should be given to all children under the age of 1 who present with injuries. It is essential to consider:-

- Is the injury feasible given the child's age and developmental stage?
- Are there any other concerns regarding the child's presentation, e.g. indicators of neglect?
- Has there been a delay in seeking medical attention?
- Are there known adult/family risk factors that may affect the safety of their child?

Infants under the age of 1 with injuries suspicious of physical abuse or neglect require admission for further investigation.

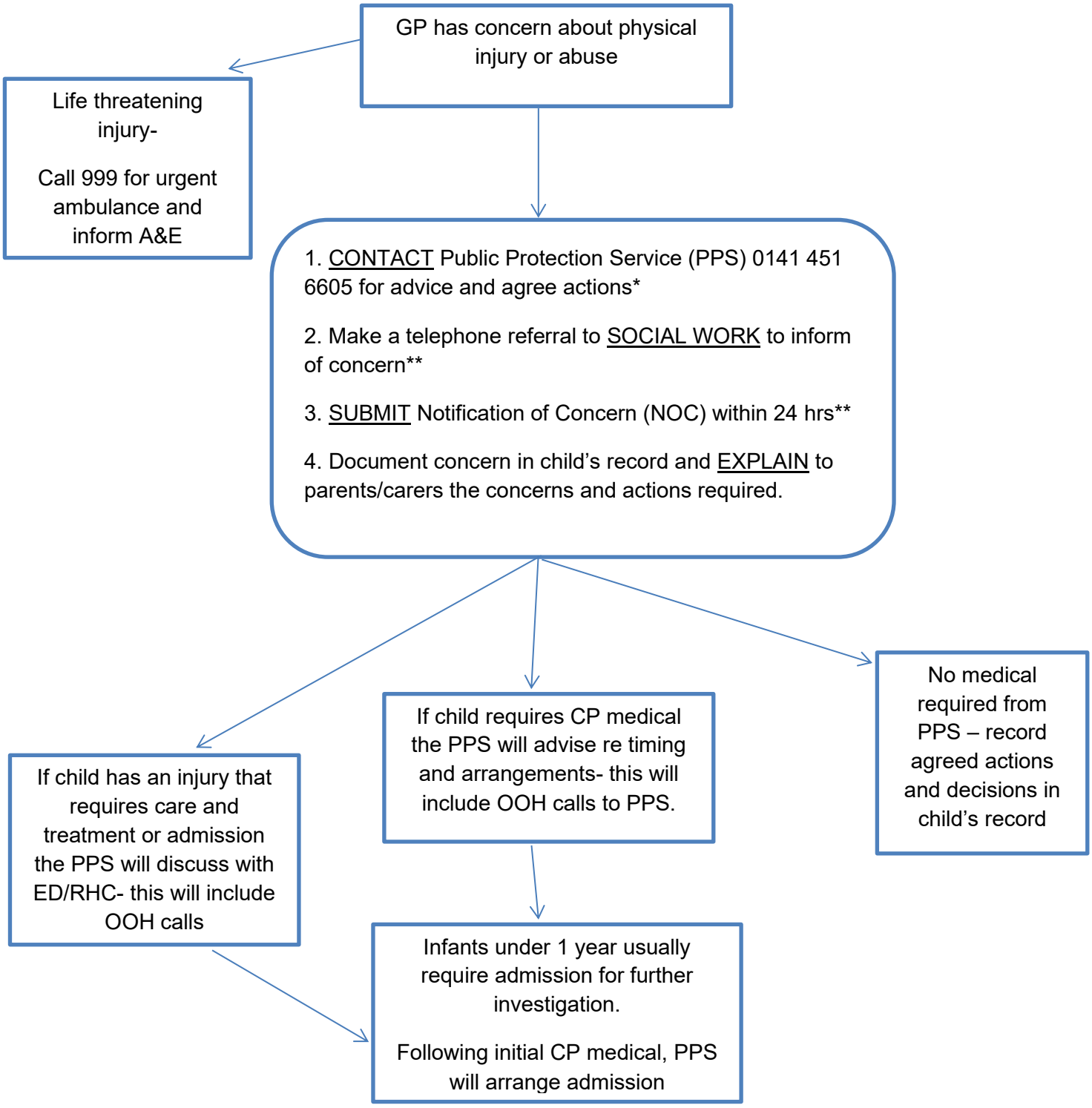
Recognition and Management of Pos

Acute Sexual Assault

Children and young people who are the victims of acute sexual assault (less than 7 days) will require consideration for forensic medical examination. This examination forms part of a wider multi-agency investigation and it is essential that social work is contacted at the point of presentation. Indications for acute forensic examination would include - a clear disclosure by child of sexual assault, an injury identified consistent with acute sexual assault or a witnessed sexual assault.

In all such cases the Child Protection Service should be contacted to discuss forensic medical requirements. In such cases an Interagency Referral Discussion (IRD) should be held to discuss the concerns and agree a plan.

2. Pathway of care for children presenting to GP where there is a concern of physical injury or abuse



* Mon-Fri 09:00-17:00 contact PPS on 0141 451 6605.

Out of hours contact Child Protection Consultant via RHC switchboard 0141 201 0000

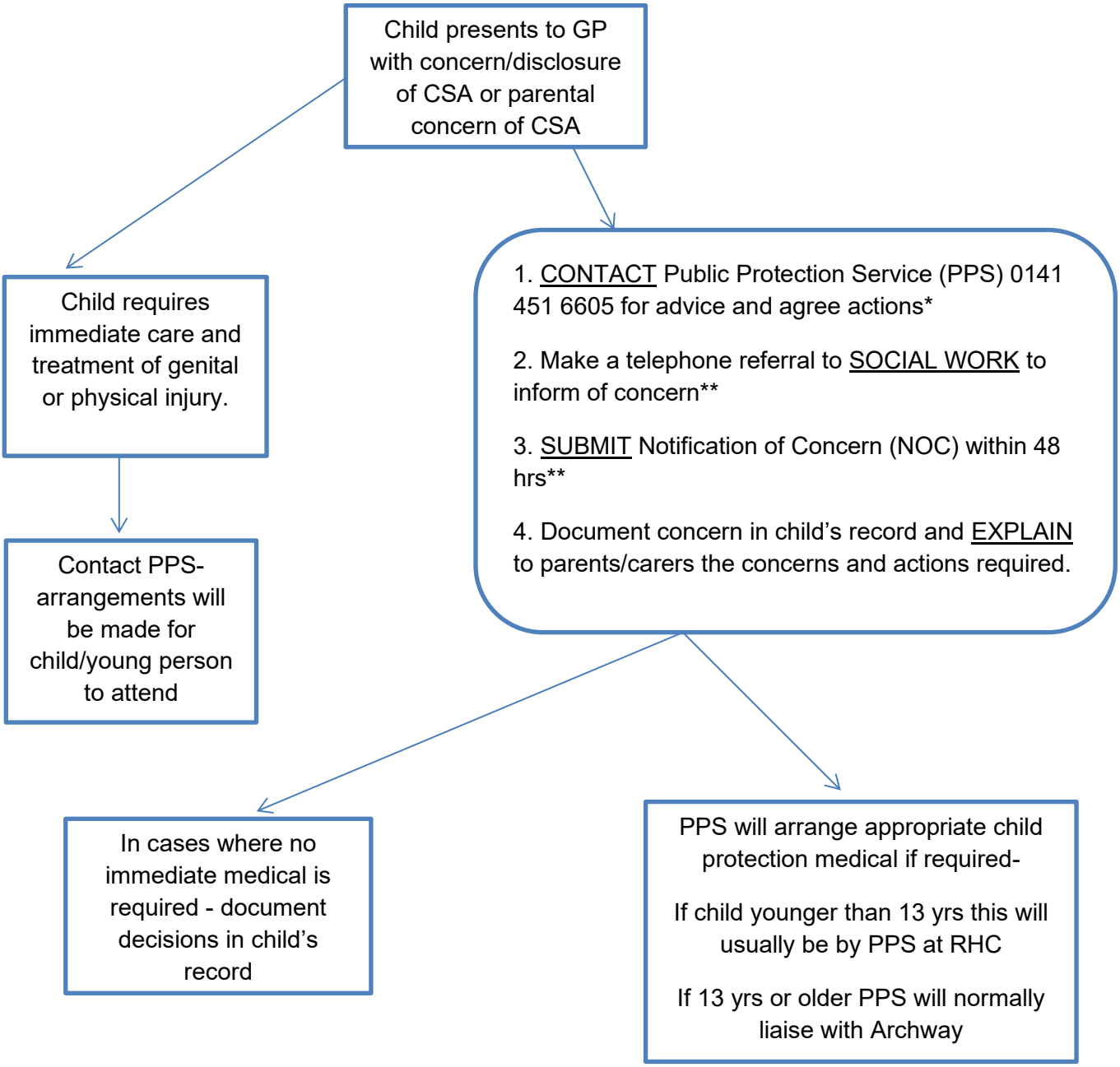
** See Appendix 1 for telephone numbers and access to NOC form.

Recognition of Physical Abuse

- The explanation for an injury should always be considered in the context of the child's development and the child's wider world.
- Children under 2 yrs are at increased risk and rarely able to contribute to the history themselves.
- Evidence is that we cannot accurately age a bruise.
- Bruising is strongly related to mobility however is the most common injury to a child who has been physically abused.
- Features in a history about an injury that must raise concern are:-
    - There is no adequate explanation for injury or does not fit pattern seen.
    - The injury is not consistent with developmental stage of the child.
    - There has been a delay in presentation.
    - Family already known to SW or previous concerns raised about care of the child.
    - 'Rough handling' or 'difficult feeders' are not acceptable explanations for injuries.

Physical Feature	**Suspect child maltreatment-**
Bruises (also scratches, abrasions and lacerations)	- if a child or young person has bruising in the shape of a hand or implement - if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition and the explanation for the bruising is unsuitable. Examples include:- • bruising in a child who is not independently mobile • multiple bruises or bruises in clusters • bruises of a similar shape and size • bruises on any non-bony part of the body or face including the eyes, ears and buttocks • bruises on the neck that look like attempted strangulation • bruises on the ankles and wrists that look like ligature marks.
Bites	- if there is a report or appearance 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.
Thermal Injuries	- in a child with a burn or scald injuries:- • if the explanation for the injury is absent, unsuitable or child is not independently mobile. • on any soft tissue area that would not be expected to come into contact with a hot object in an accident (for example, the backs of hands, soles of feet, buttocks, back). • in the shape of an implement (for example, cigarette, iron). • that indicates forced immersion (for example, scalds to buttocks, perineum and lower limbs or scalds to limbs in a glove or stocking distribution.
Oral injury	- if a child has an oral injury and the explanation is absent or unsuitable – includes fractured or avulsed teeth, lacerations and bruises to lips, palate and tongue from objects forced into mouth (including feeding bottles) or burns from hot food.

3. **Pathway of care for children presenting to GP where there are concerns about child sexual abuse (CSA)**



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Non-recent (historical) Sexual Assault

Children and young people who disclose non-recent (historical) sexual assault do not normally require an acute forensic medical. The professional (GP) being informed of the assault should contact the PPS and SW as per guidance.

In most cases an IRD and a Joint Investigative Interview (JII) should be completed before the forensic medical examination.

It is not uncommon in general practice for adults to disclose previous sexual and other forms of abuse when a child. In such circumstances GPs and other professionals are required to consider if any child or children are currently at risk of harm and therefore may require to share relevant information with police and SW in order to protect those children.

Clinical presentations of possible CSA

Children who have been sexually abused may present in many ways and often may not make an allegation at an early stage.

Certain clinical presentations may raise the suspicion of CSA and require further assessment and consideration. They include-

1. Any pregnancy or sexual activity in a child **under the age of 13** is unlawful and **must** be reported to statutory agencies even if the child suggests they have consented to the activity.
2. *Consider* CSA in all children presenting with sexually transmitted infections unless clear evidence of mother-to-child transmission during birth, non-sexual transmission from a member of the household or blood contamination.
3. *Suspect* CSA in child younger than 13 yrs with gonorrhoea, chlamydia, syphilis, genital herpes, hepatitis C, HIV or trichomonas infection and no clear evidence of mother-to-child transmission during birth or blood contamination.
4. Ano-genital injury with no clear history or explanation.
5. Unexplained vaginal bleeding – in the absence of accidental trauma or medical diagnosis. ***
6. Unexplained rectal bleeding – after excluding other medical causes- anal fissures, constipation, IBD or accidental injury.
7. Recurrent or resistant to treatment vaginal discharge/vulvo-vaginitis. ***
8. Soiling/enuresis- are common paediatric presentations usually with developmental/behavioural cause. CSA should be considered as part of the differential diagnosis.
9. Behavioural presentations- any significant and major change in a child's behaviour should prompt further assessment regarding any form of maltreatment.

*** See section 4

4. Common Genital Presentations in Children***

The following clinical presentations can be associated with CSA. It is, however, important to consider other potential causes such that a robust history with appropriate examination and investigations undertaken to exclude such causes where possible.

When there is recurrence or resistance to treatment or other concerning features, expert advice should be sought via the PPS to discuss the possibility of CSA and requirement for a specialist medical as part of a multi-agency process.

a) Anogenital Warts (AGW)

Anogenital warts can be acquired by four mechanisms in children- vertical transmission from an infected mother, autoinoculation from non-genital warts, hetero-inoculation (contact between anogenital region and infected second party) and sexual. Sexual abuse must be considered in all children presenting with AGW.

GPs should refer to dermatology using SCI gateway for children with AGW. It is important that all relevant social information including any known child protection concerns are highlighted in the referral.

On receipt of this referral a health system check is undertaken to identify any known child protection risk for the child. The child protection consultant will decide if they are to be seen by dermatology alone or if there are concerns a joint examination between dermatology and child protection will be arranged.

b) Vaginal discharge/itch/vulvo-vaginitis

Both are commonly reported in CSA; however discharge and itch is very common in young girls, usually culture negative and not significant. Most of the irritation causing itch can be resolved with hygiene measures and appropriate clothing/underwear. It is often mistaken for thrush and antifungal treatment should normally be avoided in younger girls. Bland emollients or barrier creams may reduce irritation and discomfort.

c) Vaginal bleeding

Genital bleeding in prepubertal girls often presents as blood in the child's underwear. It is essential that a complete history is taken to determine the source of blood. Bleeding reported as vaginal may be genital, or from the skin, urinary tract or anus.

While CSA must be considered, other common causes include lichen sclerosis, infections, vaginal foreign bodies, constipation and rarely tumours and anatomical abnormalities.

d) Rectal bleeding

Differential diagnosis would include constipation, anal fissures, inflammatory bowel disease, accidental trauma and rarely anatomical difficulties. It is essential that a history and examination is undertaken to exclude such causes in the absence of any direct disclosure of CSA or any other concerning features.

5. Concerns about Neglect

Neglect is the persistent failure to meet a child's physical or psychological needs that is likely to result in serious impairment of the child's health or development. It is the most prevalent form of maltreatment in the UK.

There are different forms of neglect – emotional, medical, nutritional, educational, physical and failure to provide adequate supervision and guidance. GP practices may identify children affected by neglect from a variety of presentations - the physical appearance or lack of provision for a child, the engagement pattern some families have with the practice or risk factors that may make a child more at risk of neglect - e.g. parental problematic substance use, parental mental health problems and social and environmental factors such as poverty and social isolation.

It is important to recognise that children and young people with a disability are more likely to be neglected or harmed than their peers although often under-recognised and under-reported.

Medical Neglect

This is parents/carers disregarding or minimising their child's health need, failing to seek medical attention or administer required medicines or treatments. This may be for an acute ill health episode or for a child with a long term condition.

Children may also not be brought for essential appointments or screening opportunities. Generally a one-off missed appointment would not be a concern however a pattern of not being brought and the context of these missed appointment can be a sign of neglect. When children are not brought to an appointment the practitioner should code this event and consider the impact on the child.

Neglect is rarely a one-off event and GP practices should have effective communication processes to ensure concerns are shared with HVs and others working with children and young people who may be affected by neglect.

Response to concerns about neglect

1. In all cases where GPs are concerned about neglect advice can be sought from the Child Protection Service on 0141 451 6605 (Mon-Fri 09:00-17:00)
2. Good record keeping is essential in order to identify patterns of engagement or behaviours from multiple presentations that may indicate neglect.
3. Rarely after an isolated presentation that indicates acute neglect (young baby with significant weight faltering) or following an accumulation of concerns about neglect a notification of concern should be submitted to the local SW service.
4. In cases where there is evidence of medical neglect/unmet health needs a child protection assessment may be required via the Vulnerability Service.

Communication and Interpreting Needs

In all cases communication or interpreting needs of the child or young person should be considered and appropriately addressed. A parent or family member should not interpret or speak for the child.

6. Vulnerable Pregnancies

In NHSGGC women are directed to contact maternity booking services directly to initiate antenatal care. Following this the GP practice will be contacted to provide additional information via agreed SCI gateway form.

Critical information sharing between maternity and general practice to support early identification of vulnerable pregnancies has been identified as a recurring theme in a number of Learning Reviews and SAERs.

The early identification of factors which may place an infant at risk, during pregnancy and/or the postnatal period is crucial for a proactive prevention strategy for the protection of vulnerable babies. Ensuring that vulnerable families get the right help at the right time and early provision of safe, effective family centred care will ensure best outcomes for children.

GPs have a critical role in the identification of vulnerable pregnancies and are also often responsible for initiating referrals to specialist services such as mental health teams. On occasion they may be aware of previous child protection concerns or children requiring to be cared for elsewhere due to child protection concerns.

When GP practices are contacted to provide information it would be considered best practice for there to be professional oversight of the information returned to maternity services to ensure that all relevant information in relation to vulnerabilities or child protection concerns is within the SCI gateway referral.

GPs can also refer directly to SW a pregnancy where they believe there are child protection concerns using the process described above and via the NOC form on SCI gateway (Appendix 1). When requested GPs should also share relevant information with SW when they are undertaking assessments in relation to vulnerable pregnancies.

Appendix 1 - SW telephone numbers and access to NOC form

Social Work Area Teams Numbers:
Typically SW offices are open:-

- Monday to Thursday inclusive: 08:45 - 16:45
- Friday: 08:45 – 15:55

Out with these times staff should contact Glasgow and Partners Emergency Social Work Service (Standby) on 0300-343-1505

Glasgow City	0141 287 0556
Glasgow Social Care Direct	

Renfrewshire	0141 618 2535
Paisley	
Johnstone	
Renfrew	

East Renfrewshire	0141 577 8300
Clarkston	
Barrhead	

East Dunbartonshire	0141 777 3000
Kirkintilloch	0141 355 2200

West Dunbartonshire	
Clydebank	0141 562 8800
Dumbarton/Alexandria	

Inverclyde	
Greenock	01475 715 365
Port Glasgow	01475 715 270

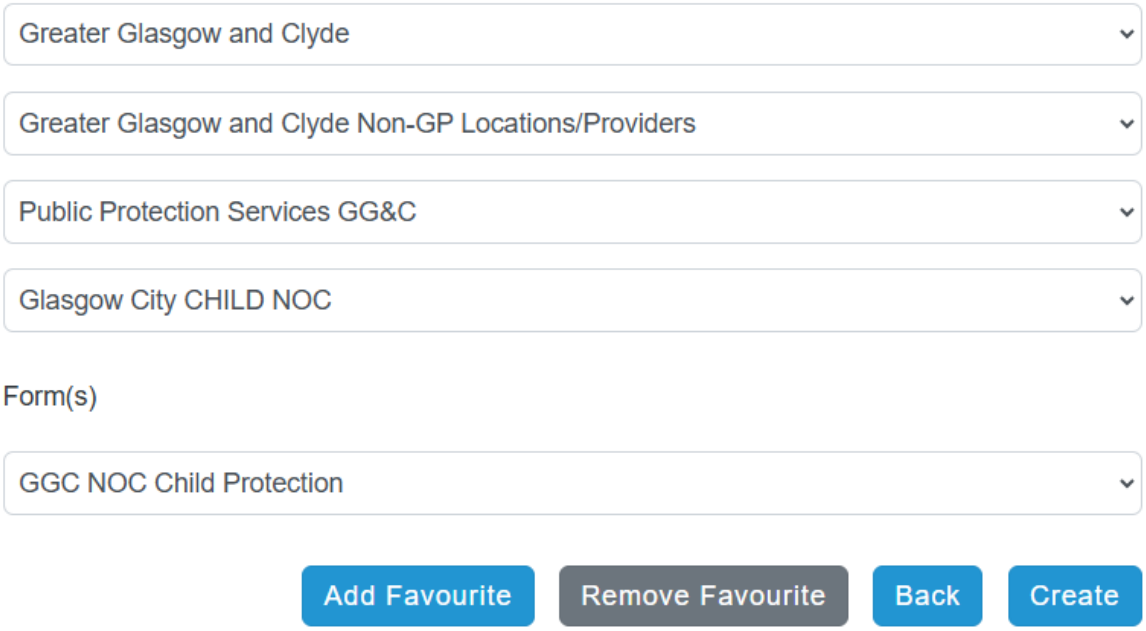
Notification of Concern Form

GPs can access the notification of concern form via SCI gateway.

GPs should log into SCI gateway as normal and select-

- Public Protection Services
- Relevant area
- NOC or AP1

For example for Glasgow GPs-



Systems are now in place within each HSCP for SW services to access submitted NOCs and process locally. The Public Protection Service will also access SCI gateway to retrieve NOCs and upload into all relevant children's EMIS records.