INTRODUCTION

Child Abuse Paediatrics / Forensic Paediatrics
PRINCIPLES, PITFALLS and PEARLS
What does this have to do with me?
Paediatricians’ roles

- Prevent
- Protect
- Suspect and Act when suspicious
- Recognise Abuse and Neglect
  - Exclude the mimics
- Raise the alarm
- Respond (holistically) – as part of multidisciplinary team & Multiagency intervention
- Reduce risk of harm
- Remediate / Repair
- Monitor progress
Principles

• This IS my business
• Intervene early = best
• Identify risk and actual abuse & neglect
• Identify modifiable and remediable risk factors
• Act to protect child and remediate & reduce risk of harm
• Act to improve parenting capacity & relationships

• Be brave
• Stay involved
• Work as a team
• Respect others’ roles and responsibilities
Child abuse is common
I WILL have contact ...

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic.</th>
<th>Qld</th>
<th>WA a</th>
<th>SA</th>
<th>Tas. b</th>
<th>ACT</th>
<th>NT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>23,175</td>
<td>9,075</td>
<td>6,598</td>
<td>2,759</td>
<td>2,139</td>
<td>1,025</td>
<td>861</td>
<td>1,705</td>
<td>48,420</td>
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<td>2012-13</td>
<td>26,860</td>
<td>10,489</td>
<td>8,069</td>
<td>2,915</td>
<td>2,221</td>
<td>1,035</td>
<td>720</td>
<td>1,357</td>
<td>53,666</td>
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<tr>
<td>2013-14</td>
<td>26,215</td>
<td>11,952</td>
<td>7,406</td>
<td>3,267</td>
<td>2,737</td>
<td>778</td>
<td>449</td>
<td>1,634</td>
<td>54,438</td>
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<tr>
<td>2014-15</td>
<td>26,424</td>
<td>14,115</td>
<td>6,435</td>
<td>3,623</td>
<td>2,335</td>
<td>904</td>
<td>595</td>
<td>1,992</td>
<td>56,423</td>
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<tr>
<td>2015-16</td>
<td>30,226</td>
<td>14,888</td>
<td>6,104</td>
<td>4,582</td>
<td>1,857</td>
<td>868</td>
<td>627</td>
<td>1,797</td>
<td>60,989</td>
</tr>
</tbody>
</table>

Notes: There are differences in definitions and process around notification, which means figures are not comparable across jurisdictions. (a) In WA, notifications where the primary concern at notification was emotional/psychological, physical, sexual abuse or neglect are counted as notifications in this table. The definition of emotional abuse in WA has been broadened to include children witnessing family and domestic violence from 2015-16. (b) Notifications in Tas. have decreased due to changes in the way notifications have been defined.

Source: AIHW (2017b, Table 3.1)
- Asthma = 0-14 years, males = 11.4%, females = 7.2% (ie 1 in 10)
- Autism 1 in 59 children
- Cerebral palsy = 3 per 1,000 (ie 1 in 333)
- Childhood diabetes 1 in 720
- Childhood cancer ~ 184 new diagnoses in 2019
What do the Colleges do regarding Child Protection?

• Create Policy
• Create Procedural guidelines
  – Consensus statements
• Set Training requirements *(mandate CP)*
• Approve training pathways/ accredit sites
• Certify successful completion of training and award Fellowship
• MOPS and CPD (recertification)
Faculty of Clinical Forensic Medicine

Faculty of Clinical Forensic Medicine
Established in 2014, the RCPA Faculty of Clinical Forensic Medicine was founded to be the representative and training body for doctors working in the field of Clinical Forensic Medicine. Our objectives are to foster the highest standards in the provision of clinical forensic medicine.

Clinical Forensic Medicine is that branch of medicine concerned with the provision of forensic medical services primarily to the living and the collection and interpretation of information for the purposes of civil and criminal law, the judiciary and the police. It is that branch of clinical medicine that deals with both the medical and legal aspects of patient care.
What do governments do regarding child protection?

1. Policy – Federal Government
   **COAG**
   - **National Framework for Protecting Australia’s Children 2009-2020**
     - 3rd stage

2. Funding

3. Inquiries – Eg Institutional Responses to Child Sexual Abuse (Fed), Enquiry into Family Violence (Vic) + Mental Health (Vic) and many more

4. Collate data (Eg, AIHW)

“Just as a health system is more than hospitals so a system for the protection of children is more than a statutory child protection service”
State Governments

Each state and territory in Aust has its own approach. Funding, structures & programs differ

Active agenda - social policy

Differing
- Legislation re child protection
- Legislation re crimes
- Agencies for child protection / reporting criteria and processes
- Police and courts / Youth Justice
- Targeted support and intervention programs
- Interagency collaborations (join up silos)
Australian State Legislation protecting children

Children, Young Persons and their Families Act 1997 (Tas)

Children and Young People Act 2008 (ACT)

Children and Young Persons (Care and Protection) Act 1998 (NSW)

Care and Protection of Children Act 2007 (NT)

Child Protection Act 1999 (Qld)

Children’s Protection Act 1993 (SA)

Children, Youth and Families Act 2005 (Vic)

Children and Community Services Act 2004 (WA)
What do Hospitals & Health Services do regarding Child Protection?

• Create policy and procedures
• Clarify roles and responsibilities
• Create clinical practice guidelines
• Child Safe Standards (set by CCYP)
• Committees
  – (eg Vulnerable Children’s Committees)
  – Morbidity and Mortality
• Establish and support teams
• Monitor workforce performance
• Respond to complaints and critical incidents (VHIMS)
• Report to authorities

• Expect us to have expertise regarding abused and vulnerable children
About VFPMS

The Victorian Forensic Paediatric Medical Service (VFPMS) is a statewide coordinated medical service providing assessment and care for abused, assaulted and neglected children and young people.

Our services are provided using the most efficient and effective aspects of the Health system. We work collaboratively with Victoria Police and Child Protection to ensure service integration.

VFPMS offers 24 hour access to expert medical opinion regarding possible child abuse and neglect. We encourage early consultation as this may minimise complications and reduce any angst experienced by children and young people.

Our services are provided at The Royal Children's Hospital and Monash Medical Centre. Appointments can be arranged by calling 1300 66 11 42.
Definitions – Abuse categories

Vary across regions
Data collection “rigor” varies too… (fruit salad)

Definitions rarely mutually exclusive

Organisational culture influences “coding”
Data are frequently not complete or accurate
Physical abuse

Non-accidental use of physical force against a child that results in harm to the child

+/- intent

Some physical forces are considered abusive even if no injury results (eg shaking a baby)

Includes shoving, hitting, slapping, shaking, throwing, punching, kicking, biting, burning, strangling, and poisoning

Includes fabricated/induced illness by a parent or carer
Emotional Maltreatment

Emotional/psychological abuse/maltreatment

Parent or caregiver's inappropriate verbal or symbolic acts toward a child and/or a pattern of failure over time to provide a child with adequate non-physical nurture and emotional availability. Can damage a child's self-esteem or social competence.

Garbarino et al. (1986) defined 5 main behavioural forms:
- rejecting
- isolating
- terrorising
- ignoring
- corrupting

Pearl (1998) suggested 7 categories: ignoring, rejecting, isolating, terrorising, corrupting, verbally assaulting and over-pressuring.

Some class emotionally neglectful behaviours (rejecting, ignoring) as a form of neglect. DANYA GLASER (NB parental behaviour that is persistent and harmful)
Observed behaviours – attributed to fear & toxic stress (impact of trauma)

Maladaptive behaviours
- Hypervigilance – anticipate threat
- Inattentive – scanning environment
- Memory – both incorporating new memories and recall of old ones
- Learning difficulties, low levels of educational achievement
- Angry and defensive / combative (anticipate conflict) easily-angered
- Poor attachment, lack of trust (difficulty forming trusting relationships)
- Emotionally isolated, “hard to get close to”
Neglect

Failure by a parent or caregiver to provide a child (where they are in a position to do so) with the conditions that are culturally accepted as being essential for their physical and emotional development and wellbeing

Different sub-categories include:

- physical neglect – hygiene, clothing, housing, food, health care (some consider this medical neglect)
- emotional neglect - lack of caregiver warmth, nurturance, encouragement and support
- educational neglect
- environmental neglect
Sexual abuse

Complicated - varies depending on the relationship between victim and offender

- The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to ... or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. (WHO, 1999, p. 15)

Very general definition - "the use of a child for sexual gratification by an adult or significantly older child/adolescent" Tomison (1995)

“Any act which exposes a child to, or involves a child in, sexual processes beyond his or her understanding or contrary to accepted community standards" Broadbent & Bentley (1997)

Behaviours can include the fondling of genitals, masturbation, oral sex, vaginal or anal penetration by a penis, finger or any other object, fondling of breasts, voyeurism, exhibitionism and exposing the child to or involving the child in pornography
Other: eg., witnessing of family violence

A child being present (hearing or seeing) while a parent or sibling is subjected to physical abuse, sexual abuse or emotional maltreatment, or is visually exposed to the damage caused to persons or property by a family member's violent behaviour, (Higgins, 1998)

Some classify this as a special form of emotional maltreatment

Children can experience significant disruptions in their psychosocial wellbeing - affects self-concept, world view, sense of the future, relationships and may result in fearfulness and maladaptive behaviours
Witnessing violence by someone of any age towards someone of any age is harmful to children

This includes exposure to siblings’ violent behaviour (rage / destruction of property)

This includes violence directed by an adult or a child to towards a child’s siblings
• Includes physical punishment
• Includes cruel & controlling behaviour
• Includes emotionally abusive behaviours
Additional forms of child maltreatment

1. fetal abuse
2. bullying, or peer abuse
3. sibling abuse
4. witnessing community violence, war
5. institutional abuse
6. organised exploitation,
7. state-sanctioned abuse – neglect in orphanages, stolen generation, “forced” adoption
8. FGM, initiation rites eg Indigenous Australians
Which children are most at risk?

Different demographic x abuse type

- PA + neglect = infants & young children
- CSA = females > males (school age / older)
- Emotional abuse = all (underpins the harm of all child abuse & neglect)
- Beware subcategories of high risk – FASD, psychosocial adversity, ATSI, violence, D&A, Mental illness, ACEs,
Which children fare worst?
Worst outcomes?

- In general terms – younger age, longer duration, consistently awful, no remediable or modifiable factors, no positive attachment / protective factors,
- More ACEs
- Genetic vulnerability (eg males with
- Familial patterns of abuse/neglect (intergenerational)
OUTCOMES – longer term
Adverse childhood experiences

ACEs are linked to…
• Shorter lifespan
• More cancer, heart disease, respiratory illness, mental illness,
• More obesity, diabetes
• Poor lifestyle choices (smoking alcohol, drug use, sexual risk-taking),
• Relationship difficulties, violence
• Disability
    …. To name a few…. 
Resilience factors

- Optimism
- Locus of control
- One person who makes the child feel that they are valued / have value / are special
- Mediating relationships and experiences
- Fewer ACEs, less “severe” abuse / neglect
- Intermittent CAN (some “good times”)
- Genetic factors
Child Maltreatment Perpetrators by Relationship to Victim

- 41%: Mother
- 21%: Father
- 5%: Mother & Father
- 3%: Mother & Non-parent
- 7%: Other, Involving Parent
- 20%: Non-parent relative
- 2%: Partner of Parent
- 1%: Other/Unknown

USA Child Maltreatment 2017
AIHW definitions = all of Aust

**Notification** – contact made to child protection department regarding allegations of harm to a child

**Investigation** – obtain more information to determine if notification is substantiated or not substantiated

**Substantiation** – sufficient reason to believe that a child has been, is being or is likely to be abused, neglected or otherwise harmed
Types of abuse substantiated across Australia

- Physical
- Sexual
- Emotional
- Neglect
Figure 3.12: Children who were the subjects of substantiations, by abuse type, 2012–13 to 2016–17 (rate)

Note: See Appendix B: Technical notes for the methodology used to calculate rates.

Sources: Tables S19 and S64.
Figure 3.3: Children who were the subjects of substantiations of notifications received during 2016–17, by primary type of abuse or neglect, states and territories (%)

Note: Only the abuse type that is most likely to place the child at risk, or be most severe in the short term is reported for the first substantiation in the year.

Source: Table S9.
Figure 3.1: Investigations, by source of notification, 2016–17 Australia (%)
State and Territory based – Australian Bureau of Statistics

- 3rd cause of injury death after transport related deaths and accidental drowning
- 0.6 per 100,000
  - under 12 months = 2.1 per 100,000
- Under recognition is likely
PITFALLS
Lack of “expertise”

The Gladswell 10,000 hour rule for "expertise."

- It applies to outliers who are world-class performers.
- You don't need 10000 hr to be a regular expert
- BUT you do need to consult “experts” and adhere to policies, protocols and guidelines

Expertise is

- Knowledge
- Skill
- Behaviour (attitude, action)

Being & staying competent
- And working within limits of expertise / role
- And using other professionals as required
Overconfidence

- All it takes is a good heart…
  - (any paediatrician can do it)
- A little knowledge …the unknown unknowns
- Dunning-Kruger effect
- Hoping to hide discomfort or uncertainty
- Reluctance to admit “not sure”/ “don’t know”
Bias & other thinking “traps”

Eg.,

• Contextual bias
• Confirmatory bias / Anchoring
• Implicit / unintentional bias
• Group think / Bandwagon effect
• Framing effect
• Need for closure / Premature closure
• Many others….

Prejudice

Implicit bias – being positively or negatively predisposed towards certain people

- “such nice people” / “really good parents”

OR

- “he was odd” “she seemed drug affected” “they were dirty/smelly”

- “Just like us” versus “they looked like child abusers” or “he/she was angry / evasive”

This is a very powerful influence on thinking and a dangerous problem for doctors and nurses who might diagnose (or miss) child abuse
Blind eye

WHY?
• Laziness
• Avoidant personality / attitude
• Excuses… Too busy.. Not my job…
• In unfamiliar territory / uncomfortable role
• Rose coloured glasses (unjustified optimism)
• Lack of organisational expectation / support
• Working in isolation / lacking scrutiny or accountability
PEARLS
General tips

• Search for and value TRUTH
  – Aim for as close to TRUTH as you can get
• Believe in a just world
• Value friends, colleagues, professionals. Work together. Help them /don’t get in their way…
• Advocate for the individual child and groups of children – for a better trajectory in life
• Read widely, use range of resources to save time
• Work smart… Work hard… Don’t give up….
• Promote resilience, achieve work-life balance
• ……….. yes, Mum…..
More “tips” – with an evidence base

- Valuable and time saving resources
  - What and where are they?
- Guidelines – CPG
  - Where are the good ones?
  - Are USA and UK “OK” in Australia?
- Advice for PROCESS of evaluation of CAN
  - Best books? Best internet sources
- CDR (clinical decision rules)
Reference materials

• TEXTBOOKS

• The Quarterly Update

• College websites for links
  – CORE-Info - > Child Protection Evidence
  – Child Protection Companion RCPCH
  – AAP website / Child Welfare Information Gateway

• Journals / Google = not the initial step but good for recent (important) publications

• UpToDate
Guidelines (CPR/CPG) for practice

- Colleges (note AAP, RCPCH, Canada)

- For Investigation of
  - Bruising
  - Burns/scalds
  - Occult fracture
  - Head trauma/Suspected head injury (? AHT)
  - Abdominal trauma (? Internal injury)
  - Strangulation
  - Sexual assault
  - Sibling/household contacts of index/injured child
  - Factitious and induced illness
  - Neglect/emotional maltreatment

- TEXTBOOKS – best resource for study (flowcharts best for quick use)
Child Protection Evidence
RCPCH - website

https://www.rcpch.ac.uk/key-topics/child-protection/evidence-reviews

<table>
<thead>
<tr>
<th>Our reviews</th>
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<tr>
<td>Bites</td>
<td>Bruising</td>
<td></td>
</tr>
<tr>
<td>Burns</td>
<td>Dental neglect</td>
<td></td>
</tr>
<tr>
<td>Ear, nose and throat</td>
<td>Early years neglect</td>
<td></td>
</tr>
<tr>
<td>Fractures</td>
<td>Neurological injuries</td>
<td></td>
</tr>
<tr>
<td>Oral injuries</td>
<td>Parent-child interaction</td>
<td></td>
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<tr>
<td>Retinal findings</td>
<td>School-aged neglect</td>
<td></td>
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<tr>
<td>Spinal injuries</td>
<td>Teenage neglect</td>
<td></td>
</tr>
<tr>
<td>Visceral injuries</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note the limitations of systematic reviews & effect of circular reasoning
AAP – child maltreatment, child physical abuse - HISTORY

BE ALERT WHEN

- no explanation or a vague explanation for significant injury;
- explicit denial of trauma in a child with obvious injury;
- important detail of explanation changes in substantive way;
- explanation provided inconsistent with the pattern, age, or severity of the injury or injuries;
- explanation given inconsistent with child’s physical and/or developmental capabilities;
- unexplained or unexpected notable delay seeking medical care;
- different witnesses provide markedly different explanations for the injury or injuries.
Examination

Top to toe + diligent search (good light)
- TEN 4 sites
- Scalp – in hair and behind ears
- Mouth – frenula & palate
- Palpate all bones
- Think? Intrathoracic and intra-abdo trauma
- Neurological – + symptoms & signs
- Growth & development
- Interactions w caregivers
Clinical Practice Guidelines

• Vary between regions
• Evidence base is soft (for many indicators)
• Changing over time
  – As new evidence becomes available
  – New technologies & tests become available
  – As “group think” lessens and standards increase

• Most CPG = Consensus / working groups’ opinion
• Not all groups follow recommended CPG development process (eg, NHMRC)
Eg – when is skeletal survey necessary? If < 2 years old and...

• One known fracture = > search for more
• Bruising
• Suspected AHT / known AHT
• Burns
• Other – eg young sibling of AHT /PA case
• History => suspicions
• Exam => suspicions
Box 1. Canadian Assessment of Tomography for Childhood Head Injury: the CATCH rule

CT of the head is required only for children with minor head injury* and any one of the following findings:

High risk (need for neurologic intervention)

1. Glasgow Coma Scale score < 15 at two hours after injury
2. Suspected open or depressed skull fracture
3. History of worsening headache
4. Irritability on examination

Medium risk (brain injury on CT scan)

5. Any sign of basal skull fracture (e.g., hemotympanum, “raccoon” eyes, otorrhea or rhinorrhea of the cerebrospinal fluid, Battle’s sign)
6. Large, boggy hematoma of the scalp
7. Dangerous mechanism of injury (e.g., motor vehicle crash, fall from elevation ≥ 3 ft [≥ 91 cm] or 5 stairs, fall from bicycle with no helmet)
Box 3:
The Canadian Assessment of Tomography for Childhood Head injury 2 (CATCH2) rule

**CT of the head is required for children with minor head injury** and any 1 of these findings:

- GCS score < 15 at 2 hours after injury
- Suspected open or depressed skull fracture
- History of worsening headache
- Irritability on examination
- Any sign of basal skull fracture
- Large, boggy hematoma of the scalp
- Dangerous mechanism of injury
- ≥ 4 episodes of vomiting

Note: CT = computed tomography, GCS = Glasgow Coma Scale.

*Minor head injury is defined as injury within the past 24 hours associated with witnessed loss of consciousness, definite amnesia, witnessed disorientation, persistent vomiting (> 1 episode) or persistent irritability (in a child aged < 2 yr) in a patient with a GCS score of 13–15.

†Signs of basal skull fracture include hemotympanum, raccoon eyes, otorrhea or rhinorrhea of the cerebrospinal fluid, and Battle sign.

‡Dangerous mechanism is a motor vehicle crash, a fall from elevation ≥ 3 ft (≥ 91 cm) or 5 stairs, or a fall from a bicycle with no helmet.
### Table 5:

Sensitivity and specificity of the 8-item CATCH2 rule for children with minor head injury

<table>
<thead>
<tr>
<th>Variable</th>
<th>No. of patients*</th>
</tr>
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<tbody>
<tr>
<td>Neurosurgical intervention</td>
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<tr>
<td>Result of rule assessment</td>
<td>Yes</td>
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<tr>
<td>Positive</td>
<td>23</td>
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<tr>
<td>Negative</td>
<td>0</td>
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<tr>
<td>Sensitivity, % (95% CI)</td>
<td>100</td>
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<tr>
<td>Specificity, % (95% CI)</td>
<td>45.7</td>
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<tr>
<td>Brain injury on CT</td>
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<tr>
<td>Result of rule assessment</td>
<td>Yes</td>
</tr>
<tr>
<td>Positive</td>
<td>196</td>
</tr>
<tr>
<td>Negative</td>
<td>1</td>
</tr>
<tr>
<td>Sensitivity, % (95% CI)</td>
<td>99.5</td>
</tr>
<tr>
<td>Specificity, % (95% CI)</td>
<td>47.8</td>
</tr>
</tbody>
</table>

Note: CATCH = Canadian Assessment of Tomography for Childhood Head injury, CI = confidence interval, CT = computed tomography.

20,137 children & adolescents with head injuries.
  – 2106 (10%) had CTs
  – 4544 (23%) were admitted,
  – 83 (<1%) underwent neurosurgery, and
  – 15 (<1%) died.

In the comparison cohort of 18,913 patients with mild injuries, sensitivities for clinically important TBI were similar.

Negative predictive values in both analyses were higher than 99% for all rules.

• PECARN = 4011 (75%) of 5374 patients younger than 2 years and 11,152 (76%) of 14,763 patients aged 2 years and older.

• CATCH = 4957 (25%) patients

• CHALICE = 20,029 (99%).

• “The highest point validation sensitivities were shown for PECARN in children younger than 2 years (100·0%, 95% CI 90·7–100·0; 38 patients identified of 38 with outcome [38/38]) and PECARN in children 2 years and older (99·0%, 94·4–100·0; 97/98), followed by CATCH (high-risk predictors only; 95·2%; 76·2–99·9; 20/21; medium-risk and high-risk predictors 88·7%; 82·2–93·4; 125/141) and CHALICE (92·3%, 89·2–94·7; 370/401).”

Babl et al 2018
PECARN - CT or NO CT
younger than 2 years, GCS 14 or 15
More to come

- Do the “pre-reading” tonight…
- Take notes throughout the seminar
  - Reflect daily “what were key learnings today?”
- Consider “What will I do if/when….?”
  - it’s all about me… I am here to learn…
  - Pay attention to CPG / advice
- Ask questions! “Sit at the table” ie engage

Re Friday - See VFPMS template -how to write report
  - Just do it