Introduction to Safeguarding Children in General Practice

DR VIMAL TIWARI

NAMED SAFEGUARDING GP

HERTS VALLEYS CCG

QUESTIONS AND FURTHER ENQUIRIES TO vtiwari@nhs.net

Child Protection

RESPONSE: WHAT TO DO IF YOU ARE WORRIED ABOUT A CHILD

Statutory Child Protection Agencies

NSPCC

POLICE

SOCIAL CARE

SEVEN STAGES IN ASSESSMENT, ANALYSIS AND PLANNING INTERVENTIONS cf. Bentovim, Cox, Bingley Miller, Pizzey & Tapp (2014)

- **Stage 1: initial recognition (and referral)**
- **Stage 2: gathering information**
- Stage 3: organising the information available
- Stage 4: analysing patterns of harm and protection
- Stage 5: predicting the likely outlook for the child
- Stage 6: developing a plan of intervention – which might include referral
- Stage 7: identifying outcomes and measures for intervention

Assessment of Best interests: the acutely ill or injured child

If the child is acutely ill or injured arrange immediate treatment;

Try to share your concerns with the parent or carer unless to do so would increase risk or harm to the child;

Alert the receiving hospital to the possibility that the child has been maltreated;

Contact the police if you suspect a crime has been committed.

What to do if you are worried about a child

URGENT REFERRALS: CHILD AT RISK OF ABUSE OR HAS ALREADY BEEN ABUSED

If you suspect that a child is acutely ill or injured as a result of abuse or neglect refer to the on-call paediatrician telling them of your concerns. Also contact the following numbers:

If you have evidence of immediate risk to the child: The Police **999**

The Child Abuse Investigation Unit can be contacted on: **101**. This is a specialist team that is a department within the police with countywide responsibility for undertaking child protection investigations.

If you think the child requires a child protection medical examination: Children's Services (including out of hours): **0300 123 4043**

Child Protection referral form may be found at https://www.hertfordshire.gov.uk/media-library/documents/childrens-services/hscb/child-protection-form.pdf

NON-URGENT REFERRALS: CHILD IN NEED

Referral form may be found at https://www.hertfordshire.gov.uk/media-library/documents/childrens-services/counselling-in-schools/singleservicerequestform.pdf

Early Help and Families First: https://directory.hertfordshire.gov.uk/kb5/hertfordshire/directory/advice.page?id=1qoC89WJaGo

Support for families and carers: https://directory.hertfordshire.gov.uk/kb5/hertfordshire/directory/results.page?familiesfirstchannel=1-3

Assessment of ‘best interest’: the less urgent situation

Use	If delaying a referral is in your judgement unlikely to result in increased risk or harm, use your internal referral and advice systems before accessing external sources;
Familiarise	Familiarise yourselves with your local policies and protocols (In Hertfordshire available online at http://hertsscb.proceduresonline.com/index.htm)
Seek	Always seek advice on any child safeguarding issue especially if uncertain.

Referring children in special circumstances

Child Sexual Exploitation https://www.hertfordshire.gov.uk/services/childrens-social-care/child-protection/hertfordshire-safeguarding-children-board/child-sexual-exploitation/child-sexual-exploitation-in-hertfordshire.aspx

Fabricated and Induced Illness http://hertsscb.proceduresonline.com/chapters/p_fab_ill.html

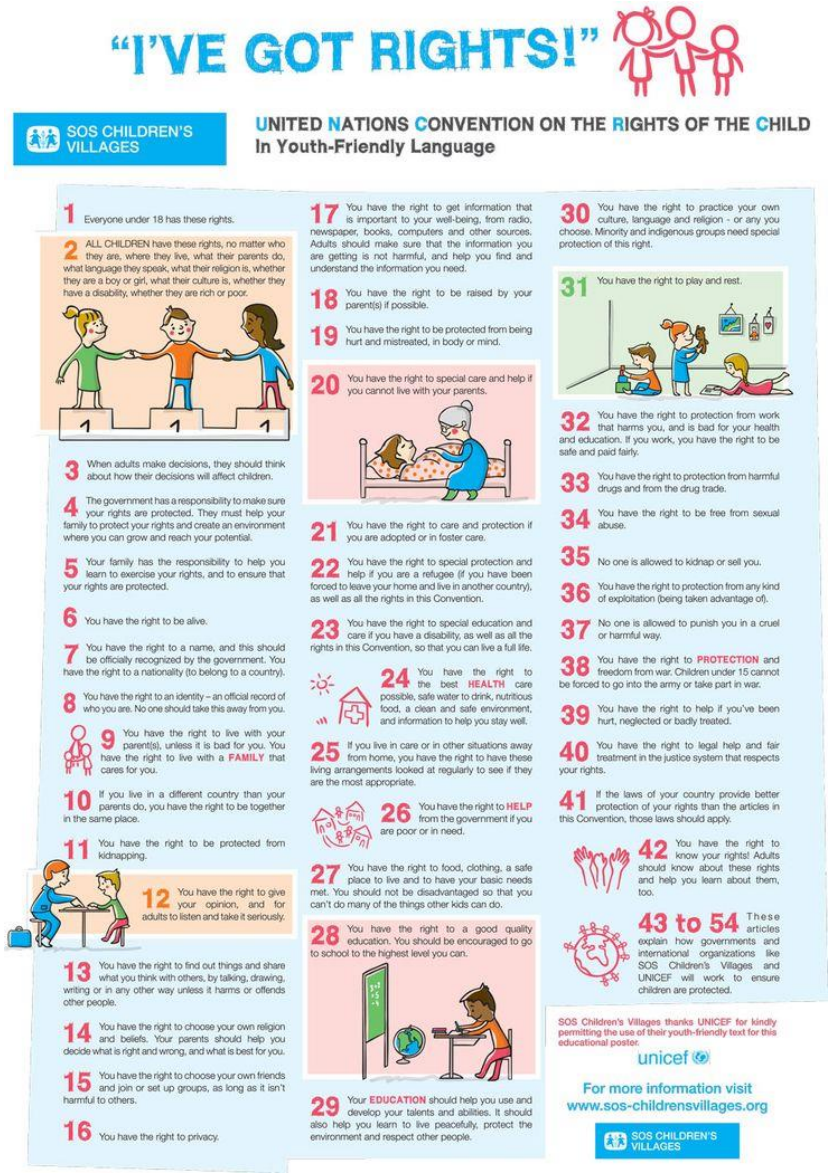
Female Genital Mutilation https://www.hertfordshire.gov.uk/media-library/documents/childrens-services/hscb/professionals/final-fgm-protocol-pathway-hertfordhsire-14.07.2017.pdf

Forced Marriage https://www.hertfordshire.gov.uk/media-library/documents/herts-sunflower/forced-marriage-factsheet.pdf

Media and Internet Abuse CEOP https://www.ceop.police.uk/safety-centre/

Modern Slavery and Trafficking https://www.hertscommissioner.org/modern-slavery

Radicalisation https://www.gov.uk/government/publications/protecting-children-from-radicalisation-the-prevent-duty



Best Interests: UN Convention on the rights of the child 1989

The Convention has 54 articles that cover all aspects of a child's life and set out the civil, political, economic, social and cultural rights that all children everywhere are entitled to. It also explains how adults and governments must work together to make sure all children can enjoy all their rights.

Article 19

article 19 (protection from violence, abuse and neglect) Governments must do all they can to ensure that children are protected from all forms of violence, abuse, neglect and bad treatment by their parents or anyone else who looks after them

Child Maltreatment: All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust, or power.

WHO 1999

UN Convention on Rights of the Child

The 3 Ps:

► **Protection**: The right to be protected against actions and certain behaviours. For example, the right to be protected from discrimination or exploitation.

► **Provision**: The right to access benefits, services, or activities. For example, the right to receive an education, The right to health and nutrition, the right to an adequate standard of living.

► **Participation**: The right to engage in activities. For example, the right to have views and to make these views known, the right to participate and express an opinion relating to decisions affecting the child, the right to enjoy freedom of expression.

Assessment of ‘Best Interests’

Flexible to the unique needs and rights of an individual child

- Must take into account:
  - the child’s views;
  - the child’s identity;
  - care, safety and protection of the child;
  - situation of vulnerability;
  - the child’s right to health;
  - and the child’s right to education.
  - Wherever possible preservation of the family environment and relationships.

Department of Health, Department for Education and Employment & Home Office (2000)

Benefits of Early identification and intervention

- Avoid long-term damage
- Effects of emotional abuse and neglect cumulative
- All types of abuse have serious adverse long-term consequences across all aspects of development, including children's social and emotional wellbeing, cognitive development, physical health, mental health and behaviour
- Reference Bellis MA, Hughes K, Leckenby N, et al. Measuring mortality and the burden of adult disease associated with Adverse Childhood Experiences in England: a national survey. Journal of Public Health 2014b; doi: 10.1093/pubmed/fdu065.

Advice and support

For GPs: Every GP Surgery has a GP Safeguarding Lead and there is a Named Safeguarding GP covering each locality in Hertfordshire and supporting the surgeries within that locality

Hertfordshire Child Safeguarding Team 01707 685349 or 01707 685460 will signpost to the best source of advice depending on the problem.

The hospitals and community trusts each have their own child safeguarding teams

General information **Hertfordshire Safeguarding Children Board Procedures Manual**

http://hertsscb.proceduresonline.com/chapters/key_chapters.html

MASH

Multi-Agency Safeguarding Hub (MASH) **http://www.hertsdirect.org/your-council/hcc/childserv/aboutcs/futservchil/mash/**

NB GPs cannot refer into the MASH or seek advice from them but the MASH has authority to contact any GP Surgery and request confidential information within a time scale of 2 hours.

If a surgery is contacted by the MASH:

a) Validate the telephone number- if this is not possible ask for the name of the person contacting the surgery and use the generic number **0300 123 4043** for further contact

b) Ask if there is parental consent to provide information, check from whom and for whom consent has been obtained, e.g. is it from both parents? as you may hold information about parents which they might not wish to be disclosed to their partners or ex-partners

c) if social care are unable to email you written consent, consider whether you need to obtain consent from the patient/s before sharing information and whether you should send the patient/s a copy of what has been shared

d) If information is being provided to social care by telephone, ask if the call is being recorded and if a transcript will be shared with the patient/s - this precaution applies to any telephone contact with social care not just the MASH

Remember the importance of accurate, contemporaneous documentation

- The key details of every patient contact including telephone calls should be summarised in medical records

Good clinical records also include:

- the information that patients have been given,
- any prescribed drugs or other treatment or investigation and
- who is making the record and when.
- Notes should also subsequently be made on the patient's progress, alongside findings on examination, monitoring and follow-up arrangements.

Overview

Context and Definitions

"The history of childhood is a nightmare from which we have only just begun to awaken. The further back in history one goes, the lower the level of child care, and the more likely children are to be killed, abandoned, beaten, terrorized, and sexually abused" (deMause,L., 1976 *A History of Childhood*,Condor).

Safeguarding: term originally came from *Safeguarding Children: A Joint Chief Inspectors' Report(2002)* In its simplest terms ' safeguarding' can be defined as 'keeping children safe from harm, such as illness, abuse or injury'

Child Protection: is the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect. It involves measures and structures designed to prevent and respond to abuse and neglect.

Patient safety is the prevention of errors and adverse effects for patients associated with health care.
RCGP Patient Safety Toolkit
http://www.rcgp.org.uk/clinical-and-research/toolkits/patient-safety.aspx

- safe systems,
- safety culture,
- communication,
- patient reported problems,
- diagnostic safety,
- prescribing safety

Practitioner Challenges

- Pressure of more urgent cases.
- Belief in natural love between parents and children.
- Faith in the particular family (rule of optimism).
- Disbelief.
- Over pessimism regarding taking children into "care".
- Lack of experience.
- Burnt out/high thresholds.
- Fear of upsetting a "good" relationship.
- Fear of violence.

'How can the healthcare professional actually build partnerships with parents and children in situations of suspected or substantiated child abuse and still deal rigorously with maltreatment issues?'

What does legislation do?

Safeguarding and protecting children

- Children Act 1989
- Children Act 2004
- Sexual Offences Act 2003

Recruitment and selection of staff and volunteers

- Safeguarding Vulnerable Groups Act 2006
- Protection of Freedoms Act 2012

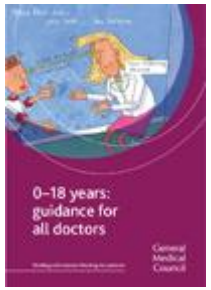
Other legislation

- Human Rights Act
- UN Convention on the Rights of the Child

Professional Bodies and Regulators

General Medical Council http://www.gmc-uk.org/publications/standards_guidance_for_doctors.asp

The standards expected of healthcare professionals by their regulatory bodies may at times be higher than the minimum required by the law.



Care Quality Commission

Nigel's surgery 33: Safeguarding children

https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-33-safeguarding-children

The Evidence Base

Case studies and case reviews including serious case reviews

Survivor accounts

Survivor morbidity and mortality

Reference: *Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment* Carolyn Davies and Harriet Ward Childhood Wellbeing Research Centre http://www.cwrc.ac.uk/about/843.html

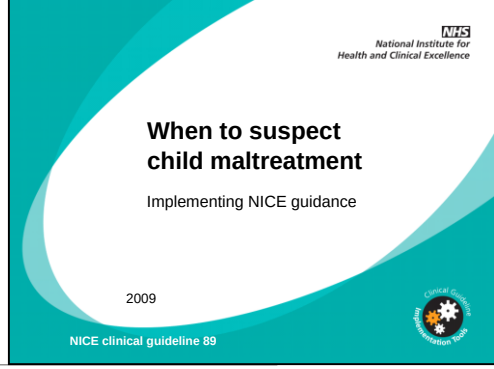
NICE Guidance CG 89 Child maltreatment: when to suspect maltreatment in under 18s https://www.nice.org.uk/Guidance/CG89

NICE Guidance NG 76 Child abuse and neglect https://www.nice.org.uk/guidance/ng76

Centre on the Developing Child at Harvard University https://developingchild.harvard.edu/

Adverse Childhood Experiences Public Health Institute Liverpool John Moores University http://www.cph.org.uk/case-study/adverse-childhood-experiences-aces/

NICE Guidance



CG 89 When to suspect child maltreatment: https://www.nice.org.uk/Guidance/CG89

Consider maltreatment

Suspect maltreatment

NG 76 Child Abuse and Neglect: “soft signs, the behaviours or emotions a child is exhibiting, which could indicate something might be wrong”

“red flags include a child regularly attending school unclean or with injuries, overtly sexual behaviours in children who are below the age of puberty, and parents excessively smacking their children.”

https://www.nice.org.uk/guidance/ng76

Serious Case Reviews

Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Improve intra and inter-agency working;

Better safeguard and promote the welfare of children.

Key themes from SCRs: those most at risk of dying or serious injury from maltreatment

Babies< than 12 months

young people >14 years

Circumstances of Children living in the UK

2.6 million children in the UK are living with parents who drink hazardously; 705,000 of those are dependent on alcohol

110,123 adults who were parents or lived with children were treated by the National Agency for Substance Misuse in 2013–14

130,000 children are living in families where family life has been damaged by past or present domestic abuse

17,000 children are living with parents with a severe and enduring mental illness7

657,800 concerns about children were referred to children's social care services during 2013–14, an increase of 10.8% compared with the previous year

Facts

- On average, every week in the UK, at least one child is killed at the hands of another person.
- Over a third of serious case reviews involves a child under one.
- For every child placed on a child protection plan or the child protection register, we estimate there are another eight children who are suffering from abuse and neglect and not getting the support they need.
- There were 72670 looked after children in England on 31 March 2017.
- Deaf and disabled children are more than three times more likely to be abused or neglected than non-disabled children.

Figures based on Radford et al (2011) *Child abuse and neglect in the UK today*.

Prevalence of child maltreatment in the UK compared with common physical conditions

CHILD MALTREATMENT

5% children under 11

18.6% children 11-17

25% of young adults reported abuse and/or neglect in a retrospective study (about 14% had been known to services) (Radford, L., Corral, S., Bradley, C., Fisher, H., Bassett, C., Howat, N. with Collishaw, S. (2011) Child abuse and neglect in the UK today London: NSPCC www.nspcc.org.uk/childstudy)

COMMON PHYSICAL DISEASES

diabetes mellitus Types I and II 7.4%

cardiovascular disease 13.6%

lifetime incidence of cancer (any) 1 in 3

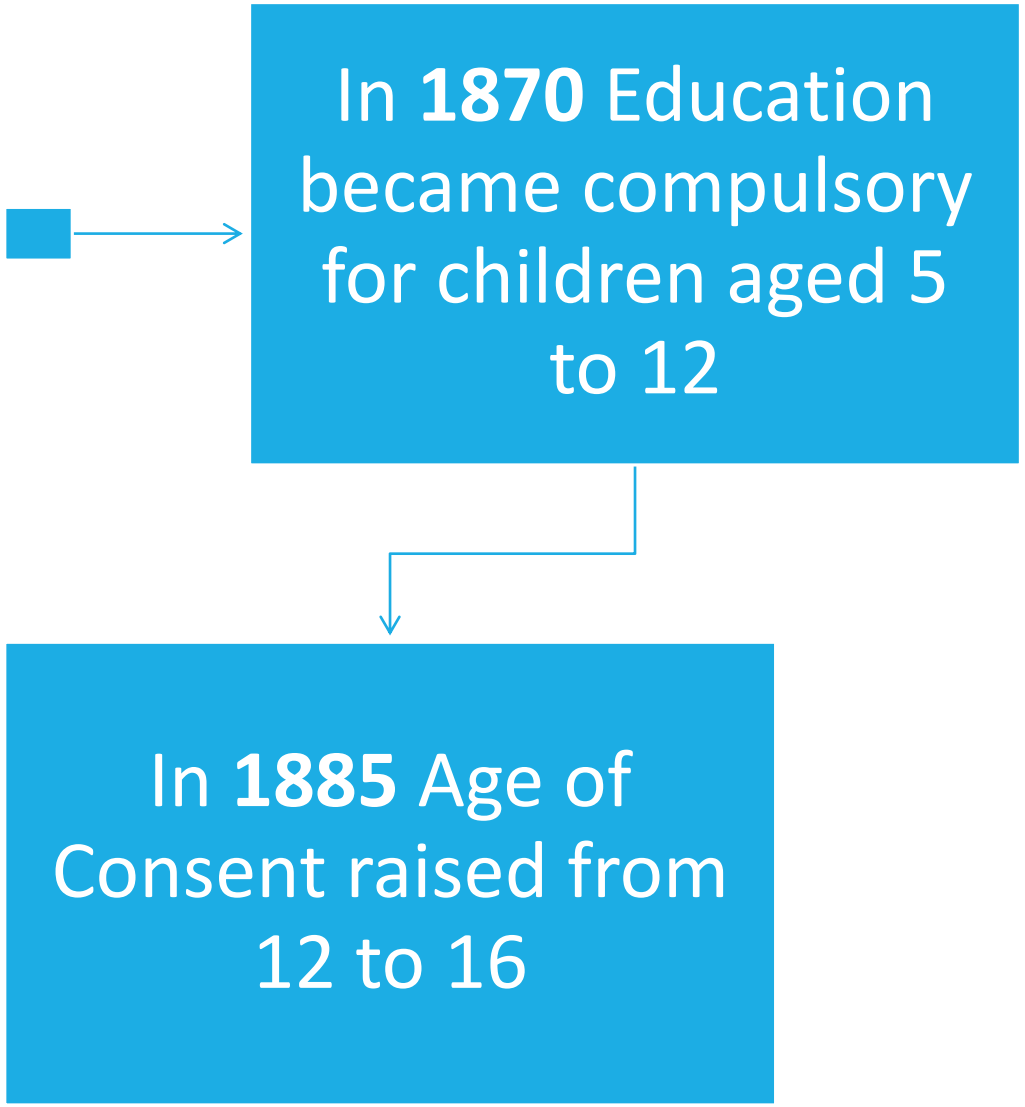
The evolution of child protection legislation

- Children from poor families started work as young as 4. They worked in coal mines, factories including textile mills and as chimney sweeps.
- Child prostitution was accepted as normal.
- A combination of hard physical work and sub-nutrition could lead to stunting of growth and skeletal deformities. Occupational diseases including heavy metal poisoning, pulmonary conditions and STDs shortened life and these children could be dead before the age of 25.
- Industrial accidents causing serious injuries and fatalities were frequent.
- Beating was a common punishment in the workplace and in schools.

- Imagehttp://www.victorian-era.org/victorian-children-in-factories.html

The Factory Act 1833

Children under the age of 9 not allowed to work
-Children not allowed to work overnight
-Compulsory two hours schooling each day



Current legislation

In England the law states that people who work with children have to keep them safe.

This safeguarding legislation is set out in The Children Act (1989) and (2004).

It also features in the United Nations Convention on the Rights of the Child (to which the UK is a signatory) and sets out the rights of children to be free from abuse.

Safeguarding legislation and government guidance says that safeguarding means:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- taking action to enable all children and young people to have the best outcomes

Policy Document: Working together to safeguard children

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

This document sets out how organisations and individuals should work together to safeguard and promote the welfare of children, bringing together all duties under the various pieces of legislation.

It is addressed to practitioners and front line managers who have particular responsibilities for safeguarding and promoting the welfare of children, and to senior and operational managers, in organisations that:

are **responsible for commissioning or providing services to children, young people, and adults who are parents/carers**; or

have a particular responsibility for safeguarding and promoting the welfare of children.

Who?

Why?

Kyra Ishak
2010: lack of information sharing between agencies

Victoria Climbie
2000: Children Act 2004

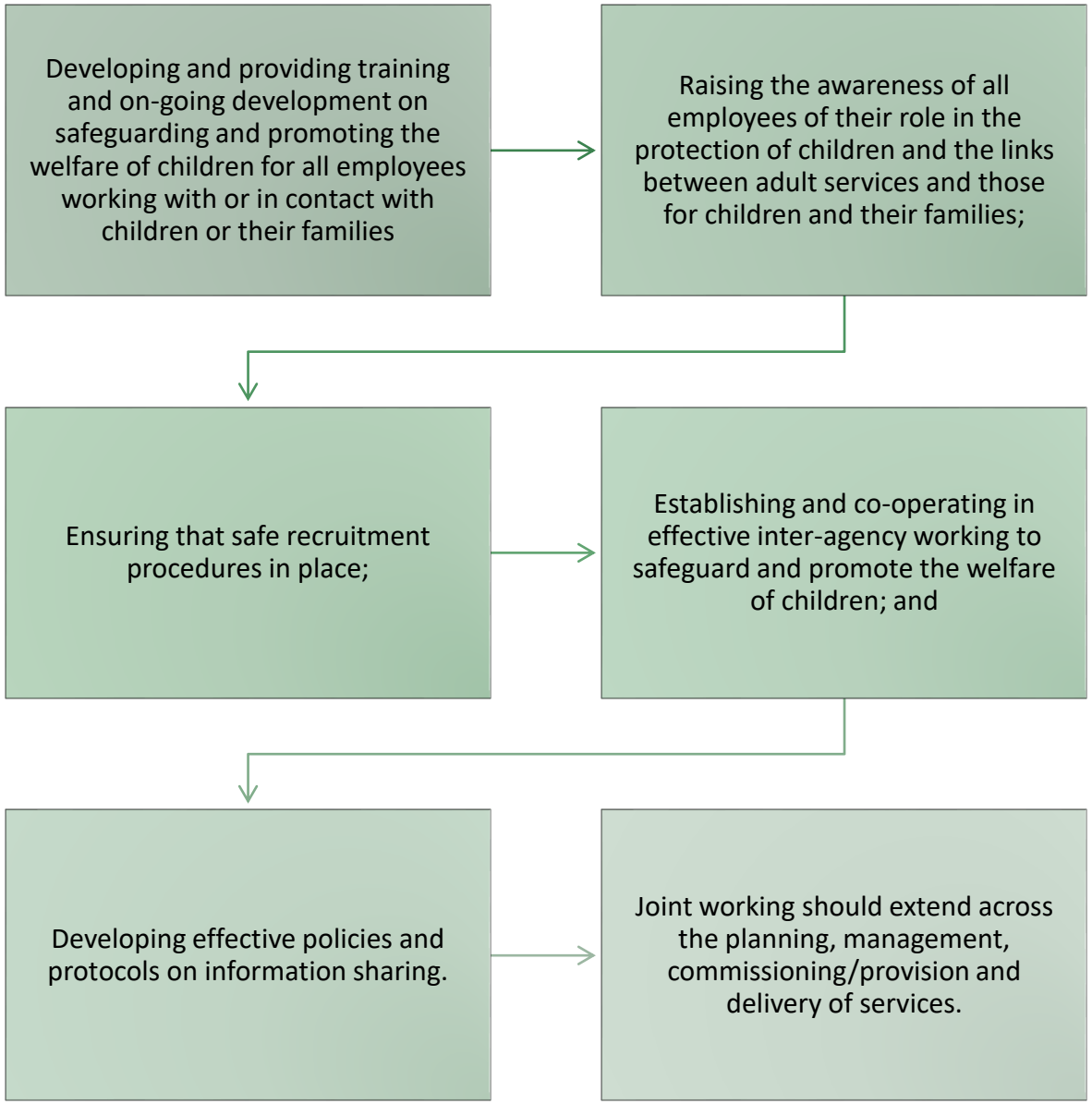
Peter Connelly
2009: suspension of two doctors and a social care review

Daniel Pelka
2013: Interagency response to domestic abuse and effective use of interpreters

Children Act 2004 Section 11: key duties for Healthcare organisations

Providing	senior management commitment to the importance of safeguarding and promoting children's welfare;
Ensuring	that the agency fulfils its obligations under the Children Act 2004, particularly where they are under a duty to: (a) co-operate with local authorities in making arrangements with a view to improving the well-being of children;
Ensuring	that the agency commits the resources necessary to meet its obligation under the Children Act 2004;
Developing	a clear written statement of the agency's responsibilities towards children that is available for all employees and agency clients;
Establishing and maintaining	a clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children;
Having	continuing service development that takes account of the need to safeguard and promote welfare and is informed, where appropriate, by the views of children and families;

Children Act 2004 Section 11: key duties for Healthcare organisations continued



Resource

SafeNetwork
http://www.safenetwork.org.uk/getting_started/Pages/Why_does_safeguarding_matter.aspx

References

► Butchart, E., Harvey, A. P., Mian, M. & Fürniss, T. (Eds.) (2006). Preventing child maltreatment: a guide to taking action and generating evidence. Geneva, Switzerland: World Health Organization.

► Coram Children's Legal Centre, Coram Voice, European Roma Rights Centre, Child Law Clinic, & Family Child Youth Association (2016): Unlocking Children's Rights; Strengthening the capacity of professionals in the EU to fulfill the rights of vulnerable children

► European Commission(2010). Feasibility Study to assess the possibilities, opportunities and needs to standardise national legislation on violence against women, violence against children and sexual orientation violence. Brussels.

► Krug, E., Dahlberg, L., Mercy, J., Zwi, A. & Lozano, R. (2002): World report on violence and health. http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf

► UN Committee on the Rights of the Child (CRC) General comment No. 13 (2011): The right of the child to freedom from all forms of violence. http://www.refworld.org/docid/4e6da4922.html

► UNICEF (2008). Early Childhood Development: The key to a full and productive life. https://www.unicef.org/dprk/ecd.pdf

► European Parliamentary Research Service (2014). Violence towards children in the EU. http://www.europarl.europa.eu/RegData/etudes/IDAN/2014/542139/EPRS_IDA(2014)542139_EN.pdf

► World Health Organisation (2002). World Report on Violence and Health.

► WHO (2013): European report on preventing child maltreatment. http://www.euro.who.int/__data/assets/pdf_file/0019/217018/European-Report-on-Preventing-ChildMaltreatment.pdf

► World Health Organization (1999): Report of the Consultation on Child Abuse Prevention, 29-31 March 1999. Geneva. http://apps.who.int/iris/handle/10665/65900

Revision:
Levels 1 and 2 Child Safeguarding

https://www.rcpch.ac.uk/sites/default/files/page/Safeguarding%20Children%20-%20Roles%20and%20Competences%20for%20Healthcare%20Staff%20%2002%200%20%20%20%20(3)_0.pdf

Risk Factors

Child Risk Factors

- Age - younger children
- Gender: girls: higher risk for infanticide, sexual abuse, educational and nutritional neglect

  boys: higher risk for physical abuse
- Special Characteristics – twins, children with handicaps, prematurity, unwanted pregnancy

Parent/Caregiver Risk Factors

- Young age
- Single parent
- Unwanted pregnancy
- Poor parenting skills
- Substance abuse
- Physical or mental illness

Risk Factors

Family Risk Factors

- Overcrowded living circumstances
- Poverty
- Social isolation
- Major stress
- Domestic violence

Community/Societal Factors

- poorly enforced child protection laws
- Limited value of children
- Social acceptance of violence (family, community or society – including war)
- Cultural norms
- Social inequities - poverty

Professional Risk Factors

Failing to:

- Acknowledge that child maltreatment exists
- Identify and address child maltreatment
- Offer necessary services to children and families
- Help prevent maltreatment
- Promote health, development and safety
- Address major risk factors

Types of Abuse

- Neglect
  - Neglect is the persistent failure to meet a child's basic physical and/or psychological needs
- Physical Abuse
  - Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child.
- Sexual Abuse
  - Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities
- Emotional Abuse
  - emotional maltreatment of a child, may involve conveying to children that they are worthless or unloved, inadequate

Not forgetting:

- Fabricated and induced illness
- Sexual exploitation
- Radicalisation
- Female genital mutilation
- Forced marriage
- Modern slavery
- Trafficking
- Media and internet abuse

Legislation

CHILDREN ACT 1989

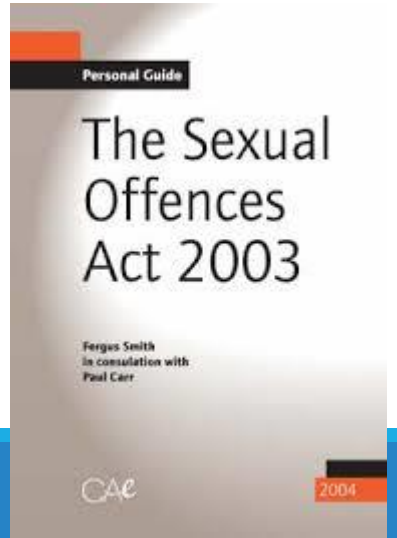
Section 17 Child in Need

Section 47 Child at Risk

CHILDREN ACT 2004

Duty of agencies to share information

Duty to ensure all working with children have level of safeguarding training appropriate to their roles



Caring for Adult Survivors of Childhood Abuse

THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES ON LIFE COURSE

Adverse childhood events study Felitti et al Am J Prev Med 1998

Physical/sexual/emotional abuse.

Neglect (physical/emotional).

Domestic substance abuse.

Domestic violence.

Parental mental illness.

Parental criminality.

Adverse Childhood Experiences (ACEs) such as abuse, neglect and dysfunctional home environments have been shown to be associated with the development of a wide range of harmful behaviours including smoking, harmful alcohol use, drug use, risky sexual behaviour, violence and crime.

They are also linked to diseases such as diabetes, mental illness, cancer and cardiovascular disease, and ultimately to premature mortality

Adverse Childhood experiences

Adverse childhood events study Felitti et al Am J Prev Med 1998

Adult Outcomes if 4 or more ACEs

- 2 x times more likely to currently binge drink and have a poor diet
- 3 x times more likely to be a current smoker
- 5 x times more likely to have had sex while under 16 years old
- 6 x times more likely to have had or caused an unplanned teenage pregnancy
- 7 x times more likely to have been involved in violence in the last year
- 11 x times more likely to have used heroin/crack or been incarcerated

For the creation of health….

the social and physical environment must be:

Comprehensible.

Manageable.

Meaningful.

……or the individual would experience chronic stress

What are we doing wrong?

Health Deficits approach

- We tend to focus on people's problems, needs and deficiencies.
- We design services to fill gaps and fix their problems.
- They become passive recipients of services.
- We do things to people rather than with them

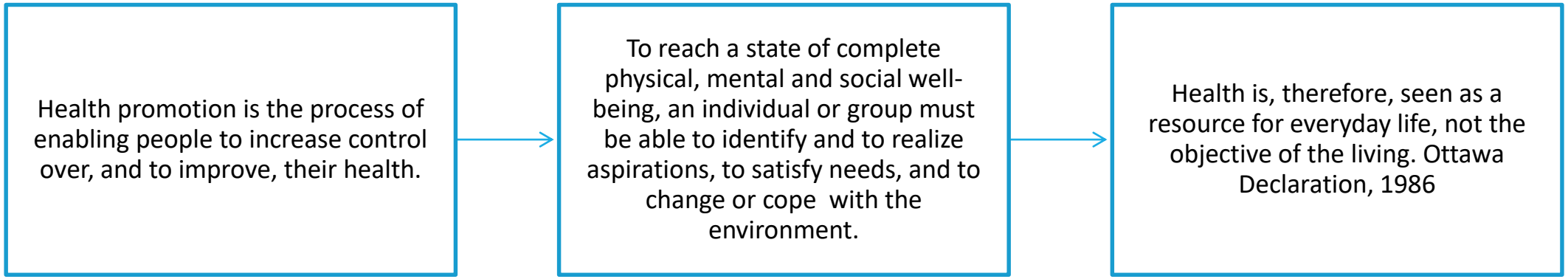
Routine **E**nquiry about **A**dversity in **Ch**ildhood (REACH) screening tool

enable practitioners to identify adults with high ACE scores who have experienced multiple adverse experiences, which may lead to not only poor health and social outcomes but are also at higher risks of exposing their own children to adverse experiences.

to support these individuals and families through targeted parenting programmes and interventions to enable them to provide safe and supported childhoods for their own family.

enquiring early/responding appropriately: reduce costly interventions that focus on symptoms

The assets approach



References

BLACKBURN WITH DARWEN: ACE (ADVERSE CHILDHOOD EXPERIENCES) SCREENING PILOT http://www.eif.org.uk/case-study/blackburn-with-darwen-ace-adverse-childhood-experiences-screening-pilot/

National Scientific Council on the Developing Child. Excessive stress disrupts the architecture of the developing brain, Working Paper No. 3 [online]. 2005 [cited 2008 Feb 20]. Available from www.developingchild.net.

Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine 1998;14(4):245–58.

Runyan D, Wattam C, Ikeda R, Hassan F, Ramiro L. Child abuse and neglect by parents and caregivers. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002. p. 59–86.

The Ottawa Charter for Health Promotion www.who.int/healthpromotion/conferences/previous/ottawa/en/

Safeguarding Children: Red Flags in the 10 minute Consultation

DR VIMAL TIWARI

NAMED SAFEGUARDING GP HERTS VALLEYS CCG

UK Homicide Statistics 2015

https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2015/chapter2homicide#summary

- 518 homicides (murder, manslaughter and infanticide) in year ending March 2015 in England and Wales
- 10% were under 16, with all but 4 being killed by a parent or step-parent

There were 25 children under one year old, with infants under 12 months continuing to have the highest homicide risk in the population

- For children aged one or over, homicide rates were higher for one to four year olds than for five to fifteen year olds.

Adolescent issues

Suicide remains a leading cause of death in young people in the UK

the number of deaths due to intentional injuries and self-harm have not declined in 30 years.

Sexual Exploitation: 2,409 children were confirmed as victims of sexual exploitation in gangs and groups during the 14-month period from August 2010 to October 2011.

16,500 children from across England were identified as being at high risk of CSE during the period April 2010-March 2011. This figure is based on children who displayed three or more signs of behaviour indicating they were at risk of CSE.

Trafficking: 1278 referred to the National Referral Mechanism

Life cycle approach: Vulnerable Groups

Pre-conception: Known issues e.g. care leavers, mental health and addiction, victims of domestic abuse, offenders, chronic long-term conditions

Pregnant women and women having given birth

Infants

Children with long-term chronic conditions and/or disability

Children of parents with domestic abuse, mental health or alcohol dependency/substance abuse issues

Adolescents

Survivors of abuse

Children of certain cultures/ethnicities

Red Flags: Pre-conception- The Vulnerable Patient

The troubled adolescent

School refusal, truanting

Mental Health issues, Learning difficulties,

Substance and/or alcohol abuse

Offending

History of abuse

History of child protection procedures

In care or care leaver

Importance of pre-pregnancy risk-assessment

Red Flag: Teenage Pregnancy

- Teenage Pregnancy in UK still high compared with some Western European countries but is falling. In England in 2015, 20351 women under the age of 18 became pregnant, 34% of all conceptions, approximately 3466 of whom were under the age of 16.

Teenage parents are prone to poor antenatal health,

Lower birth weight babies, higher infant mortality rates.

Their health, and that of their children, is likely to be worse than average;

- Adolescents in foster care or who are care leavers are more likely to become pregnant in their teens;
- Children born to teenage parents are more likely to enter foster care and to have several carers in their lives.

http://www.thenationalcampaign.org/why-it-matters/pdf/child_welfare.pdf

Hertfordshire pre-birth protocol

http://hertsscb.proceduresonline.com/chapters/p_prebirth.html#unborn

Two fundamental questions when deciding whether a pre-birth assessment is required:

- Will this new-born baby be safe in the care of these parents/carers?
- Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?

Childbirth & Mental Health

- Exacerbates pre-existing mental health disorders up to 50%
- Poorly understood
- Lack of training
- Emphasis on ‘wellness’
- Screening often ineffective
- Medication advice poor
- Stigma, labelling, shame & embarrassment
- Fear of not being a ‘good enough’ mother
- Fear from the ‘authorities’
- Great deal at stake
- **Midwives often first point of contact**

Peri-natal mental health

Incidence of ‘baby blues’ ? Possibly most new mothers

Incidence of post-natal depression probably around 1 in 10

Incidence of puerperal psychosis 3-4 per 1000

Consequences of peri-natal mental health problems

Very few mentally ill mothers physically harm their babies but it is difficult to predict which mothers will do so

BUT psychological distress during pregnancy and following the birth is a significant risk factor for a range of adverse outcomes in the child.

Up to 20% of all women develop a mental health condition during or after pregnancy

Perinatal mental health problems carry a total economic and social long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.

RCGP Peri-natal Mental Health Toolkit http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

Red Flags: The Infant

- Multiple attendances>1 per month;
- Check charts in PHCR: Weight and Head; Circumference, have pre-determined strategy for dealing with concerns such as failure to thrive or rapidly expanding head circumference;
- Difficult pregnancy or/and delivery;
- Who brings the child to the GP?

Babies <12 months: red flags

Sub-conjunctival haemorrhage

Bulging fontanelle

Bleeding from orifices

Torn frenula

Bruising

Failure to move a limb

Unexplained swellings

Failure to thrive

Mothers and Babies: importance of 6-8 week check

- **Opportunity to check on mother - child relationship.**
- **Bonding, attachment, coping**
- **Paternal role and social support, environment**
- **Domestic violence**
- **Post-natal depression**
- **Physical examination:** only routine check in child's life carried out by a physician **http://newbornphysical.screening.nhs.uk/**

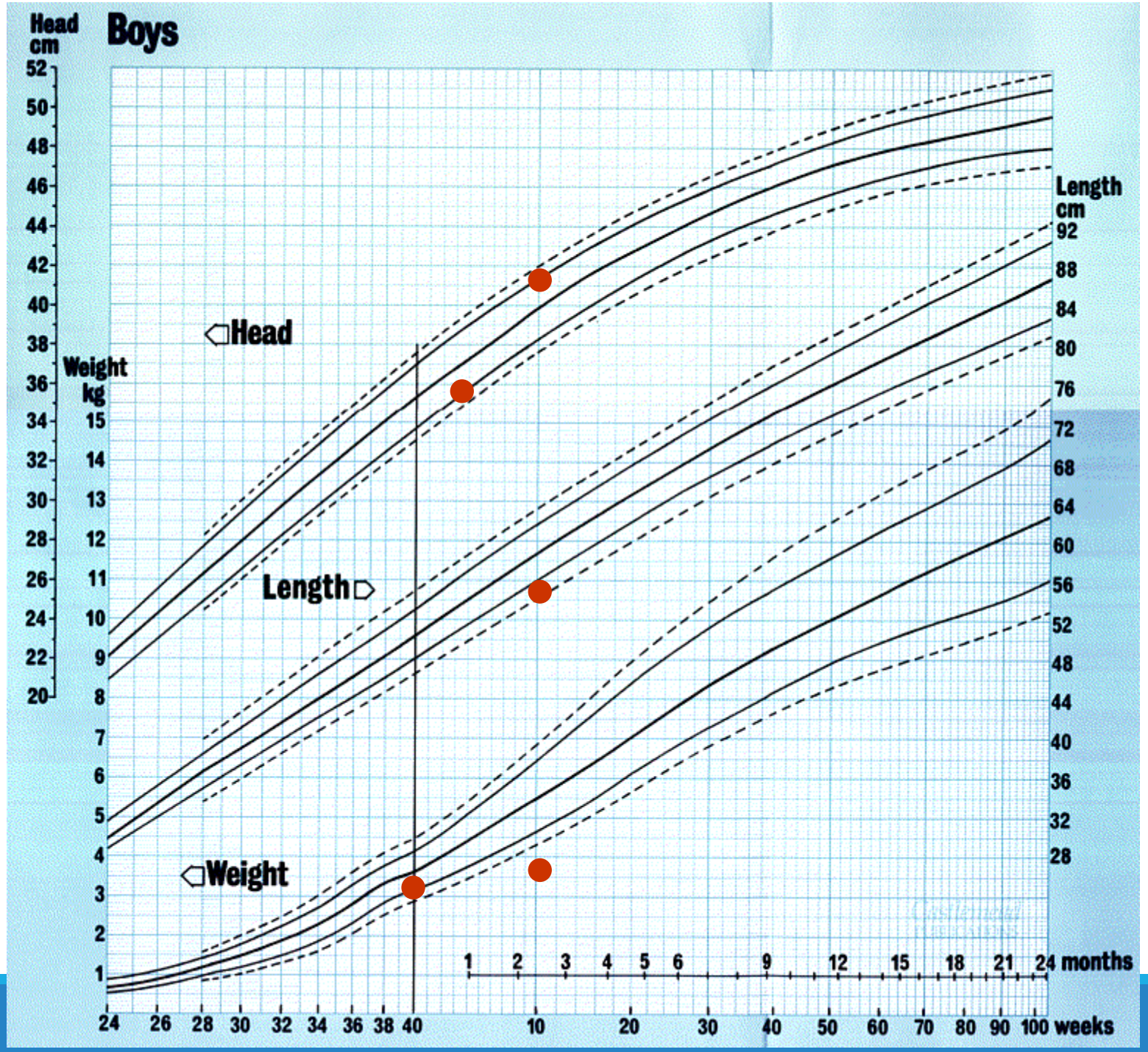
The Personal Child Health Record

A shared patient record

An opportunity for parents to record developmental stages

Partnership working with parents

Please remember to use it!


Head cm
Boys
52
50
48
46
44
42
40
38
36
34
32
30
28
26
24
22
20
Head
Weight kg
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
Length
Weight
Length cm
92
88
84
80
76
72
68
64
60
56
52
48
44
40
36
32
28
1 2 3 4 5 6 9 12 15 18 21 24 months
24 26 28 30 32 34 36 38 40 10 20 30 40 50 60 70 80 90 100 weeks

Additional risk factors in children with disability and long-term conditions

- Increased likelihood of being socially isolated with fewer outside contacts than non disabled children
- Dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour
- An impaired capacity to resist or avoid abuse e.g. may have mobility impairment or speech, language and communication needs which may make it difficult to tell others what is happening
- Often do not have access to someone they can trust to disclose that they have been abused
- Are especially vulnerable to bullying and intimidation

Looked after disabled children

Looked after disabled children are not only vulnerable to the same factors that exist for all children living away from home, but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical care needs

When Childhood Obesity becomes a Child Protection Concern

- When parents behave in a way that actively promotes treatment failure in a child who is at serious risk from obesity even when the parents or carers understand what is required, and are helped to engage with the treatment programme.
- Parental behaviours of concern include consistently failing to attend appointments, refusing to engage with various professionals or with weight management initiatives, or actively subverting weight management initiatives.
- **These behaviours are of particular concern if an obese child is at imminent risk of co-morbidity—for example, obstructive sleep apnoea, hypertension, type 2 diabetes, or mobility restrictions.**
- Clear objective evidence of this behaviour over a sustained period is required, and the treatment offered must have been adequate and evidence based.

Reference: R. Viner et al **Childhood protection and obesity: framework for practice** *BMJ* 2010; 341 doi: http://dx.doi.org/10.1136/bmj.c3074 (Published 15 July 2010)

Bruising indicating the possibility of physical abuse

- bruising in children who are not independently mobile
- bruising in babies
- bruises that are seen away from bony prominences
- bruises to the face, back, abdomen, arms, buttocks, ears and hands
- multiple bruises in clusters
- multiple bruises of uniform shape
- bruises that carry an imprint e.g. of an implement or cord
- bruises with petechiae around them.

Hertfordshire Bruising Protocol
http://hertsscb.proceduresonline.com/pdfs/brusing_protocol.pdf

Indications of non-accidental fractures

children under 18 months with a fracture

children whose fracture is inconsistent with their developmental stage

multiple fractures, particularly of different ages, in the absence of an adequate explanation

rib fractures in children with normal bones and no history of major accidents

a fractured femur in a child who is not yet walking.

Red Flags: The Child

Who accompanies the child?

The unaccompanied child

The dirty child

The inappropriately dressed or made-up child

The unhappy child

A history which does not match the symptoms/signs

Unexplained injuries

The child regarded as a ‘problem’ by one or both parents

Red Flags: Infants, Children and Young People<18

- Multiple unscheduled attendances at GP, OOHs, A&E;
- Failure to attend scheduled appointment for routine screening and immunisations, OPD, Dental Care, Therapies; **“child not brought”**
- Unexplained injury or constellation of allegedly ‘accidental’ injuries;
- Reported Illness where parents/carers are the only witnesses to the symptoms and signs while examination and investigations are always normal.

Young People >14

Serious case reviews have found that agencies focused on the young person's challenging behaviour, seeing them as hard to reach or rebellious, rather than trying to understand the **causes** of the behaviour and the **need for sustained support**

Young people were treated as adults rather than being considered as children, because of confusion about the young person's age and legal status or a lack of age-appropriate facilities

Worrying signs in adolescence

Sudden behaviour change

Change in routine

Change in appearance

Change in language

Unusual and/or expensive gifts

Excessive time spent on computer

Sudden onset of aggressive behaviour

Self-harm/overdosing

Mood swings

Depression

School refusal or excessive attendance

Running away

Sexual Risk in Adolescents

- **HIGH RISK:**
- First sex under 16 years old and poor contraceptive use
- Multiple sexual partners
- Sexually active but not using contraception
- Demonstrating or exposed to inappropriate and/or risky sexual behaviours
- Vulnerable to or has been sexually abused or exploited
- Repeated access to Emergency Hormonal Contraception
- **Any sexually active young person under 13 years old must be referred to child protection services (Sexual Offences Act 2003)** http://www.legislation.gov.uk/ukpga/2003/42/part/1/crossheading/rape-and-other-offences-against-children-under-13

Assessing sexual risk in adolescents

The BASHH Proforma

http://www.rcgp.org.uk/clinical-and-research/toolkits/~/media/4714C849CF8348B4AD6BB107FDF2ED9E.ashx

Fabricated or induced illness

A child is presented with a persistent or recurrent, unusual illness featuring perplexing symptoms and signs

Clinical findings do not fit the history and histories may not be consistent between absences over a period of time

Symptoms trail off or fail to present when the child is under professional management and the carer is not present

Symptoms recur shortly after a well child has been discharged from hospital

An explained discrepancy in symptom constellation is corrected within the same or next episode

Accounts of illness are not borne out by GP's records

The child or other children in the family have been presented elsewhere with illness

Unusual illness or unexplained death in siblings

There may be previous history of abuse

Medical Indicators of neglect

Child not brought for developmental checks and immunisations

Child not brought to scheduled appointments at GP, OPD, community services, therapies

Inappropriate and/or frequent unscheduled attendances at A&E, OOHs services

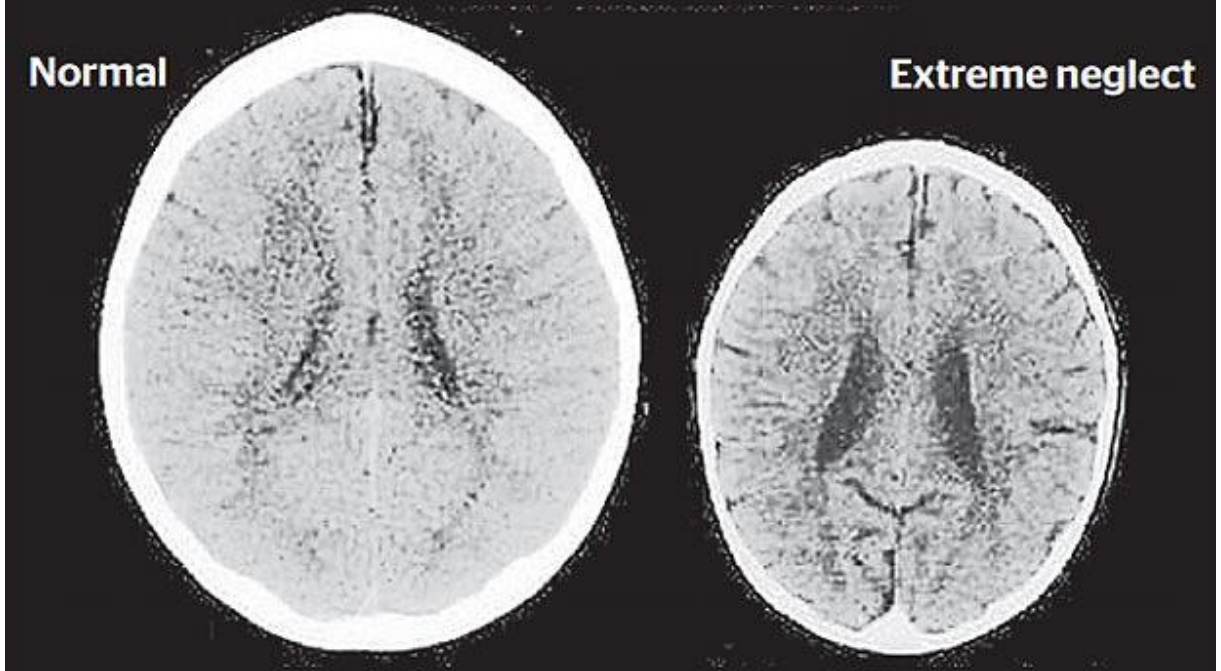
Unexpected incidence of injuries

Dental caries at or before age 5

Remember the impact of neglect can be delayed and show in many different ways e.g. failure to thrive, developmental delay, learning difficulties

HOW STRESS CHANGES A CHILD'S BRAIN

3-YEAR-OLD CHILDREN



- Prolonged exposure to trauma triggers physiological changes in the brain.
- Neural circuits are disrupted, causing changes in the hippocampus, the brain's memory and emotional centre.
- This can cause brain shrinkage, problems with memory, learning and behaviour.
- A child does not learn to regulate emotions when living in state of constant stress.
- Associated with greater risk of chronic disease and mental health problems in adulthood.

Indicators of Emotional Abuse in Primary Care

- Behavioural disturbance
- Failure to thrive
- Anxiety
- Poor school performance
- Running away and truanting (NB can be signs of any type of abuse)
- Enuresis (wetting) /Encopresis (soiling)

Indicators of Sexual Abuse in Primary Care

- Sexualised behaviours, age-inappropriate behaviours
- Behavioural disturbances
- Sexually transmitted diseases
- Pregnancy
- Abrasions or/and bruises of external genitalia and thighs
- 90% of children suffering sexual abuse will not have physical signs

Be aware of Hidden Abuse

Child Sexual Abuse and Sexual Exploitation

Human Trafficking

Human Slavery

Female Genital Mutilation

Radicalisation

Forced Marriage

Media and/or internet abuse

The evidence base

DfE 2014 A Study to Investigate the Barriers to Learning from Serious Case Reviews and Identify ways of Overcoming these Barriers https://www.gov.uk/government/publications/barriers-to-learning-serious-case-reviews

Mental health in pregnancy, the postnatal period and babies and toddlers: needs assessment report 2016 http://www.chimat.org.uk/PIMH_Needs_Assessment

NSPCC 2015 Learning from case reviews https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/

References and Useful Websites

Advisory Council on the Misuse of Drugs. Hidden harm- responding to the needs of children of problem drug users. London: Advisory Council on the Misuse of Drugs, 2011 Available from: www.gov.uk/government/publications/amcd-inquiry-hidden-harm-report-on-children-of-drug-usersHogg S. Prevention in mind. All babies count: spotlight on perinatal mental health. London: NSPCC, 2012 (cited 2015 Sep 03). Available from: www.nspcc.org.uk/services-and-resources/research-and-resources/all-babies-count-spotlight-perinatal-mental-health/Network of Public Health Observatories http://www.apho.org.uk/resource/view.aspx?RID=116350

NICE. Social and emotional wellbeing: early years. NICE guideline (PH40). London: National Institute for Health and Clinical Excellence, 2012 Available from: www.nice.org.uk/guidance/ph40/

NICE CG62 Antenatal care: NICE guideline http://guidance.nice.org.uk/CG62/NICEGuidance/pdf/English

NICE CG110 Pregnancy and Complex Social Factors http://www.nice.org.uk/Search.do?x=0&y=0&searchText=pregnancy+and+complex+social+factors&newsearch=true#/search/?reload

NICE. Antenatal and postnatal mental health: clinical management and service guidance. NICE guidelines (CG192). London: National Institute for Health and Care Excellence, 2014 Available from: www.nice.org.uk/guidance/cg192

NICE. Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE guidelines (PH50). London: National Institute for Health and Care Excellence, 2014 Available from: www.nice.org.uk/guidance/ph50

NSPCC Adults Abused in Childhood http://www.nspcc.org.uk/help-and-advice/worried-about-a-child/online-advice/adults-abused-in-childhood/adults-abused-in-childhood_wda87228.html

The Lifelong Effects of Early Childhood Adversity and Toxic Stress *Pediatrics Vol. 129 No. 1 January 1, 2012 pp. e232 -e246* *http://pediatrics.aappublications.org/content/129/1/e232.full.html*

RCGP/NSPCC Safeguarding Children Toolkit 2014

http://www.rcgp.org.uk/clinical-and-research/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

Core-Info

A series of systematic literature reviews of physical abuse and neglect in children

http://www.rcpch.ac.uk/child-protection-evidence/

Children in Care and Care Leavers

UNDER THE **CHILDREN** ACT 1989 A COUNCIL CAN APPLY FOR A **CARE** ORDER IF IT BELIEVES A CHILD IS SUFFERING OR AT RISK OF SUFFERING SIGNIFICANT HARM.

HTTPS://WWW.GOV.UK/GOVERNMENT/UPLOADS/SYSTEM/UPLOADS/ATTACHMENT_DATA/FILE/664995/SFR50_2017-CHILDREN_LOOKED_AFTER_IN_ENGLAND.PDF

Care Orders

Under the Children Act 1989, a child is looked after by a local authority if he or she falls into one of the following:

is provided with accommodation, for a continuous period of more than 24 hours, [Children Act 1989, Section 20 and 21]

is subject to a care order [Children Act 1989, Part IV]

is subject to a placement order

Statistics

The number of looked after children continues to increase;

it has increased steadily over the last nine years.

At 31 March 2017 there were 72,670 looked after children, an increase of 3% on 2016.

In 2016 the number of adoptions fell for the first time since 2011, by 12%

in 2017 the number of looked after children adopted have fallen again, by 8% to 4,350.

Reasons for being in care

62% Abuse and/or neglect

15% Family dysfunction

8% Family in acute stress

7% Absent parenting

3% Parental illness or disability

3% Child disability

2% Socially unacceptable behaviour

Outcomes for care leavers https://www.nao.org.uk/report/care-leavers-transitions-to-adulthood/

50% have emotional well being problems

25% of those who were homeless had been in care at some point in their lives;

49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience;

22% of female care leavers became teenage parents;

and looked-after children and care leavers were between four and five times more likely to self-harm in adulthood

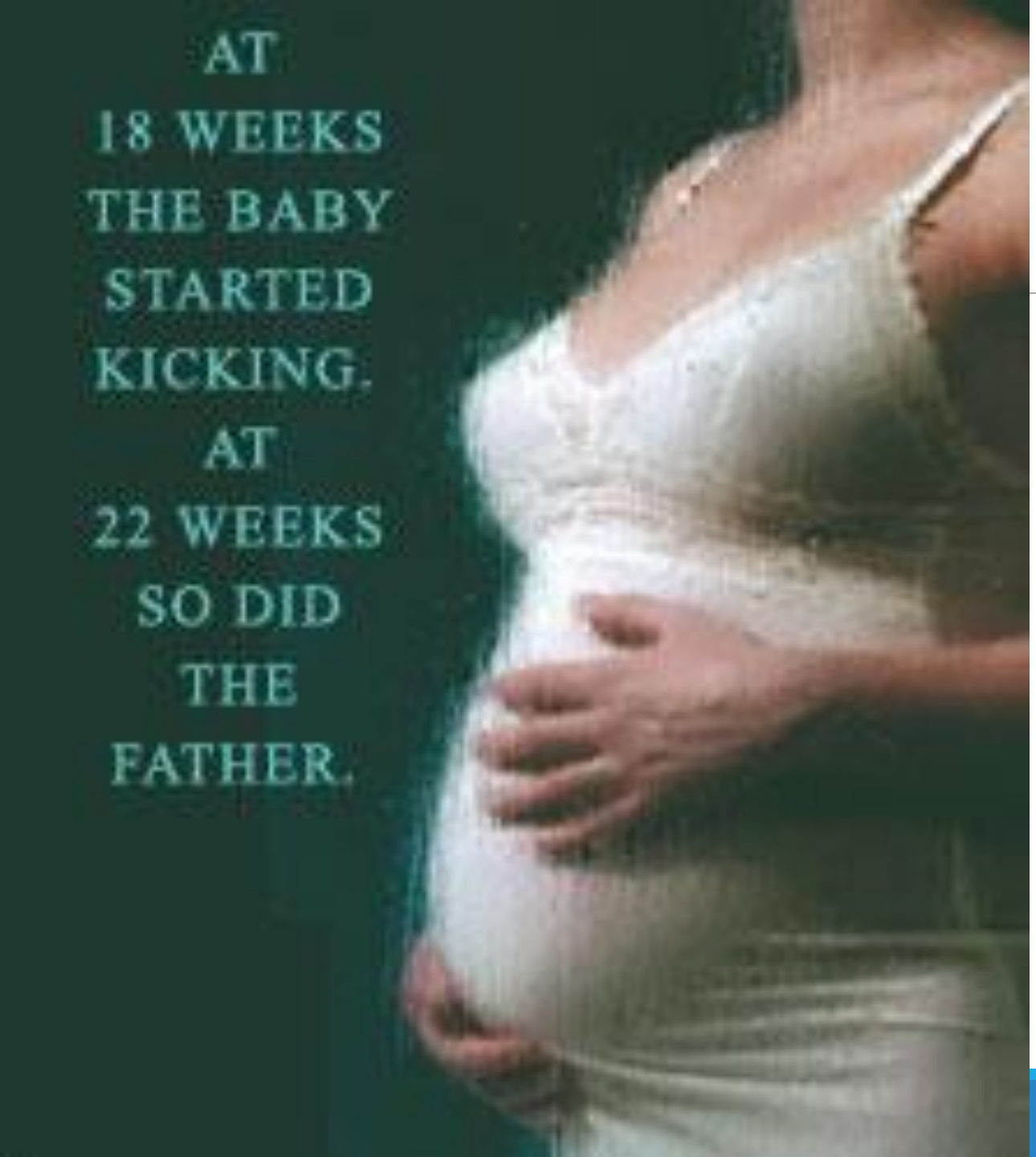
GP role

Ensure that children in care and care leavers are identified on your systems by appropriate coding and summarising

Ensure alerts are in place to enable administrative staff to provide appointments appropriately

Be aware of their vulnerabilities when seen at the surgery

Be alert for signs of changes in circumstances e.g. sexual exploitation, gang involvement, radicalisation



Domestic Abuse

What is Domestic Violence ?

The term `domestic violence' is used to describe the physical, sexual or emotional (including verbal and financial) abuse inflicted on a man or woman by their partner or ex-partner.

Parental Factors most commonly associated with child abuse in Hertfordshire, and elsewhere

Domestic violence;

Drug and alcohol abuse;

Anti-social behaviour and offending;

Mental health disorders.

References

Becker,F.,French,L(2004) Making the links: Child Abuse, animal cruelty and domestic violence *Child Abuse Review* 13:399-414

Browne,K.D., Herbert,M.,(1997) .*Preventing Family Violence* Chichester:Wiley

Lung, C. T. and D. Daro. 1996. Current trends in child abuse reporting and fatalities: The results of the 1995 annual fifty state survey. Chicago, IL: National Committee to Prevent Child Abuse.

Wolfe,D.(1993) Child Abuse Prevention *Child Abuse Review* 2(2):153-165

Image Source www.refuge.org.uk who run a 24 hour National Domestic Violence Helpline 08082000 247

Incidence of Domestic Violence

16% of all violent crime, children are present in half of all reported incidents

1 in 4 women and 1 in 6 men in their lifetime

Revictimisation: Has more repeat victims than any other crime

Claims the live of 2 women per week and 30 men per year

Is the largest cause of morbidity worldwide in women aged 19-44, greater than war, cancer or motor vehicle accidents Home Office statistics 2006

Around 1 in 5 children have been exposed to **domestic** abuse

Domestic Abuse

Confidential enquiry into Maternal Deaths 2001

3 mothers were murdered by their partners

Led to change in legislation and police policy in dealing with DA: Domestic Violence, Crime and Victims Act (2004).

Physical abuse by a partner often is triggered by a pregnancy

Women subjected to domestic violence may have to be hit more than 30 times before disclosure, may deny the occurrence, think it is their fault, deny risk to children

Domestic abuse static perpetrator factors associated with risk of serious harm

Used severe violence with injuries requiring medical treatment

Attempted strangulation-most common killing method

Alcohol and/or drug abuse by the perpetrator

Used or threatened to use a weapon

Threatened to kill himself and/or partner/ex partner

Was violent to current/former partner when pregnant

Used sexual violence such as rape

Assaulted children and/or other family members

Previous stalking behaviour

Estrangement (separation)

Risk Factors for becoming a Victim of Domestic Abuse

being female

long-term illness or disability (women and men with a long-term illness or disability were almost twice as likely to experience domestic violence as others)

use of any drug in the last year

marital status (married people had the lowest risk, while those who had previously been married had the highest risk)

NICE2011

The British Crime Survey

every year more than one million women experience domestic abuse;

one in four women will be affected by domestic abuse.

more than 300,000 women are sexually assaulted

60,000 women raped;

more than one in twenty women will be stalked.

http://www.homeoffice.gov.uk/media-centre/press-releases/domestic-homicide-reviews

Multi-Agency Risk Assessment Conference

A MARAC, or multi-agency risk assessment conference, is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors

After sharing all relevant information about a victim, representatives discuss options for increasing safety for the victim and turn these options into a co-ordinated action plan.

The primary focus of the MARAC is to safeguard the adult victim.

Children must be referred through the usual local child protection procedures.

Serious psychological harm

The mental health of women victims is often badly affected:

1) Depression, symptoms of trauma (PTSD), attempted suicide
2) Depression varies between studies, 38%-83%
3) PTSD symptoms, flashbacks, numbness and denial and hyper-vigilance (not able to sleep)

How are children involved?

In relationships where there is domestic violence, children witness about three-quarters of the abusive incidents.

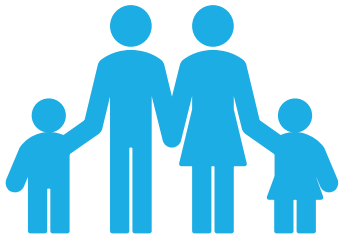
About half the children in such families have themselves been badly hit or beaten.

Sexual and emotional abuse are also more likely to happen in these families.

How are children affected?

- Upset, anxiety, distress
- Children with these problems often do badly at school
- They may also get symptoms of post-traumatic stress disorder,
- for example have nightmares and flashbacks, and be easily startled.

Older children



Boys :

express their distress much more outwardly.

may become aggressive and disobedient;

sometimes start to use violence to try and solve problems, as if they have learnt to do this from the way that adults behave in their family.

Older boys may play truant

may start to use alcohol or drugs.

Effect on Girls

Girls are more likely to keep their distress inside.

They may withdraw from other people and become anxious or depressed.

They may think badly of themselves and complain of vague physical symptoms.

They are more likely to have an eating disorder,

Or harm themselves by taking overdoses or cutting themselves.

Impact on the child

Always has a negative effect and some will be at risk of significant harm

Under an amendment to the Children Act 1989 significant harm includes “impairment or suffering from seeing or hearing the ill treatment of another”

Cawson (2002) 8 out of 10 young people who suffered serious physical abuse also experienced domestic violence which in nearly half of cases was constant or frequent.

DV Children and the Criminal Justice system in Hertfordshire

8 times more likely to be excluded from school

25% of all child arrestees come from DV homes

75% of YOT managed children come from DV homes

DV Children in Hertfordshire

50% of children (from top 20 DV locations) have special educational needs in Herts

85% of all Serious Case Reviews including a child death at hands of a violent parent have DV as a feature

Are there any long-term effects?

Children who have witnessed violence are more likely to be either abusers or victims themselves.

Children tend to copy the behaviour of their parents.

Boys learn from their fathers to be violent to women.

Girls learn from their mothers that violence is to be expected, and something you just have to put up with.

Children from violent families often grow up feeling anxious and depressed, and find it difficult to get on with other people.

GP Role

Ask the question

Train staff to respond appropriately to disclosure

Have relevant information to hand- police phone number, local support groups, safety plan

RCGP GUIDELINES: http://www.rcgp.org.uk/clinical-and-research/a-to-z-clinical-resources/domestic-violence.aspx

Know how to refer to MARAC or respond to requests for information

http://www.safelives.org.uk/sites/default/files/resources/MARAC%20FAQs%20General%20FINAL.pdf