Child Abuse and Neglect

Case Definitions

Child: under 18 years old

- Child abuse and neglect means the harm, or likely harm, experienced by a child as a result of the actions, or inactions, of an adult who has a care responsibility for the child. WA Department of Health: Guidelines for Protecting Children 2020.
- Physical abuse is when a child is significantly physically harmed or injured as a result of severe and/or persistent actions or inactions by another person.
- Emotional abuse/Psychological abuse is the sustained, repetitive, inappropriate, ill treatment of a child or young person through behaviours including threatening, isolating, discrediting, belittling, teasing, humiliating, bullying, confusing, ignoring and other inappropriate behaviour. This abusive style of parenting damages a child's intellectual faculties and processes, including intelligence, memory, recognition, perception, attention, imagination and moral development.
- Sexual abuse is when a child has been exposed or subjected to sexual behaviours that are exploitative and/or inappropriate to his/her age and developmental level (see Child Sexual Abuse Protocol).
- Neglect is the intentional or unintentional failure of the caregiver to provide a child with adequate food or shelter, effective medical, therapeutic or remedial treatment and/ or care, nurturance or supervision to a severe and/or persistent extent.
- Medical child abuse is the deliberate production or fabrication of physical or psychological symptoms in a child by a parent or carer.

Screening

Consider the possibility of neglect, child abuse, or family and domestic violence including child sexual abuse (CSA) during:

- Routine child health checks (see Healthy Kids Protocol).
- Opportunistically at any age, particularly if routine health checks missed.
- Seek explanations for any injuries. Does the explanation seem logical / match the injuries present?
- "At Risk" children should be screened as arranged with the Department of Communities and GP/paediatrician and added to the Enhanced Aboriginal Child Health Schedule Guideline.

"At Risk" includes: child with known previous abuse (any type); siblings of known victims of abuse; known witness to domestic violence or environment of violence, parental alcohol abuse or drug use in home; increased vulnerability due to age, intellectual or physical disability.

> **A** Note that the Department of Communities should also be notified where there are concerns related to harm or risk of harm to an unborn child – Refer to Pre-birth Bilateral Schedule

Presentations of abuse may include:

- Disclosure by the child.
- Observation or concern raised by others – carer, teacher, parent, health worker, nurse or doctor.
- Bruising in children who are not yet mobile / walking.
- An explanation of the injury that is inconsistent or changes.
- Injury/bruises in unusual patterns, differing ages, shapes or places e.g., on soft areas on face, palms or soles.
- Fractures of different ages, multiple, particular types, or on ribs in children who are not mobile.
- Injuries outside of developmental stage of the child.
- Severe neglect e.g., lack of food or response to other needs, not accessing medical care with significant implications.
- Any injury / burn (including cigarette burns) / ingestion / poison in child under 12 months.

Caregivers presenting with injuries or disclosures related to violence in the home.

TEN 4 FACES Clinical Decision Rule (adapted from Pierce et al 2009)
If these criteria are met, have clinical concern for abuse: • Bruising in TEN location (Torso, Ear, Neck) in child <4 years old • Any bruising in child <4-6 months old • Injury to FACES (Frenulum, Angle of jaw, Cheek, Eyelid, Sclera) in child of any age

CSA may co-exist with physical abuse in children, though it is a distinct entity which is covered separately in the Child Sexual Abuse Protocol. Specific presentations which should raise concerns about CSA include:

- Sexualised behaviour inappropriate for developmental stage.
- STI and / or pregnancy in a young person below the age of 16 years old.

If there are any concerns CSA may be occurring, refer to the Child Sexual Abuse Protocol for detailed guidelines.

> **A** Child Sexual Abuse (CSA), whether confirmed or suspected, requires Mandatory Reporting to the Department of Communities.

Principles of Management

- Ensure child's safety as a priority.
- Be aware the perpetrator could be the person presenting with the child.
- Attend to immediate/urgent medical concerns.
- Take time to carefully document everything.
- Believe the child who discloses abuse.
- Non-leading questions that help make a determination if abuse has occurred. Be mindful that this may result in a criminal investigation.

Note: Health clinicians are not required to conduct an investigation. The threshold for reporting to the Department of Communities is that a "reasonable suspicion of harm" has occurred.

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Ensure Child's Safety

- If serious injury is evident consult the on-call paediatrician.
- ALL disclosures by children must be referred to the Department of Communities.
- In ALL cases of suspected child abuse, discuss with the Department of Communities. Referral does not mean automatic removal of the child.
- The Department of Communities keeps records of previously reported concerns of which health staff may not be aware, therefore all information is relevant.
- If you are not confident of the child's immediate safety, discussion with the Department of Communities must occur before the child leaves the clinic.
- It is not your responsibility to assess if abuse has occurred but it is your responsibility (duty of care) to report child abuse concerns. If you are uncertain about reporting, discuss with the Department of Communities and/or on-call paediatrician.

Special Cases

Discuss with Paediatrician and the Department of Communities:

- Infant under 2 years may need tertiary level assessment and investigations.
- Children under 5 years old
- Child with disabilities.
- Child with mental health concerns. If risk of suicide/self-harm/harm to others, may require hospital admission and involvement of Kimberley Mental Health and Drug Services.

Emergency Presentations

- This includes all acute presentations of child abuse, including suspected or known acute child sexual abuse.
- If there are serious injuries, immediately stabilise and transfer to hospital (via RFDS if required), according to usual emergency protocols.
- IN ADDITION: inform the Department of Communities and on-call paediatrician.
- If the child is at immediate risk, and at risk of being removed from the health service, hospitals have the ability to put in place a temporary holding order via the Senior Medical Officer (SMO) for children under 6 years.
- The Department of Communities can issue emergency care orders if required under section 40 of the *Children and Community Services Act 2004*.
- In remote settings, Police may be able to assist for emergencies or acute concerns.
- Confidentiality is vital and discussion should be limited only to those directly involved.
- It is very important to ensure that you document everything clearly, carefully and in detail. Your record may form the basis of a legal document and you could be called as a witness.
- Note time and place of consult/examination plus name, title and role of those present during different parts of consultation.
- Document questions asked and the responses of both the child and adult if present, word for word if possible. Questioning must be open and non-directive. See Recognising Child Abuse Guideline.
- Check immunisation status, particularly hepatitis B and tetanus, if injuries present.
- Consider use of other local staff members with knowledge of family structure or local factors to gain information.
- WACHS Emergency Departments should use the Paediatric Injury Proforma (MRK9) for any child younger than 2 years presenting with any injury.

Examination

Avoid re-traumatising the child. If the child becomes distressed, STOP, examine only those areas that are not distressing and consult the paediatrician. Where possible, examination should include:

- Height, weight, head circumference, general demeanor.
- General systems examination.
- Check for external signs of trauma including hidden areas such as ears, mouth and tongue, scalp, buttocks, genitalia, feet and hands (including nails and web spaces).
- Child's observed stage of development – e.g., crawling, walking, speech.
- Consider signs indicating other forms of abuse (sexual abuse, neglect).
- Document any examination findings including area, type, size, shape and colour of injuries, evidence of healing.
- Photograph injuries if appropriate/available, such that body-part and characteristics of injury are identifiable. (E.g., injury with ruler alongside). Photographs must be labelled with date, time, patient details, photographer, and stored on a secure health service computer and/or as a hard copy in the patient notes. Avoid the use of personal devices and delete from any device as soon as possible.

Medical Investigations

- Children under 2 years: discuss with paediatrician first.
- If parent/guardian refuse consent but you have concerns, contact the on-call paediatrician for advice (or Child Protection Unit at Perth Children's Hospital if unavailable).
- In children with concerning bruising, check Full Blood Count and Coagulation studies.
- If fracture possible arrange x-rays and consider prior discussion with radiologist regarding required views. Liaise with paediatrician if considering skull x-ray.
- Request reporting is done by a paediatric radiologist.
- Other investigations as clinically indicated and directed by Paediatrician.

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Follow Up

- The importance of psychosocial follow-up and support cannot be overemphasised. Be aware that suicide risk is heightened in children who have been abused.
- Ensure that child and family have access to appropriate on going counselling and support services. Although specialist counselling may be required, support from a trusted local health worker will be a valuable resource.
- Staff involved are encouraged to contact their Employee Assistance Provider (EAP) for support.

References

- Guidelines for Protecting Children (Department of Health)
- Child Sexual Abuse Protocol (KAHPF)
- Enhanced Child Health Schedule Guideline
- Pre-birth Bilateral Schedule
- Recognising Child Abuse Guideline

Useful Contact Information

Service	Details	Contact
Kimberley Regional Paediatrician	24-hour on-call service (via Broome Health Service)	(08) 9194 2222
WA Police	Contact nearest station or via Broome head office	(08) 9194 0200
Department of Communities	Available Monday to Friday from 8:30am to 4:30pm Each district office manages an afterhours response when directed by Crisis Care	Email
	Central Intake Team – report concerns for a child's wellbeing	1800 273 889
	Crisis Care After Hours Service	1800 199 008
	West Kimberley, Broome office (and for transfer to Derby or Fitzroy Crossing)	(08) 6277 4888
	East Kimberley – Kununurra office (and for transfer to Halls Creek)	(08) 6414 3300
	Child Protection Concern Referral Pathway	Form here
Perth Children's Hospital	Child Protection Unit (Monday to Friday from 8:30am to 5:00pm)	(08) 6456 4300 Email
	Emergency Department (after hours)	(08) 6456 2222
KAMS Social and Emotional Wellbeing (SEWB) Team	Available Monday to Friday from 8:00am to 4:30pm Offer SEWB services, referral and advice,	(08) 9194 3200
Marninwarntikura Women's Resource Centre	Available Monday to Friday from 8:00am to 4:30pm. Offer (adult) sexual assault counselling.	(08) 9191 5284
Social Support Unit, OVAHS, Kununurra	Available Monday to Friday from 8:00am to 4:30pm. General counselling / social support.	1800 839 697
Anglicare	Statewide telephone counselling service.	1300 114 446
	Kimberley Sexual Abuse Prevention and Support Service (contact nearest office) Broome Kununurra	(08) 9194 2400 (08) 9166 5000
Kimberley Mental Health, Drug and Alcohol Service	Available Monday to Friday from 8:00am to 4:30pm Offer mental health services, referral and advice	(08) 9194 2640
Kids Helpline	24/7 online and phone counselling service for young people aged 5 to 25	1800 55 1800

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