

NON ACCIDENTAL INJURY IN CHILDREN

Screening

Consider the possibility of child abuse, including child sexual abuse (CSA) during:

- Routine child health checks (see [CHILD HEALTH SCREENING](#) protocol).
- Opportunistically at any age, particularly if routine health checks missed.
- "At Risk" children should be screened 3 monthly or as arranged with DCP and paediatrician.
- "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, alcoholism, drug use in home; intellectually or physically disabled children.

Presentations of abuse may include:

- **Observation or concern raised by others** - e.g. child carer; teacher; other parent, health worker; nurse or doctor. Includes:
 - Bruising in children who are not yet mobile / walking.
 - Injury / bruises in unusual patterns, shapes or places e.g. on soft areas (not over bony areas such as the shins or knees); on face, palms or soles.
 - Fractures of different ages, ribs, multiple, particular types (metaphyseal fractures/Salter Harris 2), or in children who are not mobile.
 - Burns including cigarette burns.
 - Any injury/burn/ ingestion in child under 12 months.
- **Disclosure by child.**

Child Sexual Abuse may co-exist with non-accidental injury / physical abuse in children, though it is a distinct entity which is covered separately in the Child Sexual Abuse (CSA) protocol.

Specific presentations which should raise concerns about CSA include:

- Sexualised behaviour inappropriate for developmental stage.
- STI and / or pregnancy in a minor.

If there are any concerns CSA may be occurring, refer to the [CHILD SEXUAL ABUSE](#) protocol for detailed guidelines.

Case Definition

Child: under 16 years old.

Non-accidental injury/ physical abuse:

- Physical trauma to a child by another person.
- May be a single episode or repeated / multiple episodes.
- May not result in physical signs.

Principles of Management

- Be aware the perpetrator could be the person presenting with the child.
- Proceed through following management steps according to your level of skill, experience and confidence: seek help early if needed (see box next page).
- Ensure child's safety as a priority.
- Attend to immediate / urgent medical concerns.
- Take time to carefully document everything.
- Believe the child who discloses abuse.

Management

Special cases: Discuss with Paediatrician and DCP:

1. Infant under 12 months, may need tertiary level assessment and investigations.
2. Child with disabilities.
3. 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.

Ensure Child's Safety

- **ALL** disclosures by children should be referred to DCP (Crisis Care after hours).
- In ALL cases of suspected child abuse, discuss with the DCP (Crisis Care after hours). Referral does not mean automatic removal of the child. DCP keeps records of previously reported concerns of which health staff may not be aware, therefore all information is relevant. Duty of Care applies.
- If you are not confident of child's immediate safety, discussion with DCP must occur before child leaves the clinic.
- Inform parent/guardian that you are contacting DCP with sensitive explanation of your concerns.

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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 DCP and Paediatrician on call. Hospital has ability to put in place a temporary holding order and DCP can issue emergency care orders if required.
- In remote settings, police may be able to assist for emergencies or acute concerns.

History and Documentation

- 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.
- 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 (refer to Department of Health Guidelines for examples of questions).
- In cases of suspected abuse, further history can be sought in conjunction with DCP to clarify level of suspicion, if required, prior to extensive investigations being undertaken.
- Seek explanations for any injuries. Does the explanation seem logical / match the injuries present?
- Check immunisation status, particularly hepatitis B and tetanus if injuries present.

Examination

Avoid re-traumatising the child. If the child becomes distressed, **STOP**, examine only those areas that are not distressing and seek advice from the Paediatrician. Where possible, examination should include:

- Height, weight, head circumference, general demeanour.
- 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 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. Pictures are helpful.
- Photograph injuries if appropriate/available, such that body-part and characteristics of injury are identifiable. (e.g. injury with ruler alongside).

Investigations

- Obtain consent (if verbal consent, to be documented) from parent / legal guardian before undertaking investigations. If parent / guardian refuse consent but you have concerns, contact Paediatrician (or Child Protection Unit at Princess Margaret Hospital if unavailable) to get advice.
- In children with concerning bruising, check Full Blood Count and Coagulation studies.

Imaging / X-rays

- Request that reporting is done by a paediatric radiologist.
- Children under 2 years: discuss with paediatrician first, may recommend full skeletal survey or radionuclide imaging.
- X-rays of relevant areas if fracture considered possible (liaise with paediatrician if considering skull X-Ray).

Other investigations as clinically indicated and directed by Paediatrician.

Follow-up

- The importance of psychosocial follow-up and support can not be overemphasised. Be aware that suicide risk is heightened in children who have been abused.
- Ensure that child and family have access to appropriate ongoing counselling and support services. Although specialist counselling may be required, support from a trusted local health worker will be a valuable resource.

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