Child Protection Medical Assessment Pathway

Toolkit for Practitioners

Pathway for dealing with marks/injuries/bruises in children aged 0-18

(see page 7 for pathway)

This pathway is:

- for professionals working with children in Birmingham and Solihull. This includes those working in education, healthcare, social services and police,
- to aid with decision making when a child has a mark, bruise or an injury (including injuries caused from extra familial harm linked to weapon injury) or tells you they have been hurt and you are concerned about possible safeguarding or that a child is suffering or likely to suffer significant harm (child protection),
- for guidance only and does not cover every situation. You should seek further advice including conversation with your local Children's Advice Support Services/Multi Agency Safeguarding Hub (CASS/MASH) Team. Where child sexual abuse is suspected see Sexual Assaults Referral Centres (SARC) Pathway.

Supplementary Information to support the Child Protection Medical Assessment Pathway

What is a Child Protection Medical Assessment (CPMA)?

It is a holistic paediatric assessment of a child referred to Children's Social Care and/or the Police because of suspected abuse or neglect. It assists in the multiagency response to a child's health, welfare, and safety by:

1. undertaking an evidence-based examination to document any evidence of physical abuse and neglect,
2. undertaking a detailed paediatric assessment of the child's health and development,
3. detecting any hidden issues that might affect the child's health, social or educational outcomes,
4. assessing the child's health needs within the context of family, school and community.

CPMA should be considered an integral part of a multiagency assessment. *Lack of visible bruising alone is not a valid reason for deciding against a CPMA*. Any reason for this decision should be clearly documented.

The West Midlands Regional Safeguarding Children Procedures[1] state that where a CPMA may be required, the strategy meeting/discussion will determine, in consultation with the paediatrician, the need and timing for the assessment.

The social worker and/or police officer taking the child for the assessment should also be fully aware of the child's circumstances and the purposes of the assessment.

For healthcare professionals reference: The assessment of the child should be carried out by a paediatrician with at least Level 3 competences. Where a specialty trainee carries out the assessment there should be a supervising consultant available. The level of supervision required will be dependent on the level of experience of the trainee. All cases should be discussed with a consultant prior to hospital discharge (where applicable).

What about medicals on other children at risk e.g. siblings?

It may be necessary to examine other children that may have been exposed to abuse or neglect. For instance, if one child in the family has an injury (index/subject child) or has said that they have been abused then other children who may have been exposed to the same risk of abuse may require examination. This might be siblings of the index/subject child, other co-habiting children or other children who have been in the care or in contact with suspected perpetrator. The Strategy discussion should include consideration of CPMA of any other relevant children. This may need further consideration with the paediatrician prior to or following the CPMA.

What are the challenges and potential limitations of a CPMA?

There can often be a degree of uncertainty in relation to causation of injuries, even following a CPMA. It is not always possible to say for definite whether or not abuse or neglect has occurred. The paediatrician undertaking the CPMA will provide an opinion on the likelihood of abuse or neglect using a combination of the current evidence-base and their experience.

Language used in CPMA reports:

Various terms may be used in CPMA reports.

This is a glossary to help ensure there is a shared understanding of what these terms mean.

- **Consistent/Compatible with** – the examination findings (e.g. an injury) could have been caused by a given explanation (e.g. history from child/parent). However, this does not mean that other causes are not possible
- **Not consistent/Not compatible with** – the examination findings (e.g. injury) could not have been caused or is unlikely to have been caused by the given explanation (e.g. history from child/parent)
- **More likely than not** – one cause is more likely than another i.e. to the standard of being more than 50% likely
- **Inflicted/Non-Accidental injury** – injury caused by someone else, most likely due to physical abuse
- **Accidental injury** – injury that can be reasonably explained through an accidental mechanism sustained during normal movement/play/activities; this takes account of the developmental level/abilities/behaviour of the child
- **Unexplained injury** – an injury where no plausible explanation has been given and there is no clear medical explanation. This may require further consideration to decide whether the injury is more likely to be inflicted or accidental
- **Index/subject child** – the main child who has presented with a concern. This could be because they have an injury, have said they have been hurt or there is some other reason why abuse is suspected.

Medical terms doctors may use in reports – these should also be explained in the reports:

- **Abrasion** – a superficial injury involving only the outer layers of the skin that does not extend to the full thickness of the epidermis. Can be linear abrasion (scratch) or broad abrasion (graze)
- **Bruise** – visible evidence of leakage of blood into soft tissues as a result of injury to blood vessels
- **Erythema** – redness of the skin caused by dilatation (widening) of the underlying capillaries (small blood vessels)
- **Haematoma** – a collection of blood forming a mass or lump under the skin
- **Laceration** - wound splitting the full thickness of the skin, usually from blunt trauma
- **Incision** – wound splitting the skin, usually caused by a sharp object e.g. blade
- **Mark** – an area of skin that is a different colour to the surrounding skin. This is a generic term and could indicate an injury (recent or healed) or a skin issue (e.g. birth mark/medical cause). When this term is used a description of the appearance of the mark should be documented and an opinion on what the mark is should be offered
- **Petechiae** – small, distinct pin-prick sized bruises (<2mm) that occur when blood vessels rupture. May be single or multiple
- **Scar** – fibrous tissue that replaces normal tissue after the healing of a wound.

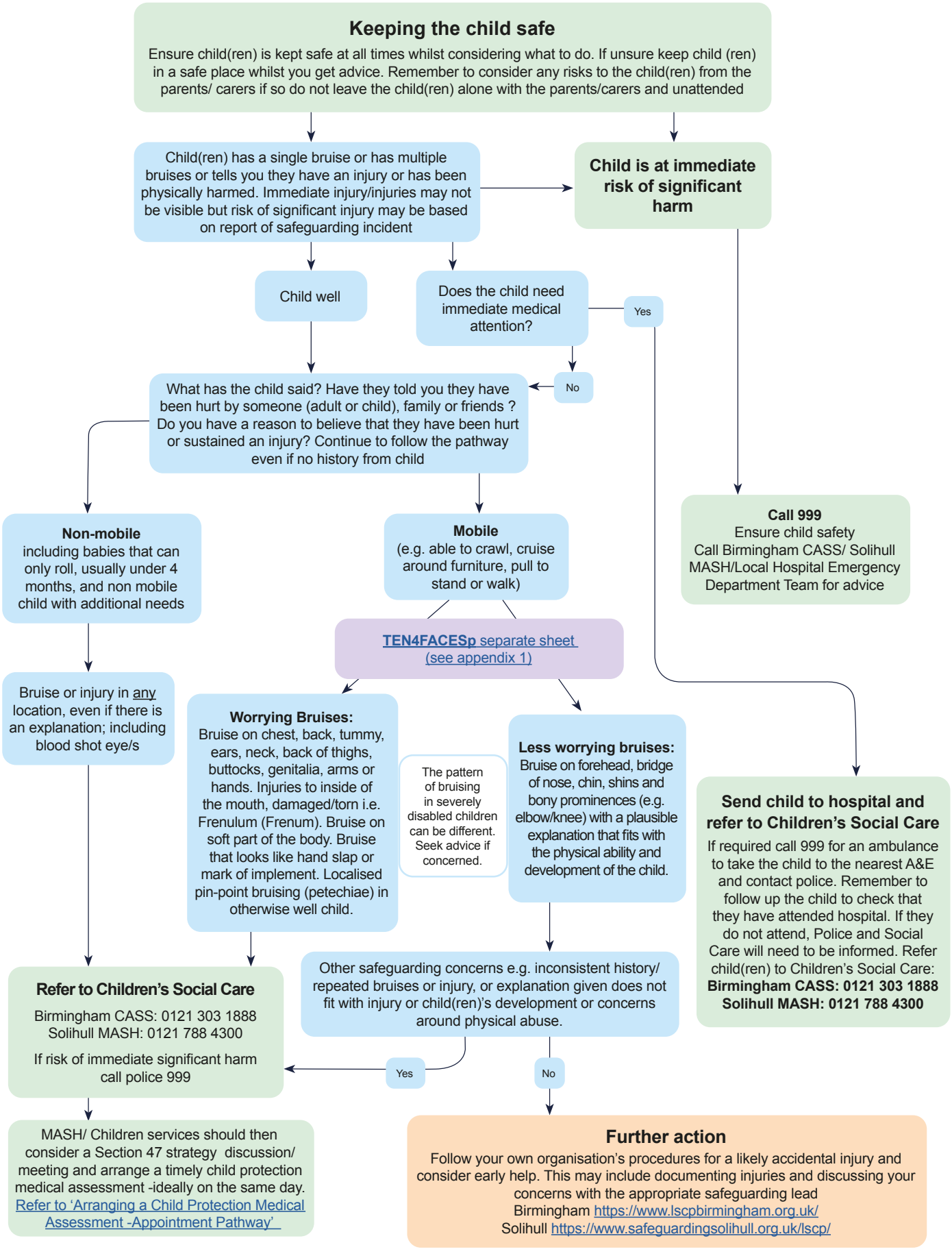
Voice of the child:

- The views of the child are essential to good practice in safeguarding. Everyone working with children must seek the voice of the child, and this should be reflected and featured in all aspects of a practitioner's work.

References

1. The West Midlands Regional Safeguarding Children Procedures https://westmidlands.procedures.org.uk/ykpzl/statutory-child-protection-procedures/additional-guidance#s536 – Medical Evidence

Child Protection Medical Assessments Pathway – Part 1



Escalation

If you feel your referral is not appropriately actioned, escalate your concerns and contact the safeguarding lead for your organisation. Refer to the Local Safeguarding Children Partnership escalation policy available at:
Birmingham: lscpbirmingham.org.uk Solihull: safeguardingsolihull.org.uk/lscp

Child Protection Medical Assessments Pathway – Part 2

Do not investigate, repeatedly question or ask the child to repeat the disclosure. Concerns are received into Children Services/ MASH (open cases or new referrals). Raised concerns are screened and information gathered from safeguarding partners

Concerns meet threshold for Section 47 strategy discussion/meeting

Section 47 strategy discussion/meeting held with safeguarding partner agencies including health. Always discuss if Child Protection Medical Assessment (CPMA) is required. Seek advice from community paediatrician if needed for additional support

Is CPMA required?

Yes

Parent/carer consent obtained. If no consent given, then discuss with the paediatrician/ manager regarding how to proceed. Document clear description of sustained marks/ injury/ bruises on a body map https://westmidlands.procedures.org.uk/assets/clients/6/Body%20map.pdf

See flowchart on how to arrange CPMA appointments

No

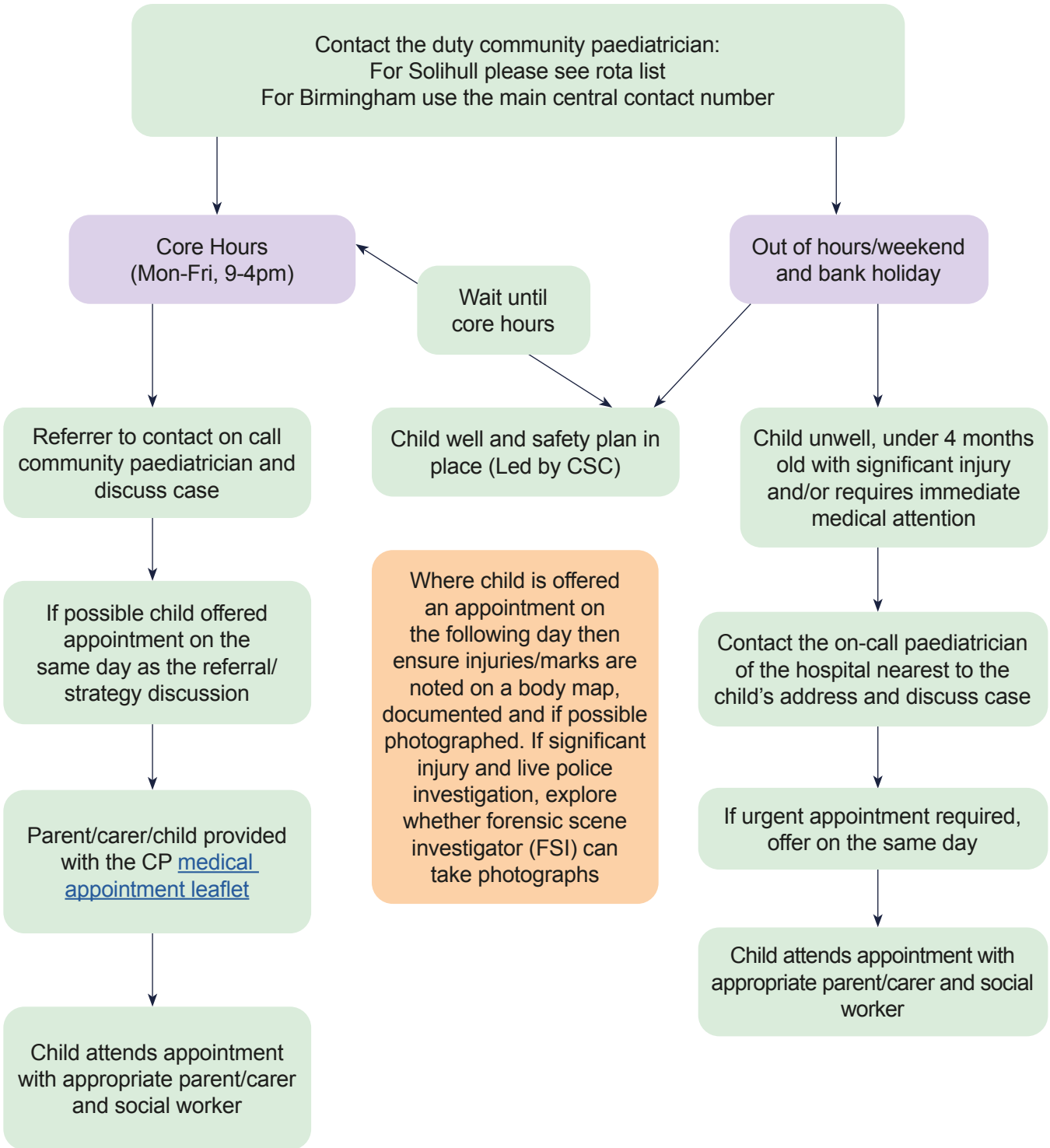
Rationale for decision making needs to be clearly documented including clear description of any sustained marks/ injury/ bruises on a body map https://westmidlands.procedures.org.uk/assets/clients/6/Body%20map.pdf

Continue following the safeguarding process and enquiries as per multi agency discussions.

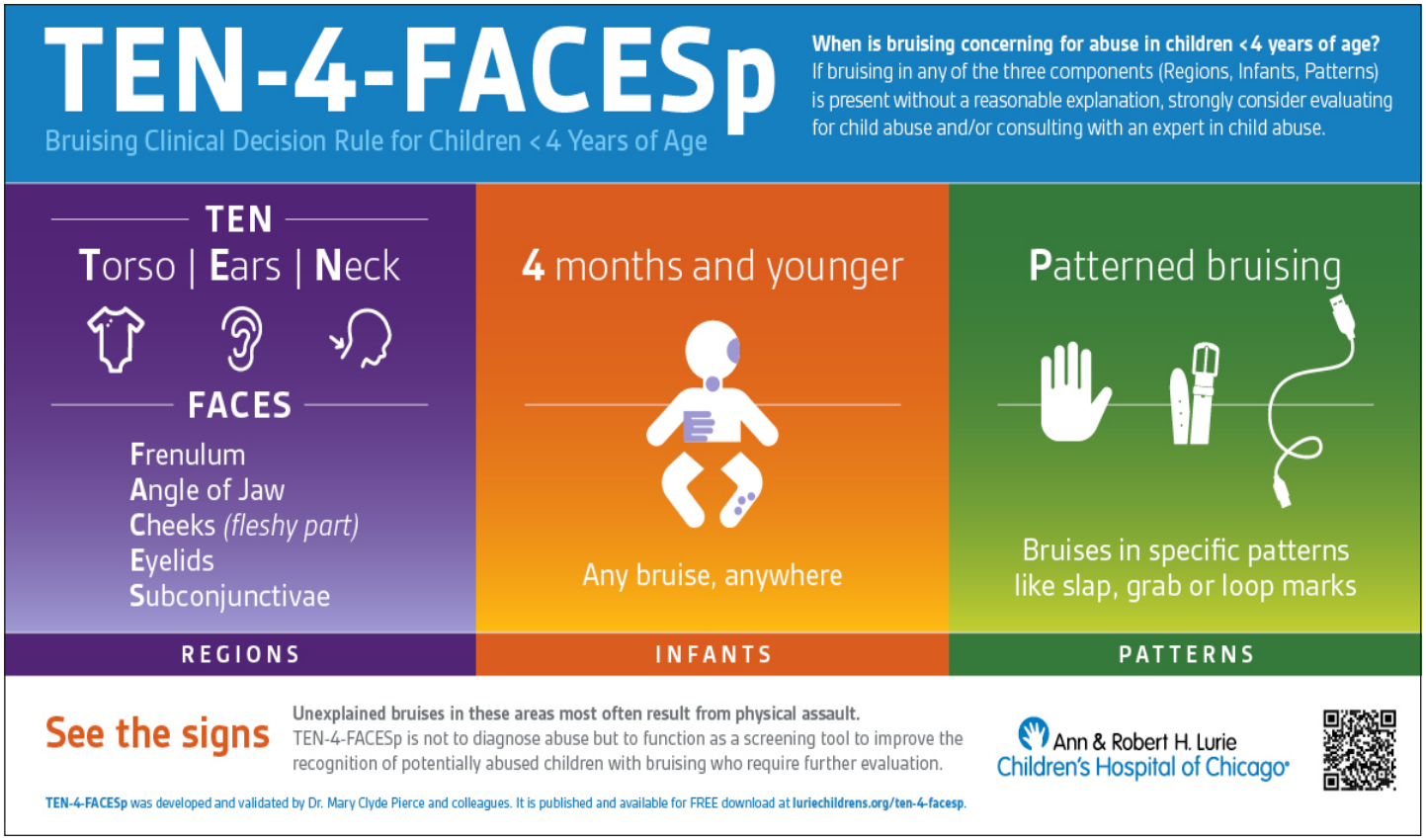
Reassess and reconsider CPMA

No further action

Arranging a Child Protection Medical Assessment Appointment Pathway – Part 3



Appendix 1: TEN-4-FACESp: a screening tool for concerning bruises*



TEN-4-FACESp is not to diagnose abuse but to function as a screening tool to improve the recognition of potentially abused children with bruising who require further evaluation.

Further information on TEN-4-FACESp, including a podcast, can be found here:

https://www.luriechildrens.org/en/research/research-areas/health-services-policy-research/teamwork-to-reduce-infant-child-and-adolescent-mortality/resources/ten-4-facesp/

Frenulum (frenum) is a piece of soft tissue that runs between the lips and gums. It is present on the top and bottom of the mouth. A torn frenum can be a sign of abuse.

Subconjunctivae (subconjunctival) haemorrhage is a red spot on the whites of the eyes caused by a broken blood vessel and can be indicative of non-accidental trauma injury, including a bloodshot eye.

If bruising in any of the three components (Regions, Infants, Patterns) is present without a reasonable explanation, seek advice and make a safeguarding referral as per flowchart.

There are several possible clinical findings suggestive of abuse. These including bruising in pre-mobile children, bruises that are seen away from bony prominences and bruises that carry the imprint of an implement used or a ligature.

*The number of bruises a child sustains through normal activity increases as they get older and their level of independent mobility increases. Remember children of any age group can sustain non-accidental injuries, bruises or mark from abuse.

Further Reading:

NSPCC: Bruises on children (CORE-INFO leaflet) (nspcc.org.uk)

West Midlands Safeguarding Procedures: https://westmidlands.procedures.org.uk/pkyzqy/regional-safeguarding-guidance/physical-abuse

RCPCH Child Protection Portal: Bruising: systematic review – RCPCH Child Protection Portal

Bruising in babies