

SUSPECTED PHYSICAL & SEXUAL CHILD ABUSE

EXECUTIVE SUMMARY

PHYSICIAN OWNER: DR. SUZANNE HANEY



PRIMARY OBJECTIVE

Create a pathway for the workup and reporting of suspected child abuse cases in order to better protect this vulnerable patient population.

CLINICAL CARE GUIDELINES

SUSPECTED PHYSICAL ABUSE

CLINICAL ASSESSMENT

Consider physical abuse:

Infants

- Irritable infants < 6 months without fever or other indefinable cause
- Brief resolved, unexplained event (BRUE)
- Altered mental status
- Respiratory distress
- Unexplained vomiting
- Any physical injury

Children

- All children < 5 years old presenting with injury, especially:
 - o No history of injury
 - o Unwitnessed injury
 - o Injury not consistent with history or with child's developmental age

History and Physical¹⁶

- History of present illness
 - o When was the child last well, or uninjured?
 - o Infants
 - Onset of symptoms, activity at symptom onset
 - Nature of symptoms
 - Alleviating/exacerbating factors
 - Feeding: duration, frequency of feed intake over past 24 hours
 - Presence of fever
 - History of injury
 - o Children
 - Details of injury: time, mechanism, initial manifestations, neurologic symptoms, supervision at time of injury, if delay in seeking care what was the reason for the delay

Updated: 7/2020

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- Past medical history
 - o Birth history
 - o Prior ED visits
 - o Prior hospitalizations
 - o Prior injuries
 - o Primary care provider – date of last visit
 - o Immunization status
- Development
 - o Normal vs abnormal
- Physical exam
 - o Review vital signs
 - o Neurologic exam
 - o Thorough skin exam
 - o Assess injury if present

Historical Indicators of Abuse¹⁶

- No/vague explanation for significant injury
- Important detail of the explanation changes dramatically
- Explanation given is inconsistent with the child's physical and/or developmental capabilities
- Different witnesses provide different explanations
- Injury occurred as a result of inadequate supervision
- Delay in seeking medical care without reasonable explanation
- Children with injuries resulting from family/domestic violence incident
- Previous history of inflicted injury
- Witnessed inappropriate behavior to a child placing them at risk for non-accidental trauma

Physical Exam Findings/Injuries Suggestive of Abuse¹⁶

- Bruising
 - o Bruises in infants < 6 months of age or non-ambulatory infants
 - o Bruising in unusual locations in any age child
 - Ear
 - Eyelids/sclera
 - Neck, under chin
 - Torso, buttocks
 - Flexural bruises
 - o Patterned bruises
 - Loop marks
 - Hand print
 - Subgaleal hematoma due to hair pulling
- Bite marks
 - o Semi-circular/oval patch
 - o May have associated central bruising
- Burns
 - o Patterned contact burns with insufficient injury
 - o Cigarette burn
 - o Stocking/glove pattern
 - o Symmetric burns on buttocks
 - o Immersion burn
 - o Multiple burn sites
 - o Mirror image burns of the extremities
- Facial injury
 - o Torn frenulum in non-ambulatory child
 - o Unexplained oral injury
 - o Ear injury
 - o Unexplained facial bruising in non-ambulatory
 - o Neck bruising

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- Eye
 - o Scleral hemorrhage
- Multi-organ system trauma without sufficient history
- Skeleton
 - o Rib fractures
 - o Multiple fractures
 - o Long bone fractures in children < 6 months
 - o Any fracture in non-ambulatory child
 - o Metaphyseal fractures
 - o Scapular fractures
 - o Vertebral fractures
 - o Sternum fractures
 - o Fractures of hands and feet
 - o Facial fractures
 - o Fractures of different ages
- Head
 - o Subdural hematoma with or without skull fracture
 - o Unexplained intracranial injury
- Poisoning
 - o Any illegal drug exposure

DOCUMENTATION

Documenting the History¹⁶

- Document clearly who is providing the history
- Appropriately attribute the statement to the source (i.e. Mrs. Smith stated Johnny told her...)
- Document what happened, when, and who was involved
- Use quotations to document exact words when a child directly discloses to you
- Document any pain a child reports being associated with the injury
- Document past medical history, social history, medications, and allergies

Documenting the Review of Systems and Physical Examination

- Document changes in behavior, nightmares, depression etc.
- Document any general symptoms, including nausea or vomiting, abdominal pain, fever etc.
- Document a full physical examination and any abnormal findings
- Describe, draw, and/or photograph any injuries

Documenting the Impression

- Provide a summary statement that includes patient's gender, age, and reason for evaluation findings
- Offer appropriate interpretation of the findings in the context of the history such as the following:
 - o 4 month old boy who presented with seizure. Noted to have facial bruising on examination. CT scan with acute SDH, skull fracture. Skeletal survey with rib fractures. Multiplicity and severity of injuries extremely concerning for inflicted trauma. Report filed with DHS and police.
 - o 18 month old girl who presented for evaluation due to refusal to walk after a fall from standing. Right femur fracture. Injury is consistent with developmental ability and history, and is consistent with accidental injury.

EVALUATION BASED ON INJURY TYPE

Head Injury

- Head imaging (CT head scan for acute/unstable patients or consider MRI brain if patient is stable and to be admitted)
- Skeletal survey in all children < 2 years (included in Children's Advocacy Team [CAT] order set). Consider in

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- children 3-5 years. Non-emergent if being admitted
- Laboratory evaluation (included in CAT order set)
 - o PT/PTT/INR
 - o CBC
 - o Chem 14
 - o Amylase/lipase
- Consider further workup if bleeding disorder is suspected
 - o Factor XII
 - o Platelet function assay
 - o Von Willebrand
 - o Consult Hematology
- Consider further workup if metabolic disease suspected
 - o Urine organic acids/serum amino acids
 - o Obtain newborn screen

Bruising, Eye or Facial Injury and/or Bite Marks

- Laboratory evaluation (included in CAT order set)
 - o PT/PTT/INR
 - o CBC
 - o Chem 14
 - o Amylase/Lipase
- Consider further workup if bleeding disorder is suspected
 - o Factor XII
 - o Platelet function assay
 - o Von Willebrand
 - o Consult Hematology
- Photographs of injuries (refer to Policy # CAT-003)
- Skeletal survey in all children < 2 years (included in CAT order set). Consider in children 3-5 years. Non-emergent if being admitted.
- Head imaging for facial bruising in children < 6 months (CT head scan for acute/unstable patients or consider MRI brain if patient is stable and to be admitted)

Fracture(s)

- Laboratory evaluation (included in CAT order set)
 - o Chem 14
 - o 25 OH vitamin D
 - o PTH/Alk phos
- Consult genetics if there are concerns for metabolic disease
- Skeletal survey in all children < 2 years (included in CAT order set). Consider in children 3-5 years. Non-emergent if being admitted.
- Head imaging if under 6 months (CT head scan for acute/unstable patients or consider MRI brain if patient is stable and to be admitted)

Abdominal Injury or Bruising

- Laboratory evaluation (included in CAT order set)
 - o PT/PTT/INR

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- o CBC
- o Chem 14
- o Amylase/Lipase
- Consider further workup if bleeding disorder is suspected
 - o Factor XII
 - o Platelet function assay
 - o Von Willebrand
 - o Consult Hematology
- If AST and ALT is > 80 consider both surgical consult and CT of abdomen and pelvis
- Photographs of injuries (refer to Policy # CAT-003)
- Skeletal survey in all children < 2 years (included in CAT order set). Consider in children 3-5 years. Non emergent if being admitted.

EMERGENCY DEPARTMENT DISCHARGE

- Patients that are both medically stable enough for discharge and have a safety plan in place may be discharged after follow-up instructions are discussed with child's caregiver(s).

ADMISSION

- Admit patients that are not stable enough for discharge to trauma service for management of symptoms of injury or care of injury.
- Patients that are medically stable enough for discharge, but do not have a safety plan in place should either be admitted to the pediatric surgery team or to the hospitalist service after consultation with trauma team.

INPATIENT MANAGEMENT

- Children admitted with non-emergent suspected abuse should follow the emergency department order sets specific to each type of injury; (i.e. head injury, bruising, or fracture)
- When evaluation is complete, social work should be contacted to assess child placement and discharge
- A CAT consult should be ordered
- Retcam evaluation is indicated for children with intracranial bleeding or altered mental status
 - o Ophthalmology consult for abnormal Retcam results

INPATIENT DISCHARGE

- When patient is medically stable, a safety plan is in place, and all testing is complete, discharge patient

SUMMARY OF IMAGING RECOMMENDATIONS¹

- Children, especially those < 12 months of age, may have significant intracranial injury without signs or symptoms of head injury or retinal hemorrhage.
- Clinical findings of abdominal pain, abdominal distention, vomiting, abdominal wall bruising and hypoactive or absent bowel sounds may suggest intra-abdominal injury. Abnormal liver transaminases and pancreatic enzymes may be seen with occult abdominal trauma.
- Contrast-enhanced CT of the abdomen is indicated in acute evaluation of the child with suspected abdominopelvic injuries. Non-contrast CT of the abdomen is not adequately sensitive in detection of intrathoracic

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- or intra-abdominal trauma.
- A skeletal survey is indicated in the initial imaging evaluation of a child 24 months of age or younger. In older children, it is usually appropriate to target imaging to the area(s) of suspected injury.
- Skeletal survey and CT head without contrast are indicated in the emergent/initial imaging evaluation of a child with neurologic signs and symptoms, complex skull fracture, apnea, multiple fractures, spine trauma, or facial injury. These examinations are not indicated for general screening.
- MRI head may provide additional diagnostic information to head CT in about 25% of children.
- MRI of the entire spine should be done at the time of head MRI, as unsuspected injury (usually ligamentous) may be present in over 33% of children with intracranial injury.
- Skeletal survey and CT chest/abdomen/pelvis with IV contrast are indicated if there are signs or symptoms of intrathoracic or intra-abdominal visceral injury (abdominal pain/distension/bruising, abnormal liver, or pancreatic enzymes, etc).
- In children 24 months of age or younger with equivocal skeletal survey or with a high clinical suspicion for abuse and a negative initial skeletal survey, a repeat limited/focused skeletal survey performed at 2 weeks should be scheduled with CAT clinic.

ADDITIONAL SUSPECTED PHYSICAL ABUSE NOTES

- **Families and caregiver(s) of suspected abuse patients should not be treated any differently than others!**
- Clinicians should consider having the senior resident or staff be the primary provider for these patients.
- An on call social worker or CAT provider may be paged at 402-888-8420 for questions related to patient treatment
- If the child is in a Children's Physician (CP) clinic, the clinic social worker (SW) should be contacted
 - o SW may facilitate making contact with LE and CPS if indicated
 - o If clinic SW is not in the clinic, call their cell phone, if they can't be reached contact the SW on-call
- If a clinician is uncertain about how to evaluate an injury or if they suspect a fracture was caused by child abuse they should consult the Children's Child Advocacy Team to assist in the evaluation, particularly if the child is non-ambulatory or younger than 1 year of age.⁸

SUSPECTED SEXUAL ABUSE

CLINICAL ASSESSMENT

- Clinicians should ensure suspected victims of sexual assault are medically stable. Medical care takes precedence over CAT workup.
- If the child is not medically stable, provide medical care as indicated.
- Social work (SW), law enforcement (LE), and child protective services (CPS) should be contacted.
- If the child is in a Children's Physician (CP) clinic, the clinic SW should be contacted
 - o SW may facilitate making contact with LE and CPS if indicated and if SW is available
 - o If clinic SW is not in the clinic, call their cell phone, and if they can't be reached contact the SW on-call

Some indicators of sexual abuse:

- Unexplained genital bleeding or discharge
- Concern from a caregiver
- Disclosure of child

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History and Physical

- **Last contact with perpetrator was < 72 hours ago and child is prepubertal:**
 - o Inform LE that a rape kit may be needed at Project Harmony / children's advocacy center
 - o ED provider will perform BRIEF exam to ensure there are no acute issues. A detailed genital exam is NOT necessary unless there are concerns for bleeding or discharge.
 - o Child should be sent to Project Harmony / children's advocacy center as directed by LE
- **Last contact with perpetrator was < 96/120 hours ago and child is pubertal:**
 - o Inform LE that a rape kit may be warranted at Methodist Hospital
 - o ED provider will perform a BRIEF exam to ensure there are no acute issues
 - o Child should be sent to Methodist Hospital as directed by LE
- **If contact with perpetrator was > 72 hours ago in prepubertal child:**
OR
- **If Contact with perpetrator was > 96/120 hours ago in pubertal child:**
 - o ED provider will perform BRIEF exam to ensure there are no acute issues. A detailed genital exam is NOT necessary unless there are concerns for bleeding or discharge.
 - o No urgent care is necessary unless child has bleeding and/or pain
 - o SW will obtain a release from family for Project Harmony /children's advocacy center
 - o Discharge patient

Taking a history/interviewing the child

- The physician should try to obtain an appropriate history away from the child, if indicated in all cases of suspected sexual abuse before performing a medical examination. Investigative interviews should be conducted by social services and/or law enforcement agencies; this does not preclude physicians asking relevant questions to obtain a detailed pediatric history and a review of symptoms. Medical history, past incidents of abuse or suspicious injuries, and menstrual history should be documented.⁹

Physical Examination at Children's Hospital and Medical Center (CHMC)

- The physical examination should NOT result in additional physical or emotional trauma to the child. For this reason, a BRIEF physical exam only should be performed while the child is at CHMC to rule out injury, particularly if a child is reporting pain or bleeding.⁹ A detailed genital exam is NOT necessary unless there are concerns for bleeding or discharge.
- In conjunction with, and under the direction of SW, LE and CPS; all children should be referred to either Project Harmony / children's advocacy center or Methodist Hospital
- Children should be encouraged not to change clothes until they are at Project Harmony/children's advocacy center or Methodist Hospital for evidence collection purposes.

REFERRALS

- All children who are suspected victims of sexual abuse should be offered a medical examination performed by a qualified provider with specialized training and expertise in child sexual abuse evaluation and treatment.¹²
- CHMC works in collaboration with Methodist Hospital to provide initial acute care exams to pubertal children when last contact with perpetrator was < 96/120 hours ago.
- CHMC also works in collaboration with Project Harmony to provide acute care exams to prepubertal children when last contact with perpetrator was < 72 hours ago.
- Project Harmony also offers chronic care to pediatric patients of all ages that are initially seen outside of the acute care windows described above as well as long-term follow up care and support services for the patient and their families.

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- Contact information for Project Harmony and Methodist Hospital is listed below:

Project Harmony	Methodist Hospital
11949 Q Street	8303 Dodge St
Omaha NE 68137	Omaha NE 68114
402-595-1326	402-354-4000

Follow-Up Care

- All children who have been sexually abused should be evaluated by a pediatrician and a mental health professional to assess the need for treatment and to assess the level of family support.⁹
- Follow-up examinations and testing may at times be necessary to assess healing of injuries and additional assessment for STD's, such as *Condylomata acuminata* infection or herpes that may not be detected in the acute time frame of the initial examination.⁹
- Reassessment for STDs may need to occur depending on medications given at the time of the initial evaluation and the intervening history of consensual sex.¹¹
- The Centers for Disease Control and Prevention recommends that syphilis and HIV testing be repeated 6 weeks, 3 months, and 6 months after the assault if initial test results were negative and infection in the assailant could not be ruled out.¹¹
- At 2 weeks pregnancy testing can be performed.¹¹
- Additional therapy and follow-up with the child and family may also be warranted to ensure that the child and supportive family members are recovering emotionally from the abuse.⁹

RATIONALE (SAFETY, QUALITY, COST, DELIVERY, ENGAGEMENT, & SATISFACTION)

- Safety Will be increased through by performing an accurate workup and reporting suspected cases so children are not being reported to authorities inappropriately and are not being returned to an unsafe environment.
- Quality: Will be improved by reducing unnecessary variation of diagnostic testing and procedures.
- Cost: Will be reduced by decreasing variation in treatment which leads to potential delays and increased length of stay.
- Engagement: Is created and supported through the involvement of the interdisciplinary care team who evaluate and treat suspected child abuse patients.
- Patient/Family Satisfaction: Shall be improved by providing the highest quality of care to ensure children are not being reported to authorities inappropriately.

METRICS PLAN

1. Monitor full lab panel use; (PT/PTT/INR, CBC, Chem 14, Amylase/Lipase) in children with concerning bruising and head injuries.
2. Monitor skeletal survey utilization in children who are under two years old who present with concerning fractures
3. Monitor photographic documentation of bruises concerning for abuse
4. Monitor phone call documentation to social work in cases of suspected sexual abuse.

TEAM MEMBERS

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Dr. Suzanne Haney & Kristi Aldridge ARNP (child abuse pediatrics), Dr. Sharon Stoolman & Dr. Sheilah Snyder (hospitalists), Dr. Thomas Deegan & Kristi Kult RN (emergency department), Melisa Paradis & Jess Bender (performance improvement), Mary Bennett-Schulte & Michelle Patton (social work), Maureen Goessling & Alexi Weber (case management)

EVIDENCE

SUSPECTED PHYSICAL ABUSE REFERENCES

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SUSPECTED SEXUAL ABUSE REFERENCES

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CLINICAL PATHWAY REFERENCES

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