

PHYSICAL ABUSE

GUIDELINES FOR THE EVALUATION OF CHILDREN IN THE EMERGENCY DEPARTMENT SETTING

These guidelines provide a brief summary of 1) the recommended evaluation of children in the emergency department setting with concerns for physical abuse, 2) reporting requirements to the Department of Social Services and law enforcement, and 3) referral to a physician/licensed medical provider with expertise in the evaluation of child abuse/neglect.

When it is suspected that any child/adolescent may have been physically abused, it is critical that these children receive a complete physical examination and any diagnostics needed to assist the evaluation. Thorough documentation to include body diagrams/photodocumentation of pertinent physical findings should be included.

We recommend the following approach:

1) OBTAINING THE HISTORY:

- a. Interview caregivers independently of each other and the child. Document who was present for the interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses being provided by the caregivers.
- b. While detailed interviewing of children should be deferred to professionals with expertise in interviewing children for concerns of abuse, children may be asked open-ended questions to obtain a history and focus for the physical examination. The child, if at all possible, should be interviewed away from accompanying caregivers. Document who was present with the child for the interview, the child's demeanor, and use quotation marks to indicate remarks/responses being provided by the child.

2) PHYSICAL EXAM:

- a. Completely examine the child (include ano-genital area, inside the mouth, between digits, palms & soles). Document any findings or lesions/injuries with photographs (permission not required when part of medical evaluation), if possible, and diagrams, being sure the site of the abnormalities/injuries are clear. Include measurement device with gray scale if possible. An identifying face photo of the child is helpful. Include with patient name, MR#, date taken and by whom.

3) DIAGNOSTICS:

- a. Use skeletal surveys, if a child under 2 years of age has suspicious fractures, bruises, or other injuries. *Do not use "babygrams" (i.e. whole-body x-rays) because of the high rate of false negatives. Skeletal surveys are rarely useful in children >5 years of age and are generally not recommended.
- b. Consider:
 - i. Baseline labs. Laboratory screening for coagulopathies with concerning bruising/bleeding. Urine/blood to detect exposure to toxic substances (alcohol, illegal substances, etc.)
 - ii. Head imaging (Head CT/MRI) to rule out intracranial injury, particularly if there are neck, facial, ear, scalp injuries, vomiting or altered consciousness present.
 - iii. Abdominal trauma with screening labs (Liver Function Tests, amylase, lipase) and/or abdominal CT. Note: Screening labs may be normal in setting of trauma, so if clinical suspicion is high for injury, proceed to abd/pelvis CT.

4) OTHER INFORMATION:

- a. Obtain the medical record, if possible, and look for repeated visits for injuries and other signs of possible maltreatment, regardless of whether history

is consistent with physical findings.

b. If possible, consult with the child's primary care provider to discuss presentation and any concerns.

5) SAFETY/ REPORTING:

a. Hold the child or admit him/her to the hospital if there are safety concerns, until a child protective services worker responds and takes over this aspect of management. [N.C. General Statute 7B-308 \(Twelve Hour Custody\)](#) states that any "physician or administrator of a hospital, clinic or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile ... " (Please refer to your medical facility's protocol regarding how to obtain twelve-hour custody)

b. Make a report to the local county Department of Social Services per the state's mandatory reporting law for suspected child abuse and neglect. The report should be made to the county DSS in the county where the child resides. If difficulty in connecting with the county DSS of residence, you may contact your local DSS agency to assist in making the report. To locate your DSS, click here: <http://www.ncdhhs.gov/dss/local/>. All citizens of North Carolina who have suspicion(s) of child abuse/neglect are mandated reporters.

c. A report must be made to law enforcement when the child has sustained serious injury or meets [G.S.90-21.20](#) . **The report is made to the law enforcement agency that has jurisdiction in which the medical facility is located.**

6) REFERRAL:

Refer the child to the appropriate physician/licensed medical practitioner with experience in the evaluation of child maltreatment in your particular region of the state to ensure that the child's medical and mental health needs will be met. The referral physician/licensed medical provider should be immediately contacted and informed of the history and results of the initial examination. **Call The NC Child Medical Evaluation Program at 919-843-9365 if you need information concerning who provides child abuse/neglect evaluations in your area.**

* ACR-SPR PRACTICE GUIDELINE FOR SKELETAL SURVEYS IN CHILDREN (2011)

APPENDICULAR SKELETON	AXIAL SKELETON
Humeri (AP)	Thorax (AP, lateral, right and left obliques), to include ribs, thoracic and upper lumbar spine
Forearms (AP)	Pelvis (AP), to include the mid lumbar spine
Hands (PA)	Lumbosacral spine (lateral)
Femurs (AP)	Cervical spine (lateral)
Lower legs (AP)	Skull (frontal and lateral)

SEXUAL ABUSE/ASSAULT
GUIDELINES FOR THE EVALUATION OF CHILDREN IN THE EMERGENCY DEPARTMENT SETTING

These guidelines provide a brief summary of 1) the recommended evaluation of children in the emergency department setting with concerns for sexual abuse, 2) reporting requirements to the Department of Social Services and law enforcement, and 3) referral to a physician/licensed medical provider with expertise in the evaluation of child abuse/neglect.

When it is suspected that any child/adolescent may have been sexually abused, the child should receive a screening exam in the ED that focuses on acute problems (e.g. trauma, vaginal discharge) and, if needed, evidence collection. The child should then be referred to a physician/licensed medical provider with experience in the evaluation of child maltreatment for full evaluation as soon as possible.

We recommend the following approach for this screening evaluation:

1) OBTAINING THE HISTORY:

- a. Interview caregivers independently of each other and the child. Document who was present for the interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses being provided by the caregivers.
- b. While detailed interviewing of children should be deferred to professionals with expertise in interviewing children for concerns of abuse, children may be asked broad, open-ended questions to obtain a history and focus for the physical examination. The child, if at all possible, should be interviewed away from accompanying caregivers. Document who was present with the child for the interview, the child's demeanor, and use quotation marks to indicate remarks/responses being provided by the child.

2) PHYSICAL EXAM:

The child should have a complete physical exam with documentation of any ano-genital/extragenital lesions/injuries. If possible, photographs (permission not required) and diagrams should be utilized to document findings. An identifying face photo is helpful. Include card with patient name, MR#, date taken and by whom.

3) REMINDERS:

- a. **A SPECULUM SHOULD NEVER BE USED ON A PRE-PUBERTAL FEMALE and RARELY NEEDED IN ADOLESCENTS.** If a speculum exam is warranted for any medical reason (unknown source of bleeding, evaluate extent of trauma, remove a foreign body resistant to being flushed from the vaginal vault), the prepubertal child should be examined under general anesthesia/conscious sedation. A CHILD (beyond infancy) SHOULD NOT BE PHYSICALLY RESTRAINED FOR THE PHYSICAL EXAMINATION. Consideration should be given to deferring the exam to the child abuse specialist in cases where it is not immediately medically necessary to examine the child/adolescent and the child/adolescent is unable to cooperate in the ED with the exam.
- b. A NORMAL EXAM DOES NOT RULE OUT SEXUAL ABUSE/ASSAULT.
- c. Current American Academy of Pediatrics' Guidelines for the Evaluation of Sexual Abuse of Children state that Sexual Assault Evidence Collection Kits (SAECK) are most productive if performed within 72 hours of the alleged incident, however, some programs may extend to longer time periods. (Note: Bedding and clothing can yield evidence for an extended period of time),

4) DIAGNOSTICS:

- a. Testing for STIs in prepubertal children can be complex. While cultures for gonorrhea and chlamydia remain the "gold standard", screening for Gonorrhea and Chlamydia may be done via nucleic acid amplification tests (NAAT's), which can be performed on a urine specimen. Follow-up repeat testing may be better accomplished by a child abuse medical provider at a subsequent appointment. (Please refer to the AAP's Redbook or the CDC's MMWR for additional information) The child abuse medical provider who will be receiving the referral should be contacted prior to treatment to ensure that a second NAAT can be obtained to confirm a true positive result, and a culture can be sent. All samples testing positive

should be saved by the lab for subsequent analysis if needed.

- b. Consider serologic testing for Syphilis, HIV, and HBV. Viral cultures for lesions suspicious of HSV.
- c. Pregnancy testing should be performed for pubertal children.
- d. Consider blood/urine testing if any suspicion of drugs or alcohol was used during the alleged sexual abuse/assault in any age child.

5) TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS:

a. Prepubertal

- i. **STI post-exposure prophylaxis is not generally indicated or advised in prepubertal children.**
- ii. Consider consultation with a pediatric infectious disease specialist to determine if HIV nPEP (non-occupational Post Exposure Prophylaxis) is warranted.

b. Pubertal

- i. STI prophylaxis should be considered for pubertal patients with particular attention to Chlamydia, Gonorrhea, Trichomonas and HIV. Testing before prophylaxis is always recommended. Consider consultation with a pediatric infectious disease specialist to determine if HIV post-exposure is warranted
- ii. Emergency Contraception (Plan B or equivalent) should be offered.
- iii. Refer to CDC website on Sexually Transmitted Diseases Treatment Guidelines, 2010: Sexual Assault and STDs for further information on testing and treatment <http://www.cdc.gov/std/treatment/2010/sexual-assault.htm>

6) **"FINAL DIAGNOSIS"**: In most cases, the "Final Diagnosis" will not be made in the Emergency Department setting but rather by a follow-up evaluation by the child abuse specialist. Therefore, use caution in the wording of the preliminary assessment (i.e. "no sexual abuse found")

7) SAFETY/ REPORTING:

- a. Hold the child or admit him/her to the hospital if there are safety concerns, until a child protective services worker responds and takes over this aspect of management. ([N.C. General Statute 7B-308 \(Twelve Hour Custody\)](#) states that any "physician or administrator of a hospital, clinic or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile ..." (Please refer to your medical facility's protocol regarding how to obtain twelve-hour custody)
- b. **Make a report to the local county Department of Social Services per the state's mandatory reporting law for suspected child abuse and neglect. The report should be made to the county DSS in the county where the child resides. If difficulty in connecting with the county DSS of residence, you may contact your local DSS agency to assist in making the report. To locate your local DSS, click here: <http://www.ncdhhs.gov/dss/local/>. All citizens of North Carolina who have suspicion(s) of child abuse/neglect are mandated reporters.**
- c. A report must be made to law enforcement when the child has sustained serious injury or meets [G.S.90-21.20](#). **The report is made to the law enforcement agency that has jurisdiction in which the medical facility is located.**

8) REFERRAL:

Refer the child to the appropriate physician/licensed medical practitioner with experience in the evaluation of child maltreatment in your particular region of the state to ensure that the child's medical and mental health needs will be met, The referral physician/licensed medical practitioner should be immediately contacted and informed of the history and results of the initial examination. **Call The NC Child Medical Evaluation Program at 919-843-9365 or go to <http://www.med.unc.edu/cmep/> if you need information concerning who provides child abuse/neglect evaluations in your area.**

Space to document who the facility uses as their child abuse specialist