

**Child Maltreatment
A Sample Policy for the
Care of Children in the Emergency Department**

Date: February 2022

Purpose

To describe and outline the evaluation and treatment of the child or adolescent who presents to the ED and for whom there is a concern for abuse/neglect, thus ensuring consistent and thorough medical care of patients, appropriate reporting practices, and initiation of follow-up services.

Target Group: The target group for these guidelines include the emergency physician, nurse, nurse practitioner, physician assistant, and sexual assault nurse examiner (SANE), who all serve to care children and adolescents in the ED, ensuring appropriate initial and follow-up care.

Introduction

Outline of Priorities

When there is reasonable-concern that a child presenting to the emergency department (ED) has been abused or neglected, the priorities of the clinician are:

1. Identify injuries
2. Provide appropriate stabilization and diagnostic work-up
3. Consult child maltreatment medical subspecialists early, if available and appropriate
4. Accurately document the history provided by child and/or parent/caregiver
5. Report to child protective services (CPS) and/or law enforcement agencies when appropriate (refer to your state's laws and facility policies on reporting)
6. Collect forensic evidence when appropriate (refer to your state's laws, state evidence collection procedures and national standards):
<https://www.justice.gov/ovw/file/846856/download>
 1. Maintain chain of custody
 2. Communicate with CPS and/or law enforcement agencies as necessary (in most states, CPS and/or law enforcement will determine a safety plan for the patient and their siblings if they deem it necessary)
7. Assist in the arrangements for follow-up medical care and counseling.

For those children with severe injuries, multisystem injuries, or those who require pediatric subspecialty consultation or inpatient care, rapid assessment and transfer to the closest tertiary-care pediatric hospital is essential.

When obtaining a history from children who may have been abused/neglected, if possible, limit repeated history takings and examinations to reduce the potential for psychological trauma to the patient.

Definitions

Child Maltreatment: There are varied definitions both medically and legally for child maltreatment and its types which include physical abuse, sexual abuse, neglect, psychological maltreatment, and medical child abuse. The varied definitions tend to have commonalities as represented in the definition here. Child maltreatment is an act of omission or commission that harms or threatens to harm a child or adolescent, typically by a parent or caregiver.¹

Physical Abuse: An act of commission to a child or adolescent which results in physical injury such as fractures, burns, bruises, welts, cuts and/or internal injuries (i.e., solid organ injury, hollow viscus organ injury, internal bleeding, ischemia), not caused by accidental mechanisms or solely the result of underlying medical condition(s), regardless of intent. Determining intent is not within the scope of medical practice.¹⁻⁴

Sexual Abuse: The involvement of a child/adolescent in sexual acts or the simulation of sexual acts that they do not understand, for which they cannot give informed consent, and/or that violates societal norms. These acts can be through various possible means (e.g., use, persuasion, coercion, inducement, enticement), can include exploitation (e.g., sexual acts with the minor child for financial or other gain, pornography), penetrative contact and/or non-penetrative contact. The penetrative contact may include penetration of the patient's genitals, oral cavity or anus or include penetration to the alleged abuser's genitals, oral cavity, or anus. Non-penetrative contact may include contact of the genitals, buttocks, breasts or other body part by hands, genitals, other body parts, or objects either to or by the alleged abuser.⁴⁻⁷

Sexual assault and commercial sexual exploitation of children/youth, a subgroup of human trafficking, would fall into this category of maltreatment.^{4,6}

Human trafficking: The act of recruiting, harboring, transporting, providing or obtaining a person for compelled labor or commercial sex acts using force, fraud, or coercion.

Child Neglect: A culpable act of omission that harms or threatens to harm a minor child (e.g., not providing enough food or fluids, not picking up/providing medications as prescribed, not following up on medical/dental/psychological care as recommended, not seeking medical care when it is needed, exposure to repeated incidents of interpersonal violence, exposure to environments where substances are used/abused/manufactured, and so forth); there are

multiple types including physical, medical, dental, psychological, supervisory, environmental, and educational.^{4,8-10}

Medical Child Abuse: "Child maltreatment caused by a caregiver who falsifies and/or induces a [minor] child's illness, leading to unnecessary and potentially harmful medical investigations and/or treatment."¹¹ This can include falsification by reporting the minor child has an illness they have not been diagnosed with, falsifying and/or exaggerating the minor child's symptoms and/or utilizing various methods to induce the minor child to corroborate the caregiver's reports regarding symptoms/disease state. Induction of illness means the caregiver performs an act that leads to signs/symptoms in the minor child (e.g., suffocation, introduction of substances orally, rectally, vaginally, topically, via catheters/IV lines, or in collected laboratory specimens). Other names for this include Pediatric Condition Falsification Disorder, Factitious Disorder by Proxy, Munchausen by Proxy.¹²

Psychological maltreatment (abuse/neglect): "Repeated pattern of parental [caregiver] behavior that is likely to be interpreted by a child that he or she is unloved, unwanted, or serves only instrumental purposes and/or that severely undermines the child's development and socialization."¹³ There are multiple types including spurning, terrorizing, isolating, exploiting/corrupting, neglecting mental health, medical, educational needs, exposure to environments where intimate partner violence occurs.^{12,13}

Mandated Reporter: A mandated reporter is someone determined by state statute who is required to make a report to a specified agency (i.e., CPS, law enforcement) when there is a reasonable concern of child maltreatment. Each state has their own legal statutes defining who is considered a mandated reporter. In some states, all adult citizens are mandated reporters and in others, the law specifically defines who is a mandated reporter, typically based on their likely contact with children. Regardless, medical professionals are mandated reporters in all states.

Mandated reporters have a statutory requirement to report concerns for child maltreatment to child protective services (CPS) and/or law enforcement. Please refer to your state laws and your local facility's policy regarding mandated reporting.

Chain of Custody: The process of maintaining and documenting the handling/preservation of forensic evidence, laboratory and/or pathological specimens that includes clearly documenting who obtained, handled, transferred or processed them during the course of the patient's care and/or afterwards; this would include when the evidence/specimens are released from the medical setting and to whom. This is important in the legal environment as it is required to validate the legitimacy of the evidence/specimens and the results of the end analysis. For information about how to do this in your area, refer to your facility's policies.

Safety Plan(ning): This is developing a series of expectations for parent/caregiver behavior(s) with the purpose of keeping a child/adolescent safe. Medical providers participate in some variation of this every day by providing anticipatory guidance regarding child safety measures.

In the case of a child/adolescent for whom there is a concern of child maltreatment, safety planning takes on additional layers of complexity. In most states, safety planning is completed by CPS and/or law enforcement agencies. While these agencies may seek the medical provider's input as to the patient's clinical presentation, status, risk and subsequent interpretation, CPS and/or law enforcement agencies are typically tasked with determining risk and safety for a child and their siblings.

If a medical provider has concerns about the safety plan determination by CPS and/or law enforcement, it is appropriate to communicate those concerns with the assigned representatives for the agencies with the understanding that in most situations, the ultimate decision lies with the appropriate agencies. In some medical facilities, the option of social admission is a possible temporary consideration in situations where the medical providers have significant concerns about the immediate safety of the patient should they be discharged. Refer to your facility policies for further guidance.

Child Protective Custody: This typically occurs when CPS and/or law enforcement take temporary custody of the child when they determine it is necessary for the health and/or welfare of the child. CPS and/or law enforcement may need to communicate with the medical providers for the child/adolescent to understand the patient's medical presentation, diagnosis(es), assessment and treatment.

In a handful of states, there is statutory allowance for medical providers to place child/adolescents in temporary protective custody under a set of specific circumstances. To know if your state participates in this, please refer to your state laws and facility policies.

Consent: For all aspects of a medical and/or forensic evaluation, all attempts should be made to obtain informed consent. Whoever a medical provider has communicated information regarding the patient's illness/injury, procedure, therapy, options, risks, benefits, prognosis without prescribed procedure and/or therapy, right to refuse, right to receive answers to their questions, and who has the capacity to understand this information, is said to be "informed."

For patients who are minors, most commonly it is the parent/caregiver providing consent to evaluation and treatment in the ED. For patients where CPS is involved, regardless of whether they have **protective custody or not**, it is possible for CPS to have medical decision making privileges rather than the parent/caregiver. Consider this possibility and refer to your local facility's policies for further actions regarding the consent process.

Minors may provide consent for their own medical evaluation and treatment under certain circumstances (e.g., teen seeks treatment for sexual assault, sexually transmitted infections (STIs), or mental health services); however, this can vary by state so refer to your local state laws and facility policies.

Special Note: In some states, minors may provide consent for their own forensic evidence collection; however, this is usually linked to a particular age. Please refer to your local state laws for information about whether minors can provide consent for forensic evidence collection and under what circumstances.

Finally, for the minor who requires emergent medical treatment where consent of the responsible adult cannot be obtained and withholding treatment would harm the patient, the health and well-being of the patient supersedes signed consent. Refer to your local facility policies.

Assent: For minors who are not legally able to provide consent for medical evaluation/treatment, obtaining their assent must be considered. Attempt to include the patient in every part of the evaluation and treatment process in a developmentally appropriate manner. Provide the patient with information about why a particular evaluation/treatment is recommended, what their options are and the risks, and give them as many choices during the process as possible (e.g., "Do you want me to look at your mouth first or your ears first?"). When developing the medical plan of care, should objections arise from the patient, carefully

consider what can be done to alleviate those objections, whether the proposed plan is absolutely clinically necessary and/or there are alternative medically sound options for completion.

After addressing these considerations, if a particular part of an examination, laboratory/radiologic test, and/or treatment is **not** medically necessary at the time and the patient is adamantly refusing, consider deferring further intervention. However, if the examination, laboratory/radiologic test and/or treatment is needed emergently, rely on your clinical judgment and local facility policies to accomplish the needed intervention.

Trauma informed care: “Strengths-based, overarching framework emphasizing the effect of trauma in the approach to working with individuals and families and in designing systems of care within organizations.”^{12,14} It involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma informed care also emphasizes physical, psychological and emotional safety for both patients and providers.¹²

Procedure/Action (Responsibilities in order of patient arrival until departure from the ED)

1. Sexual Abuse/Assault^{6,7,15-18}

General Principles-Children and adolescents who have been sexually abused/assaulted may present to the ED for evaluation and treatment. They may provide limited history regarding the abuse/assault and often have no diagnostic physical findings on examination. Despite this challenge, ED staff must remain diligent to identify when sexual abuse may be occurring, and maintain an open-minded, calm, compassionate and nonjudgmental approach to the care of the patient and their family members in the ED.

A. Acute versus nonacute:

1. Acute: Refers to acuity for the purposes of forensic evidence collection and is a matter of jurisdiction. Many jurisdictions qualify an acute sexual assault as occurring within 72 hours of presentation to the ED. However, this may be longer in other jurisdictions (i.e., 120 hours, 7 days). Refer to your state’s statutes and local jurisdictions to determine what “acute” sexual assault means.
2. Any patient presenting to an ED with the report of acute sexual assault should undergo a comprehensive medical evaluation.

B. Prepubertal to pubertal patients:

1. For prepubertal *female* patients, do not use a speculum or other instrumentation that will touch the hymen.

2. For prepubertal patients, *male or female*, do not provide “presumptive treatment” (i.e., prophylaxis) for STIs with the exception of HIV PEP (Post-Exposure Prophylaxis) in specific circumstances. See below under “Treatment” for further information.
- c. Obtaining a Patient History Regardless of Acuity
1. For all children, obtain the history without their caregiver in the room, if possible.
 2. Begin taking the history with a simple introduction, rapport building, then initial open-ended medical questions, and follow-up with more specific questions if necessary. Whenever possible, return to the open-ended questions.
 3. Open-ended questions-“Tell me why you are here today,” or “Tell me more about that.”
 4. Use developmentally appropriate language.
 5. Utilize the patient’s own language in the wording of follow-up questions-“When your uncle touched your private parts, what did he use to touch your private parts?”
 6. Avoid binary answer choice questions; instead give them a third option-“When your uncle touched your private parts, were your clothes on, off or something else?”
 1. This allows children to answer more accurately when the binary answer choices do not accurately reflect the truth-“Well, he pulled my pants and underwear down, but they were still on my legs.”
 7. Avoid leading/coercive questions.
 8. Give ample time for the child to process and then to respond.
 9. Consider Commercial Sexual Exploitation of Children/Youth (CSEC/Y) in all children, especially adolescents. Screen for red flags such as difficulty isolating the patient, history of being a runaway, mental health issues, substance use/abuse, more than 5 sexual partners, multiple STIs/pregnancies, symptoms of prolonged environmental exposure. Possible questions include: Do you feel safe? Have you ever been forced to exchange sex for money, drugs, shelter, or favors? If there is concern for CSEC call child protective services and consider calling the National Human Trafficking Hotline (888-373-7888) if your facility policies allow it; you may need to obtain consent for this.
 10. For all patients, conclude the history taking session with a therapeutic message that communicates appreciation, but not for the content of what they said:
 1. “Thank you for letting me talk with you today.”
 2. “Thank you for letting me make sure you are healthy today.”
 11. Utilize principles of trauma informed care (see above definition).
 12. It is not uncommon for a patient to not disclose in the clinical setting for a multitude of reasons including the possibility that there is nothing to disclose. Do not continue to ask questions if there is no disclosure, but rather, clinically rely on the caregiver history. CPS and/or law enforcement may later schedule the patient for a forensic interview in a different setting, usually a Child Advocacy Center.

13. Documentation should be accurate, thorough, and utilize non-judgemental language unless that language is a direct quote from a caregiver/parent or the patient; document such with quotations.

D. Acute Sexual Assault

1. General Principles: The ED evaluation should accomplish the following:
 1. Identify and treat all physical injuries
 2. Reduce or eliminate the risk of sequelae of the assault
 3. Provide a permanent record of the evaluation
 4. Collect forensic evidence and maintain chain of custody
 5. Provide referrals for follow-up medical and psychological care
 6. Communicate with law enforcement and CPS personnel as appropriate

2. Triage
 - a. Evaluation requires a brief history and screening exam and should afford an “urgent” or “emergent” status.
 - b. The triage nurse then notifies the emergency physician and social worker, if available, of the patient’s presence in the ED.
 - c. A patient room is readied that allows for privacy.
 - d. Recommend not having the patient change into a hospital gown until/if forensic evidence is collected.
 - e. Recommend not allowing the patient to eat or drink until forensic evidence is collected.

3. Medical Evaluation-History includes:
 1. General medical history
 2. Social history
 3. Anogenital history (e.g., UTIs, other anogenital infections, status of self-participation/efficacy of personal toileting practices, previous sexual contact regardless of consent status)
 4. Behavioral and developmental history
 5. History of the reported assault, with a focus on
 1. The nature of the reported physical contact(s) (sexual and non-sexual)
 2. The patient’s symptoms
 3. When the reported assault occurred-Obtain from parent/caregiver or agency representative if at all possible
 4. Where the reported assault occurred-Obtain from parent/caregiver or agency representative if at all possible

4. Obtain a History from the Patient (See above)
5. Physical Examination

- a. The complete head-to-toe exam should identify:
 1. Oropharyngeal or dental trauma
 2. Skin bruising, petechiae, bites, neck trauma, ear injuries and/or other trauma
 3. Abdominal tenderness or bruising
 4. Anogenital injuries or abnormalities
 5. Potential internal, life- or limb-threatening physical injuries
 6. Psychological evaluation to assess for suicidality
6. Forensic Evidence Collection per local protocol
 - a. Some jurisdictions require law enforcement approval and documentation of such prior to evidence collection.
 - b. The forensic evidence kit should contain (not every portion of the kit needs completed; see instructions in the kit and go by the patient's provided history regarding physical contact):
 1. Instructions on how to use the kit
 2. Written documentation of the contents of the kit
 3. Signed consent for the release of the kit to the police/crime lab. Signed consent to collect the evidence. Consent and assent should be obtained prior to collecting specimens.
 4. Additional paperwork to complete with historical and examination information
 5. Swabs, slides, comb, tweezers, boxes/envelopes with specific instructions for the following collections, as necessary per patient history and local/state protocol.
 6. Hair (from scalp)
 7. Hair (from pubic area)
 8. Oral swabs for evidence
 9. Oral swabs for DNA standard
 10. Penile (periurethral) swabs Vaginal swabs
 11. Vaginal swabs
 12. Rectal swabs
 13. Perianal swabs
 14. Nail scrapings
 15. Additional swabs for vulvar evidence, evidence from other areas on body (e.g., bite marks) and evidence from areas on body identified by high-intensity blue light
 16. Trace evidence envelopes (e.g., any other evidence collected such as vaginal foreign body, speculum if used, and so forth)
 17. Include all clothing in the kit or in paper bags sealed with evidence tape. Do not use plastic bags.
 18. Label each specimen container with the following:
 - a. Name of the patient
 - b. Location of specimen source
 - c. Name of person obtaining the specimen

- d. Date and time of collection
 - 19. Blood, urine, or saliva specimens of patient, as appropriate, and per local/state protocols (i.e., concerns of drug facilitated sexual assault)
- 7. Diagnostic Testing
 - a. Based on the type of physical contact reported
 - b. Initial testing and follow-up testing at specific intervals
 - 1. If it is determined the patient needs HIV or syphilis (RPR) testing and the results are negative, the testing should be repeated 6 weeks and 3 months post sexual assault.
 - c. STI testing should be *guided by the history of contact*. Please refer to the 2021 CDC STI Treatment Guidelines for children/adolescents who may have been sexually abused/assaulted; <https://www.cdc.gov/std/treatment-guidelines/toc.htm> for additional guidance on when to consider testing in prepubertal children, postpubertal children, types of testing for the different locations of contact and biological sex of your patient, presumptive treatment (“prophylaxis”) and follow-up care.
 - d. Preserve a sample for additional testing should the first test return positive; this will be required for forensic purposes. Also, see chain of custody discussion at the beginning of this document.
 - e. Toxicologic Testing (serum and urine drug screen) should be considered in all cases where there is reasonable cause to suspect a drug-facilitated sexual assault. Such reasons may include:
 - 1. History of altered mental status or memory deficits
 - 2. Circumstances suggest a drug was given (ie, the patient woke up in an unfamiliar location, patient reports using a substance)

Refer to facility and jurisdictional policies. Refer to local crime lab and law enforcement protocols with regard to appropriate specimen collection, and the handling, documentation and transfer of specimens from hospital to crime lab.
 - f. Other diagnostic testing includes:
 - 1. Pregnancy testing (urine hCG) for all pubertal females
 - 2. Additional medical evaluation and testing as clinically indicated
 - 3. Consider placing a red top on hold for additional drug testing at a later date.
- 8. Treatment
 - a. STI prophylaxis
 - 1. Should be guided by the type of contact reported
 - 2. Should *not* be given to prepubertal children unless referring to HIV PEP
 - 3. Refer to the 2021 CDC guidelines: <https://www.cdc.gov/std/treatment-guidelines/toc.htm> for guidance about gonorrhea, chlamydia, syphilis, trichomonas,

Gardnerella/bacterial vaginosis, HIV, HPV, hepatitis B and hepatitis C.

4. Proceed with HIV testing, prophylaxis or treatment in consultation with local infectious disease specialists who will offer assistance in providing HIV therapy recommendations, counseling for families and follow-up care and testing. Typically, prior to starting HIV PEP, a baseline CBC, LFTs and creatinine should be ordered. Here are two resources regarding this:

1. <https://www.cdc.gov/std/treatment-guidelines/toc.htm>
2. National Clinician Consultation Center Post-Exposure Prophylaxis Hotline (PEpline) at 888-HIV-4911 (888-448-4911) for assistance.

b. Pregnancy prophylaxis

1. Offer pregnancy prophylaxis to pubertal patients who present within 72 hours of the sexual assault if the urine hCG testing is negative.
2. For the pubertal patient desiring pregnancy prophylaxis who presents between 72 hours and 5 days post-assault, consult gynecology or adolescent medicine to discuss other options.
3. Therapy:
 1. Levonorgesterel (Plan B)
 1. There is the possibility of decreased effectiveness of Plan B for those with BMIs > 30; consider consulting with gynecology or adolescent medicine for alternatives.
 2. Educate the patient about the expected “withdrawal” bleeding that occurs within 21 days, and the need for a repeat pregnancy test if no bleeding occurs.

c. Hepatitis B Immunization and HBIG treatment-For guidance, see

<https://www.cdc.gov/std/treatment-guidelines/toc.htm>

d. HPV Vaccination-For guidance, see [https://www.cdc.gov/std/treatment-](https://www.cdc.gov/std/treatment-guidelines/toc.htm)

[guidelines/toc.htm](https://www.cdc.gov/std/treatment-guidelines/toc.htm)

e. Serious Injury

1. For the child or adolescent with continued pain and bleeding, where there is concern about a rectal or vaginal foreign body, or serious internal injury, contact with surgeon, gynecologist, and/or urologist should be made emergently, as such cases may require an exam and repair under general anesthesia.
2. In rare cases, such serious injuries require that the exam, forensic evidence collection and/or any necessary surgical repair require moderate to deep sedation in the ED, or general anesthesia in the operating room (OR). Contact with specialists and arrangements for

appropriate consultation and/or transfer should be made expeditiously.

9. Mandated Reporting

- a. For reported cases of sexual abuse/assault, contact CPS and/or law enforcement (refer to local/state reporting policies/laws). Information provided should include the following:
 1. Name of the patient and reported abuser
 2. Relevant history of the assault event including where it occurred and when
 3. Relevant details of the medical evaluation in the ED
 4. Whether forensic evidence was collected
 5. Diagnostic test results that identify an STI or presence of sperm
 6. Concern about risk of harm to others with whom the reported abuser may have access.
 7. Use straight forward terminology; avoid medical jargon.
 8. It is recommended that the emergency physician inform the caretaker(s) of the report to CPS. The conversation with the caretaker(s) about reporting to CPS should focus on the child's health and rely on good communication techniques including non-judgmental language, transparency, closed-loop dialogue and an opportunity for question asking.

10. Documentation should include the following information:

- a. The time, place and location of the evaluation.
- b. Whether an interpreter was offered and if it was accepted/declined. If accepted, document if the interpreter was in-person, via video language line or via telephonic language line. Document the name and ID#, if applicable. Do not utilize patient family members or friends for interpretation. Do not utilize medical providers for interpretation unless specifically allowed at local facilities.
- c. Who was present when the history was obtained from the caregiver/parent.
- d. Who was present when the history was obtained from the patient.
- e. The details of the provided history of the caretaker/adult and the child.
- f. The name of the patient's primary care physician.
- g. The name of the reported abuser and relationship to the patient, if known.
- h. The patient's statements concerning the abuse event(s) as reported to personnel in the ED or patient's caretaker, using direct quotes when possible.
- i. The complete physical exam with particular detail of the anogenital exam. Use of diagrams and preprinted, standardized charts for sexual abuse/assault are particularly useful.
- j. The diagnostic testing performed in the ED and any available results.
- k. Any medical treatments, medications, consultations, and procedures in the ED.
- l. The use of diagnostic aids (eg, colposcope) or photography in the ED.
- m. The diagnosis(es) and a summary or final assessment of the child, concern or not of abuse and the relevant history, exam findings and lab data that support such statements.

- n. The plan of care for follow-up medical and psychological treatment, as well as other support services.
- o. The disposition of the child and brief description of the safety plan, if CPS or law enforcement put one in place.
- p. The personnel to whom the abuse was reported (i.e., CPS worker, law enforcement representative).
- 11. Disposition
 - a. Admission

For the patient presenting after sexual assault with serious, multiple or life-threatening injuries, or for whom no safe environment is available emergently, hospital admission should be promptly arranged.
 - b. Temporary Protective Custody:

Law enforcement, CPS, and, in some locations, medical providers treating the child, may take protective custody without the consent of the caretaker or parent if leaving the child in the care of the parent presents an imminent danger to the child's life or health. This is done on a temporary basis until time allows a court to consider the status of custody.
 - c. Transfer

For the patient requiring specialized emergency, operative or inpatient care, transfer should be arranged. For the stable patient, transfer is preferable after forensic evidence has been collected, to ensure the highest possible yield in the recovery of evidence. However, the patient's physical health and well-being must always take precedence over the criminal investigative process.
 - d. Discharge/Follow-up Care/Safety Plan

Once the medical evaluation is complete, discharge instructions should be provided to the patient and caretaker, with a documented plan that provides for prompt follow-up care with their primary care provider and ensures the safety of the patient. This is especially critical when a relative or household member is the reported abuser, or when the patient is very young or preverbal. Also, attention must be paid to the protection of all minors in the household to whom the reported abuser has access. Therefore, close communication with CPS and law enforcement is essential prior to patient discharge.

E. Nonacute Sexual Abuse/Assault:

- 1. Triage
 - 1. Triage evaluation requires a brief history and screening exam, and should afford an "urgent" status to the child.
 - 2. The triage nurse then notifies the emergency physician and social worker, if available, of the patient's presence in the ED.
 - 1. A patient room is readied that allows for privacy.
 - 3. Medical Evaluation
 - 1. May consider deferring a *comprehensive* medical evaluation (including a physical exam with colposcopy/medical photography)

to a specialty site/advocacy center if the following conditions are met:

1. The child is safe for discharge, as determined by CPS and/or law enforcement, with scheduled follow up
2. The abuse occurred beyond the “acute” time frame as determined by your local jurisdiction
3. The patient is examined including visual inspection of the anogenital area prior to discharge to ensure the patient is medically safe
4. There are no symptoms of ongoing anogenital bleeding
5. Parent/caregiver agrees to follow-up plan

The advantages of deferral of the comprehensive medical evaluation include use of subspecialty medical services, coordination of efforts by medical, CPS/law enforcement personnel, and prevention of repeated history takings from and multiple anogenital exams of the patient.

2. General Guidelines
 - a. Utilize the assistance of a social worker, if available.
 - b. Conduct an initial history with the caretaker/parent alone.
 - c. Subsequent history from the patient (if not deferred to non-ED setting) should also be conducted alone; this history should focus solely on medical information (e.g., type of contact, symptoms). Additional history may be taken from the patient by a SANE (sexual assault nurse examiner) or other forensically qualified professional at another time.
 - d. Documentation should be accurate, thorough, and utilize non-judgmental language unless that language is a direct quote from a caregiver/parent or the patient; document such with quotations.
3. History of the parent/caregiver should include:
 - a. Events surrounding abuse incident(s) such as when, who the reported abuser is, known types of physical contact, symptoms
 - b. General medical history
 - c. Review of systems
 - d. Behavioral and developmental history
 - e. Social history (who lives with the patient, is the patient in contact with the reported abuser)
4. Physical Examination
 - a. Considered medically emergent if
 1. Anogenital trauma suspected (e.g., anogenital pain/bleeding)
 2. Sexual contact within the “acute” timeframe
 - b. Includes a complete head-to-toe exam with particular attention to
 1. Oropharyngeal or dental trauma
 2. Skin bruising, petechiae, bite marks, neck trauma, ear injuries and/or other trauma
 3. Abdominal tenderness or bruising

4. Anogenital injuries or abnormalities
 5. Psychological evaluation to assess for suicidality and overall psychological health
5. Anogenital examination
 - a. Use a private, well-lighted room and a chaperone.
 - b. Honor the patient's privacy and his or her request or lack thereof for caretaker's presence during the exam.
 - c. For **prepubertal** patients:
 1. External inspection only (i.e., no evaluation of vagina, cervix, or bimanual)
 2. For a female patient, should include a labial traction examination
 3. No speculum, swabs or catheters
 4. Have the child assume a "frog-leg" position on the examining table or caretaker's lap
 1. For a female patient:
 1. Inspect the labia majora and perineal area
 2. Retract the labia to view the labia minora, the clitoral hood, the vestibular structures (urethra, hymen, vaginal opening), fossa navicularis and posterior fourchette
 - b. For a male patient:
 1. Inspect the foreskin if present
 2. Inspect the glans, scrotum, perineum
 3. Retract the foreskin, if present, and inspect the penile shaft and base
 - c. Have the supine child bring their knees to their chest to inspect the anus
6. Diagnostic Testing
 - a. Sexually transmitted infection (STI) testing
 1. Based on the type of physical contact in prepubertal and postpubertal children/adolescents
 2. Testing for the following infections should be considered: Gonorrhea, Chlamydia, HIV, Hepatitis B, Syphilis, Trichomonas vaginalis, and Herpes Simplex Virus (only if see active vesicular or ulcerative lesions).
 3. Providers should refer to the Centers for Disease Control (CDC) website for the latest guidelines regarding STI testing in child/adolescent sexual assault or abuse. The most recent guidelines were released in 2021. Here is a direct link to them: <https://www.cdc.gov/std/treatment-guidelines/toc.htm>. Refer to the special population section for "sexual assault and abuse" for details.
 4. Testing may be considered in a **prepubertal** child in the following settings (per the CDC Guidelines):
 - a. History of genital contact to anus, genitals or oropharynx

- b. Signs/symptoms of STIs
- c. Abnormal anogenital findings, concern for penetration/contact
- d. Reported abuser with known STIs (or at high risk)
- e. Reported abuser is a stranger
- f. Multiple perpetrators
- g. A sibling, another child, or an adult in the household or child's immediate environment has a STI
- h. The child lives in an area with a high community rate of STIs.
- i. The child or parents request STI testing.
- j. The child is unable to communicate the details of the assault.

5. Initial testing and follow-up testing at specific intervals (see below)

b. Other diagnostic testing includes:

- 1. Pregnancy testing (urine human chorionic gonadotropin (HCG)) in postpubertal female patients
- 2. Imaging and/or labs for suspected physical abuse or injury

7. Treatment

- a. Refer to the CDC website for STI treatment guidelines: <https://www.cdc.gov/std/treatment-guidelines/toc.htm>. Refer to the special population section for "sexual assault and abuse" for details.

8. Mandated Reporting

- a. Contact local CPS and/or law enforcement agencies to report the concerns for abuse (see local/facility protocols on reporting), provide information about the identity of the reported abuser and the patient, and share pertinent details of the medical evaluation in the ED. Be sure to communicate any concern for risk of harm to the patient and other children with whom the reported abuser may have access. Use straight forward terminology; avoid medicalease.
- b. It is recommended that the emergency physician inform the caretaker(s) of the report to CPS. The conversation with the caretaker(s) about reporting to CPS should focus on the child's health and rely on good communication techniques including non-judgmental language, transparency, closed-loop dialogue and an opportunity for question asking.

9. Documentation

a. The medical record should include the following:

- 1. All information obtained from the caretaker and the patient about the abuse incident(s), the child's medical history, social history and identity/relationship of reported abuse.
- 2. Physical exam findings

3. Results of diagnostic testing
4. Medical therapies
5. Photography and documentation it was completed, diagrams, drawings
6. Summary of evaluation (i.e., diagnosis(es), final assessment)
7. Disposition of the child and the safety plan as reported by CPS/law enforcement
8. Medical and psychological care follow-up plan
9. Names of CPS and law enforcement personnel to whom the report was made

II. Physical Abuse^{2,19-23}

1. General Principles

Concerns of physical abuse may be present in the following situations:

1. There is no explanation for the child's injury(ies)
2. The history for the injury(ies) provided is not a plausible history for the injury(ies)
3. The history provided changes over time
4. The explanation is inconsistent with the child's developmental level
5. There is a significant delay in seeking medical care for an injury
6. The patient has had repeated unexplained injuries
7. Attempts at physical discipline have resulted in physical injury

B. Triage

1. Complete a brief history and screening exam.
2. The child should be afforded an "urgent" triage status.
3. For the child with serious or multiple injuries, the triage nurse should notify the ED physician immediately and bring the child to a patient room for evaluation.

C. Medical Evaluation

The history may be conducted with the assistance of the social worker or a member of a child abuse pediatrics team, if available, and should include the following:

1. A general medical history such as a history of present illness and past medical history to include known medical diagnoses, previous surgeries and hospitalizations, medications, allergies to medications/other things, immunization status, current medications, previous injuries, etc. should be completed.
1. History of injury event(s)-The following information should be obtained from the parent or caretaker(s) without the child present if at all possible:
 1. Child's symptoms that prompted ED visit
 2. Events leading up to injury event, specifically the last time the child was known to be in their healthy state
 3. Person supervising the child at the time of the event or the onset of symptoms

4. Witnesses to the event(s) or onset of symptoms
 5. Person who first found the child injured or with onset of symptoms
 6. Details of the event (actual not presumptive), including location of child, position of his/her body, things the witnesses saw or heard, signs/symptoms of the child including swelling, bruising, bleeding, mental status, vomiting, description of objects/surfaces involved, etc.
 7. If a fall is described, details concerning height of fall, nature of landing surface, number of impacts, presence of objects on the impact surface(s)
 8. Actions of caretaker or first person responding to the injured child
 9. Time elapsed between event/trauma and seeking medical care
 10. Details of home treatments/first aid/remedies given
 11. Details of medical care prior to ED visit (eg, office visit, urgent care visit)
 12. For the child who spontaneously discloses abuse to ED personnel, obtain further details of the abuse event(s), when possible:
 1. Timing of abuse event(s)
 2. Nature of abuse
 3. Object(s) used
 4. Threats, coercion, force or weapons employed
 5. Witness(es) to the abuse
 6. Other people who have experienced the abuse
 7. Symptoms during and after the abuse
 8. Person(s) to whom abuse disclosed prior to the ED visit
 9. Name/relationship of reported abuser
 13. History from prehospital providers and/or law enforcement personnel who were present in the home or at the scene is invaluable and should detail:
 1. Child's condition on arrival
 2. Resuscitation efforts and child's response
 3. History provided by family/caretakers at the scene
 4. Condition of home environment
2. A social history should include who lives and cares for the child, prior safety concerns, history of violence involving parent/caregiver, history of substance use/abuse by parent/caregiver, previous CPS history as a parent/caregiver or for the parents/caregivers as children, previous involvement with law enforcement for the parent/caregiver.
3. A developmental history should be obtained to understand the patient's mobility status and physical capabilities.
4. A family medical history should include a history of psychological diagnoses, substance use/abuse, easy/frequent bleeding or bruising more than one would expect for a specific mechanism, more bleeding from routine procedures/dental cleanings than

would be expected, heavy menses, multiple miscarriages, multiple fractures without obvious cause, etc.

5. Review of systems should include changes in behavior/emotion/attention, vomiting without diarrhea, poor feeding, unexplained fussiness/somnolence or other changes in mental status, seizure-like activity, brief resolved unexplained events, changes in sleeping/eating habits, etc.

6. Physical Examination

- a. The physical exam should be performed in a private and well-lighted room. The child should be undressed and placed in a gown.

- b. The complete head-to-toe exam should pay particular attention to:

1. General physical appearance and emotional state

2. Head Trauma

1. Abnormal neurologic findings

2. Vital signs and growth parameters to include weight, height, and head circumference

3. Eye trauma (i.e., subconjunctival hemorrhages, corneal abrasions, retinal hemorrhages)

1. It is unlikely retinal hemorrhages will be identified by ED providers; this usually requires pediatric ophthalmologic consultation.

4. Oral trauma

1. Frenulum injury - Check all three frenum (under the tongue, inside the upper lip, and inside the lower lip).

5. Bruises^{21,22}

1. In any child \leq 4 months old, ANY bruising without an independently witnessed accident in public to account for the injury is concerning for child physical abuse.

2. In any child \leq 4 years old, bruising in the **TEN-4 FACESp** areas without an independently witnessed accident in public to account for the injury is concerning for child physical abuse. **TEN FACES p** stands for the following:

- Torso (chest, abdomen, back, bottom, genitals)

- Ears

- Neck

- Frenum

- Angle of the jaw

- Cheek (fatty portion)

- Eyelids

- Sclera

- Patterned (i.e., loop, handprint, ligature, bite and so forth)

- c. Multiple planes

- d. Any unexplained bruises in a non-ambulatory child

6. Burns-Those that may be concerning for child physical abuse include:

- a. Any burn that does not make sense with the history provided and developmental capability of the child
 - b. Immersion pattern
 - c. Bilateral, symmetric
 - d. Patterned burn, eg, steam iron, heater, curling iron
 - e. Severe, ie, partial or full thickness, extensive
 - f. Healing severe burns
- 7. Abdominal Injury (ie, solid organ hematoma/laceration, bowel perforation)
 - a. Note: Severe and multiple solid and/or viscous organ injuries can be present due to blunt force trauma to the abdomen in the *complete absence* of skin bruising or any external skin markings
- 8. Extremity Injury/Fractures
 - a. Multiple extremities/sites injured
 - b. Multiple fractures of different stages of healing
 - c. Any fracture in a non-ambulatory child
- 9. Anogenital Injury
- 7. Diagnostic Testing
 - a. In a patient \leq 6 months of age for whom there are concerns of child physical abuse, obtain the following:
 - 1. Noncontrast head CT
 - 2. Skeletal survey (NOT a babygram)
 - 3. AST and ALT
 - 4. Lipase
 - 5. +/- Urinalysis
 - b. In a patient $>$ 6 months of age and 24 months of age for whom there are concerns of child physical abuse, obtain the following:
 - 1. Skeletal survey (NOT a babygram)
 - 2. AST and ALT
 - 3. Lipase
 - 4. +/- Urinalysis
 - 5. May consider a noncontrast head CT if the patient has an abnormal neurological examination and/or there is evidence of facial/head injury
 - c. If a patient is identified as having injuries related to bleeding processes (i.e., intracranial hemorrhage, bruising), consider obtaining the following:
 - 1. CBC, PT, PTT, Factor 8 and 9 levels, vW panel
 - 2. Consider discussing with pediatric hematology if any results are abnormal or if considering additional coagulation testing.
 - 3. In patients with extensive bruising, obtain a type and cross, CK, and renal function tests
 - d. If there is concern for a diagnosis of abusive head trauma:

1. Consider obtaining a brain MRI with and without contrast; discussion with pediatric neurosurgery and/or the child abuse pediatrics team, if available, is recommended.
 2. Consider obtaining a whole spine MRI without contrast; discussion with pediatric neurosurgery and/or the child abuse pediatrics team, if available, is recommended.
 3. Consult pediatric ophthalmology to complete a dilated fundoscopic examination.
- e. If a patient has oral trauma:
1. Consider dental x-rays or follow up with a dentist
 2. Consider x-rays of jaw (Panorex, Panelipse or CT face)
 3. Consider dental consultation as needed
- f. Burns
1. For extensive or severe burns, send blood and urine for testing (i.e., blood count, electrolytes, renal function, coagulation studies, urinalysis, type and cross) as medically needed.
- g. Abdominal Injury
1. Send blood and urine for testing (i.e., blood count, liver enzymes, lipase, electrolytes, renal function, coagulation studies, type and cross, urinalysis)
 2. Emergency imaging with abdominal/pelvic CT with IV contrast if there is an elevated AST/ALT/Lipase, symptoms of abdominal injury, or significant abdominal bruising
 1. An US or FAST is **not** adequate
- h. Fractures
1. Obtain at least two radiographic views of any site with a suspected fracture
 2. For severe or multiple fractures, send blood for testing bone health (i.e., metabolic bone labs such as calcium, phosphorous, alkaline phosphatase, bioactive PTH, 25-hydroxy-vitamin D)
 3. If there are concerns for rickets or other underlying endocrinopathy, consult pediatric endocrinology.
 4. If there is a concern for a diagnosis of osteogenesis imperfecta or other skeletal dysplasia, testing should be done in consultation with a child abuse pediatrics team and/or geneticist.
 5. Obtain a skeletal survey in the following cases:
 1. Concern for physical abuse in child under 2 years
 2. Child with unexplained serious injury in a child ≤ 5 years old (i.e., bruising, fracture, burns, head trauma, abdominal trauma).
 3. Concern for physical abuse in child 2-5 years of age on a case-by-case basis, consider expert consultation
 4. Over 5 years of age, a skeletal survey has low yield and x-rays should only be obtained when there is clinical

suspicion of a specific anatomic region with expert consultation.

Note that a skeletal survey consists of a complete set of radiographic images to document each anatomic region of the child's complete skeleton. **A "babygram" is not acceptable.** Please see American College of Radiology and American Academy of Pediatrics guidelines for details.

8. Treatment/Consultation
 - a. For the physically abused child with injuries, proceed with appropriate treatment for resuscitation, stabilization, and pain control. In these cases, specialty care may be warranted on an urgent or emergent basis.
 - b. Consultation with Child abuse pediatrics team, if available
 - c. Consultation with pediatric surgical specialists (ie, general surgery, trauma surgery, neurosurgery, orthopedics, ophthalmology, plastic surgery, etc.)
 - d. Consultation with pediatric medical specialists (ie, radiology, dermatology, hematology, genetics, endocrinology, etc.)
 - e. Social work
9. Mandated Reporting
 - a. Report to CPS and law enforcement when there is a *concern* that the injuries are the result of physical abuse. Contact them as soon as possible, provide pertinent history, physical examination findings, risk of future harm to the child or other members of the household who are minors, and your final assessment and degree of concern for physical abuse. Use lay terminology.
 - b. Mandated reporting laws for concerns of child maltreatment may require reporting to CPS and/or law enforcement. Each state handles this differently. Refer to your state's laws and facility protocols to understand your requirements for mandated reporting.
 - c. It is recommended that the emergency physician inform the caretaker(s) of the report to CPS. The conversation with the caretaker(s) about reporting to CPS should focus on the child's health and rely on good communication techniques including non-judgemental language, transparency, closed-loop dialogue and an opportunity for question asking.
10. Documentation
 - a. Careful, thorough documentation of caretaker and patient statements, quoting household members directly when possible, with a highly detailed description of physical findings is essential.
 - b. Each abnormal finding should be described in detail, documented on a body diagram, and photographed. For example, a bruise on the child's back is described as "linear bruise, 0.5 cm wide and 6 cm long, extending across the back at the level of the lower edge of the scapulae, red and purple in color, photographed."
 - c. Strong consideration should be given to contacting the local crime lab or law enforcement agency for an investigator/forensics specialist to photograph injuries, with

such photography accomplished in accordance with law enforcement investigative protocols.

1. If unavailable, proceed with photography using the camera available in the ED.
 1. Begin with a photograph of the patient's name, the date and time of the photodocumentation, and who is taking the photodocumentation.
 2. Be sure that each picture has two important items in the frame: an identifying label with the date and patient's name, and a ruler.
 3. Take photographs of the upper third of the patient's body, the middle third of the patient's body, and the lower third of the patient's body.
 4. For each injury, take a wide-shot and a close-up shot of the injury with a measurement device (i.e., L ruler, measuring tape) in the image.
 1. TIP: For each image, take the photograph so the lens is perpendicular to the injury.
 - d. Standardized medical charts for child physical abuse assist greatly in providing such detailed documentation.
11. Disposition
- a. Admission-For the patient with serious, multiple or life-threatening injuries, or for whom no safe environment is available emergently, hospital admission should be promptly arranged. This may require transfer to a children's hospital or tertiary-care center with pediatric trauma services, necessitating appropriate stabilization, communication and documentation of care prior to transfer.
 - b. Temporary Protective Custody-Law enforcement and CPS may take protective custody without the consent of the caretaker or parent if leaving the child in the care of the parent presents an imminent danger to the child's life or health. This is done on a temporary basis until time allows a court order to be issued.
 - c. Discharge/Follow-up Care/Safety Plan-Once the medical evaluation is complete, discharge instructions should be provided to the patient and caretaker, with a documented plan that provides for prompt and comprehensive follow-up care with the patient's primary care provider and/or appropriate subspecialists and ensures the safety of the patient. Also, attention must be paid to the protection of all minors in the household to whom the reported abuser has access. Close communication with social services and law enforcement are therefore essential prior to patient discharge.

III. Child Neglect^{4,12}

1. General Principles-Child neglect is the most prevalent form of child maltreatment. Child neglect is a culpable act of omission that harms or threatens to harm a minor child. There are various types of neglect including:
 1. Physical-Not providing enough food, housing, clothing; poor hygiene in person or environment

2. Medical, dental, psychiatric-Not providing or following through on medical, dental, psychiatric/psychological care recommendations (e.g., not picking up/giving medications as prescribed, not taking patient to recommended medical/dental/psychological appointments, not utilizing other health devices as prescribed, delay in seeking medical care for conditions/injuries, and so forth).
3. Supervisory-"Failure of a parent or caretaker to provide the child with adequate protection from harmful people or situations"²⁴ (i.e., Inadequate protection from environmental hazards, including prescription medications, alcohol, drugs, guns, domestic/intimate partner violence, abandonment)
4. Educational-Failing to enroll a child in school, allowing ongoing truancy, and/or not complying with recommended special education⁴
5. Psychological-Not providing psychological support and affection

B. Triage

1. The child may be brought to the ED by CPS, law enforcement or an alternative caretaker.
2. Triage screening may reveal no evidence of neglect, but in the process of the physician evaluation, with a more detailed history, neglect issues may come to light.

C. History-The history may be conducted with the assistance of the on-call social worker or member of a child abuse pediatrics team, if available, and should include the following:

1. General medical history-This includes prior or ongoing medical conditions, primary care provider(s), prior surgeries, injuries and hospitalizations, medications, allergies, immunization status, general somatic complaints, and a complete review of systems, including a complete dietary history that details feeding/eating regimen, formula/foods offered/eaten, feeding/eating frequency, and any feeding/eating issues.
2. Social history-This includes identifying all members of the household(s) in which the child resides or is supervised, domestic/intimate partner violence, drug or alcohol use by those who live in the household(s), perinatal drug exposure, prior involvement with child protective services and law enforcement agencies, prior childhood abuse/neglect to the child's parents/caretakers, psychological illness in the child's parents/caretakers.
3. Behavioral history-This includes the description of any change in emotional affect, learning problems, extreme risk-taking behavior, self-isolation, or other behavioral problems/changes noted at home or school.
4. Developmental history (particularly important with the disabled or very young child.)
5. Injury/Ingestion History-Obtain a history of injuries/ingestions the child or siblings have sustained (i.e., fractures, bruises, intraoral injuries and so forth).

- D. Physical Exam-The physician should proceed with a complete head-to-toe physical exam, careful to note and document the child's general appearance and demeanor, vital signs, weight, height, head circumference (if <2 years old), any evidence of poor hygiene, untreated medical conditions including involving the teeth, cutaneous or other evidence of injury(ies), developmental delay, and interaction of the child with ED staff and child's caretaker.
- E. Diagnostic Testing-Proceed with blood, urine, spinal fluid and/or radiographic testing as appropriate for the toxic-appearing child, developmentally delayed child, or child failing to thrive. Consider serious injury due to abusive trauma in any ill-appearing or unstable child. Consider occult injury in any young child. Adjust the diagnostic testing accordingly.

If there are concerns of drug exposure (i.e., substance use/manufacturing in caretaker/living environment, and/or child with altered mental status), obtain a urine and serum drug screen with a specimen hold in case additional testing is necessary.

For those children <2 years old in homes where domestic/intimate partner violence occur, consider an age-appropriate evaluation for physical abuse (see above).

- F. Mandated Reporting-If the medical and psychosocial assessment of the child raises a reasonable concern for child neglect, reporting to child protective services should proceed. It is also important to contact the patient's primary care physician who will be providing the essential follow-up and long-term care. It is recommended that the emergency physician inform the caretaker(s) of the report to child protective services. The conversation with the caretaker(s) about reporting to child protective services should focus on the child's health and rely on good communication techniques including non-judgmental language, transparency, closed-loop dialogue and an opportunity for question asking.
- G. Disposition-Communicate with CPS and/or law enforcement agencies as is necessary to determine the safety plan. In most states, CPS and/or law enforcement will determine a safety plan for the patient and their siblings if they deem it necessary. At times, children may need to be admitted for medical and/or social reasons. This may require transfer to a children's hospital or tertiary-care center, necessitating appropriate stabilization, communication and documentation of care prior to transfer. Please refer to your local health care facility policies.

- H. Follow-up Care-Whether the child is discharged home with the primary caretaker, or placed in kinship or foster care, they must be provided with written discharge instructions that explain the plan for close medical and social services follow-up.

iv. Death of an Abused Child

It is important to remember that the workup for identifying injuries should be guided by the principles outlined in the preceding sections and that at the pronouncement of death, the child's body is now evidence. Medical equipment should NOT be removed, and the child should not be touched, held, or washed without express consent from the coroner/medical examiner. No further testing should be done, unless specifically agreed upon between local authorities and your hospital (check local statutes and health care facility policies), and efforts should be made to preserve all laboratory samples.

- A. History
 - a. The following information should be obtained from the parent or caretaker when the physician can safely leave the child's bedside. Alternatively, a second ED staff member can obtain a medical history from the parent/caregiver during the resuscitation.
 - a. Refer to sections III C & D.
 - b. Person who first found the child and events leading to the child's discovery
 - c. Recent illnesses or injuries
 - d. What made the caretaker first know there was something wrong
 - e. Were home resuscitation efforts required and what was the response
 - f. First call for help (e.g., 911, neighbors, or other family)
 - g. Over-the-counter and prescription medications in the home, controlled substances (including marijuana) in the home
 - h. Complete review of systems
 - b. History from prehospital providers (and law enforcement personnel) who were present in the home (or at the scene) should detail:
 - a. Child's condition on arrival of EMS/law enforcement
 - b. Resuscitation efforts and child's response
 - c. Individuals present at the scene
 - d. History provided by family/caretakers at the scene
 - e. Condition of home environment
- 3. Medical history assistance should be sought from the on-call social worker, who should spend time obtaining medical/psychosocial history from as many "on-scene" family members individually as soon as possible. Law enforcement and child protective services personnel may begin interviewing family members in the ED during the medical evaluation and resuscitation attempts so coordination of timing and information sharing become paramount.

- C. Prior to pronouncement of death, a complete unclothed physical exam should be performed, if at all possible, with special attention paid to the following:
1. Head, identifying any areas of swelling, discoloration, crepitus, depression, bleeding, evidence of basilar skull injury
 2. Nose and oropharynx, identifying any lacerations of the frenum (there are three in the mouth), dried blood in the nose or mouth, petechiae about the face/neck, bruising to the pinna or dental trauma (see the above physical abuse section)
 3. Eye exam-Evidence of blunt force trauma to the ocular area or the eye itself (i.e., periorbital bruising, subconjunctival hemorrhages) and retina examination to look for retinal hemorrhages (if patient fixed and dilated, should easily be able to see these; otherwise, consult ophthalmology, preferably pediatric ophthalmology)
 4. Neck, identifying any bruising or circumferential marks due to ligatures, petechiae (may not see even if strangulation occurred)
 5. Abdomen, noting distension, discoloration, bruising
 6. Complete skin inspection, including the back, noting petechiae, bruising, patterned injuries, other distinctive or unusual markings
 7. Anogenital area for injuries, but recognize with instability and death there can be perianal color change and relaxation of anal tone

D. Documentation

1. Careful, thorough and timely documentation of caretaker statements (use quotations when possible) with a highly detailed description of physical findings is crucial.
2. Each abnormal finding should be described in detail, sketched on a body diagram, and photographed. For example, a bruise on the child's back is described as "linear bruise, 0.5 cm wide and 6 cm long, extending across the back at the level of the lower edge of the scapulae, red and purple in color, photographed."
3. Strong consideration should be given to contacting the local crime lab or law enforcement agency for an investigator/forensics specialist to photograph injuries, with such photography accomplished in accordance with law enforcement investigative protocols. If unavailable, proceed with photography using the camera available in the ED, being sure that each picture has two important items in the frame: an identifying label with the date and patient's name, and a ruler. Ensure that the injury being photodocumented is clearly locatable on the child's body and, if not, obtain a primary photo showing the general location of the injury prior to proceeding with close-up photos

with measurements. Make sure the camera lens is perpendicular to the injury being photographed.

E. Diagnostic Testing prior to death

1. While the medical examiner's/coroner's examination of the child may yield significant diagnostic information about the child's cause of death, hospital testing during the resuscitation and immediately post-mortem provide invaluable data. Once again, any post-mortem diagnostic testing must be completed in accordance with local statutes and/or health care facility agreements. Check with your health care facility policies before proceeding with any post-mortem diagnostic testing.
2. For the previously healthy young infant pronounced dead in the ED, refrain from using the term "SIDS," as this is a diagnosis of exclusion, reached *after* the ED evaluation, autopsy by the medical examiner and police crime scene investigation. Also, "SIDS" should *not* be communicated to the family. When documenting the final diagnosis in the medical record do not use "SIDS;" rather, an "unexplained infant death" diagnosis can be used. For the child with obvious fatal injuries (eg, visible skull deformity with retinal hemorrhages, rib fractures and fractured femur) your diagnoses should enumerate the injuries and communicate concerns for child physical abuse if applicable.
3. Consider the following diagnostic tests in the ED **prior** to death:
 1. Nasal swabs for respiratory pathogens that cause apnea (eg, respiratory syncytial virus (RSV), pertussis)
 2. Urine or blood for toxicologic analysis
 3. Blood, or bone marrow aspirate via intraosseous needle, for bacterial pathogens that cause sepsis
 4. Blood for screening for rare metabolic disorders **not** detected by routine newborn screening
 5. Portable radiographic images (ie, skeletal survey not a babygram) that may reveal heart or lung pathology, radiodense foreign bodies, or occult rib or long bone fractures due to abuse

E. Communication is essential with the following individuals:

1. Patient family members
2. Primary care physician
3. Medical examiner/Coroner
4. Law enforcement personnel
5. CPS personnel
6. Hospital child abuse pediatrics team , if available
7. On-call social worker

8. Hospital pastoral care and clergy known to family
 9. Fellow ED staff members for support/recovery after the trauma of an unsuccessful resuscitation and child death
- F. Mandated reporting is required by law when there is a reasonable concern that the cause of death was related to child maltreatment. Contact both local child protective services and law enforcement agencies as soon as possible about a child death where there is reasonable concern for abuse/neglect.
-

Outline quality indicators

1. Completed medical record with thorough documentation of the following: the history of event(s) that are reported to cause the injury(ies); physical examination findings and injury(ies) identified; management in the ED; patient disposition/safety plan; reporting of maltreatment to individuals within CPS and/or law enforcement agencies; and follow-up plan for ongoing patient care.
 2. Appropriate collection, storage, and transfer of forensic evidence that meets legal requirements for maintaining the chain of custody.
 3. Consistent use of established procedures for the transfer to a pediatric tertiary-care hospital/trauma center of those patients who have experienced child maltreatment who have serious or multisystem injuries, who are unstable, or who require pediatric subspecialty or inpatient care.
 4. Consistent and appropriate communication/contact with primary care physicians, hospital social work personnel, CPS and/or law enforcement.
 5. Periodic case review with the local CPS, or the local children's hospital child abuse pediatrics team members or coordinator.
-

Special Considerations

Children with Special Needs

Children who have experienced maltreatment that are most vulnerable include the very young, preverbal child, and those with physical or mental disabilities. Great care must be taken in the evaluation of their injuries or conditions, as well as in formulating a plan for disposition. It is critical to communicate the importance of the patient remaining well connected to their medical and social service communities when CPS is involved and attempting to determine placement.

Cultural Sensitivity Issues

When proceeding with the evaluation of a minor child whom you suspect has been abused/neglected, remember that a minor child can be identified in all cultural, ethnic and socioeconomic groups. Establish clear guidelines for child abuse evaluation that relies on evidence-based medicine such as the age of injured patient, type of injury, and/or mechanism of injury as criteria for further evaluation. One example of such a guideline is, "for any patient

<2 years of age with a skull fracture or intracranial injury, the hospital social worker on call must be consulted for a psychosocial screening of the caretaker(s).”

In addition, the health practices, folk treatments and home remedies believed to be beneficial and safe within a particular culture, may be viewed as injurious, painful or strange to another. All efforts should be made to fully understand a family’s beliefs and intent in using folk medicine or home remedies, especially one that may pose a risk to the child.

1. Quick Reference Guidelines:

<https://www.cdc.gov/std/treatment-guidelines/toc.htm>

Relevant Joint Commission Standards can be found in sections PE.1, PE.1.9, PE.1.10.1, PE.8, and IM.2.

The Joint Commission describes standards whereby hospitals maintain the following policies with regard to the child maltreatment victim:

1. Identifying and assessing possible victims of abuse and neglect
 2. Training of hospital staff
 3. Safeguarding information and evidentiary material that arises from medical evaluation
 4. Maintaining thorough and accurate documentation, which reflects:
 - a. Appropriate consent(s) to evaluation and/or procedures
 - b. Reporting to social services and law enforcement agencies
 - c. Evidentiary material is safeguarded
 - d. Referrals are provided abuse/assault victims and families
-

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