**CHILD MALTREATMENT- GUIDELINES FOR SUSPICION and INITIAL MEDICAL EVALUATION**  **(Revised 2021)**

**PHYSICAL ABUSE: \*\*Please request a Pediatric Surgery Consult for any patient with signs/symptoms/labs/ or imaging studies consistent with physical trauma when there is a concern for possible NAT (Pediatric Trauma Evaluation).**

**For any child presenting with signs and or symptoms of an injury consider the possibility of child maltreatment if:**

1. The history provided to explain the injury (mechanism) is not consistent with the observed injury (keeping in mind type, pattern, severity and number).
2. The history provided to explain the injury is not consistent with the child’s developmental capabilities.
3. No history is provided to explain the injury(ies) especially in a non-ambulating child.
4. The history provided to explain the injury(ies) keeps changing.
5. There has been a delay in seeking medical care for an obvious significant injury(ies).

**For bruises, bites, lacerations and burns consider location, number, and pattern. Be concerned if:**

1. Bruises are observed involving the head/face, ears, neck, frenula of lip or tongue, trunk, buttocks, genitals, upper arms, or posterior legs in any age child.
2. Bruises are observed anywhere on a non-ambulating child (“if you don’t cruise, you don’t bruise.”)
3. Bruises / marks are in a pattern suggesting contact by an object, hand or foot.
4. Bite marks especially if multiple and or in the neck, chest or genital area.
5. There are well demarcated, evenly burned parts of the body, especially if there are no splash marks.
6. There are circumferential burns.
7. There are genital burns.
8. There are patterned burns (i.e.: cigarette burns).

**For fractures, be concerned if:**

1. There is any fracture in a non-ambulating child.
2. There are multiple fractures.
3. There are rib fractures (especially posterior or lateral), a scapular fracture or vertebral fracture.
4. There are long bone metaphyseal epiphyseal fractures “CML’s” (corner fracture, buckle handle fractures) in < 2 y/o.
5. There are unexpected healing fractures.
6. There are complex and or depressed skull fractures.
7. There are fractures involving the hands or feet.

 **EVALUATION:**

Consider obtaining the following labs for all patients with exam findings suspicious for physical abuse:

1. CBC with platelets
2. PT/PTT/INR
3. ALT, AST, amylase, lipase
4. Urinalysis

Consider a hematology consult if bruising is extensive and is the major physical finding and or the family/ medical history suggests an underlying bleeding disorder.

For patients with a fracture(s) especially if this is the only injury and the child is <2years old:

1. Calcium
2. Phosphorus
3. Alkaline phosphatase
4. 25 OH Vitamin D
5. PTH

Testing for OI and or other metabolic disorders should not be sent as part of the initial evaluation without further consultation with genetics and endocrine.

Consider a urine/blood toxicology screen for any patient being evaluated for possible physical abuse with an altered mental status.

Consider the following radiologic/imaging studies in children with exam findings suspicious for physical abuse:

1. Skeletal survey for children < 2 years old.
2. Skeletal survey can be considered in children between 2-4 years of age in specific cases.
3. Specific X-rays should be done in children >5 years of age if there is concern of a fracture.
4. Head CT (non-contrast) for children < 6 months of age.
5. Head CT for children < 2 years of age with injuries to the face, head or neck and /or abnormal findings on the skeletal survey.
6. Head CT for any child with abnormal mental status, seizures, and or nonspecific sign/symptoms of increased intracranial pressure.
7. Abdominal CT for children with signs/symptoms and/or concern of blunt thoracoabdominal trauma including bruising to the abdomen or trunk.
8. Abdominal CT if elevated liver or pancreatic enzymes

**ADDITIONAL EVALUATION:**

**Social Work Consult**

Pediatric Ophthalmology Consult for a dilated retinal examination in all patients with an abnormal head CT. Timing of this evaluation is important and should take place in the first 24 hours of the hospital admission unless the patient is not stable enough for the exam.

Pediatric Neurosurgery Consult for any patient with signs/symptoms/or imaging studies consistent with abusive head trauma.

Neurology Consult for any patient with signs/ symptoms consistent with seizures.

Pediatric Orthopedic Consult for any patient requiring further evaluation and treatment of a fracture(s).

**SEXUAL ABUSE:**

A child who may have been sexually abused can present to the Emergency Department in a variety of ways:

1. The child has made a disclosure to a parent/ guardian or some other adult who brings them in for an exam.
2. The parent or guardian feels the child has been sexually abused because of behavioral symptoms the child is displaying or because of a specific sign/ symptom the child has.
3. CPS, law enforcement and or some other community agency is already involved in the evaluation for possible sexual abuse and a medical exam is being requested. In Suffolk County, CPS and or the police should not be referring a suspected case of child sexual abuse to the Emergency Department for a medical exam unless the case qualifies for forensic evidence collection at < 120 hours since the last contact. All other cases can and should be evaluated at the Child Advocacy Center (CAC).

For all cases, pre-pubertal and pubertal, where the last potential contact was > 120 hours and there are no acute symptoms relating to the anogenital or urinary tract:

1. A history should be obtained from the parent/ guardian (preferably without the child in the room)
2. The case should be reported to the appropriate investigating agency (CPS and/or police)
3. A medical examination should be set up at the CAC (can only be done through CPS or the police. Dr. J. Hopgood needs to be notified by Email or phone that a report has been made so she can track the case and make sure that CPS/ police request a medical at the CAC.). These patients do not require nor should they undergo extensive medical evaluation in the Emergency Department.
4. The child should **not** be interviewed by the medical/hospital staff regarding the alleged abuse. In Suffolk County, CPS and or the police have been specially trained to conduct the forensic interview and it is their responsibility as part of their investigation. When too many people interview a child, especially if they have no training in this type of interview, it can have a negative impact on the investigation and potentially our ability to help keep the patient safe.

For children presenting with complaints of acute genital/ anal pain, bleeding or discharge and or an acute injury involving the genital/ anal area, a medical examination to assess and address any acute medical injuries/ problems should be done. If there is concern/ suspicion of abuse, the case should be reported to the appropriate agency. Dr. J. Hopgood is available for phone consultation 24/7.

For cases of possible sexual abuse presenting within the first 120 hours since the last potential incident, a S.A.N.E. evaluation should be requested. Stony Brook is a S.A.N.E. site (the others in Suffolk County are Peconic Bay, L.I. Community Hospital and Good Samaritan Hospital). A S.A.N.E. examination should be done (when possible) for children less than 12 years old **AFTER** the police and CPS (if involved) have obtained a forensic history from the patient. Patients 12 years of age and older have the right to consent to post sexual assault care without police or parental involvement according to the mature minor’s rights law as long as the specific case does not also constitute CPS involvement. Therefore, involvement of police for patients 12 years of age and older will need to be determined on a case by case basis.

All children who have a S.A.N.E. evaluation done with police involvement will also have a medical follow-up set up for them at the CAC with Dr. J. Hopgood

**In all cases where there is a suspicion of child abuse:**

1. A report needs to be made by you to the New York State Central Registry (SCR) on the mandated reporter’s line at **1-800-635-1522.** This can be done with the help of social work who can serve as your consultant throughout the reporting process. Ultimately you are legally responsible for making sure the report was made.
2. Social Work needs to be notified of all possible cases of Child Maltreatment. The appropriate paper work, Form L-DSS-2221-A (available on-line via the intranet page- Access by clicking resources A-Z- look under the letter “C” and click on Child Abuse), needs to be completed by the mandated reporter and delivered to the main Social Work Office on Level 1 of the Hospital, Room 717, within 24 hours or given to the ADN to forward.
3. Dr. Jillian Hopgood is available 24/7 (except when on vacation) for phone consultation on all cases of possible child maltreatment. For cases not requiring admission to the hospital, please call or E-mail Dr. Hopgood with information regarding the case so she can keep track of the case, communicate with CPS and or law enforcement and make sure appropriate follow-up for the patient is scheduled when indicated at the Child Advocacy Center (CAC).